



# LEGAL ENVIRONMENT ASSESSMENT FOR HIV AND AIDS IN UGANDA

UGANDA AIDS COMMISSION

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## **Disclaimer**

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## List of Acronyms

AAAQ	Availability, Accessibility, Affordability, and Quality
ACFODE	Action for Development
ADPs	AIDS Development Partners
AGYW	Adolescent Girls and Young Women
AIS	AIDS Indicator Survey
AMICAALL	Alliance of Mayors and Municipal Leaders' Initiative for Community Action on AIDS at the Local Level
ANC	Antenatal Care
APN	Assisted Partner notification
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
CDC	Centers for Disease Control
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CEHURD	Centre for Health, Human Rights and Development
CRPD	Convention of the Rights of Persons with Disabilities
CSO	Civil Society Organisation
CSSA	USAID/Uganda Civil Society Strengthening Activity
DGF	Democratic Governance Facility
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DOD	Department of Defence
DSD	Differentiated Service Delivery
EMTCT	Elimination of Mother to Child Transmission of HIV
EOC	Equal Opportunities Commission
EWMI	East-West Management Institute
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FOWODE	Forum for Women in Democracy
FSW	Female Sex Workers
GBV	Gender-Based Violence
HCIV	Health Centre Level Four
HCT	HIV Counselling and Testing
HEPS	Coalition for Health Promotion and Social Development
HIV/AIDS	Human Immunodeficiency Virus Acquired Immunodeficiency Syndrome
HIVPCA	HIV Prevention and Control Act
HRAPF	Human Rights Awareness and Promotion Forum
HRBA	Human Rights-Based Approach
ICWEA	International Community of Women Living with HIV Eastern Africa
IDI	Infectious Diseases Institute
IEC	Information, Education, and Communication
ILO	International Labour Organisation
IRCU	Inter-Religious Council of Uganda
JLOS	Justice, Law and Order Sector
KII	Key Informant Interview
KVPs	Key and Vulnerable Populations
LEA	Legal Environment Assessment

LGBTI	Lesbians, Gays, Bisexual, Transgender, and Intersex
LSDA	Local Service Delivery for HIV and AIDS Activity
MARPI	Most at Risk Populations Initiative
MARPs	Most at Risk Populations
MAT	Medically Assisted Therapy
MoGLSD	Ministry of Gender, Labour, and Social Development
MoH	Ministry of Health
MSM	Men who have Sex with Men
NAFOPHANU	National Forum of People Living with HIV/AIDS Networks in Uganda
NSP	National Strategic Plan
OPM	Office of the Prime Minister
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PNFP	Private, Not-for-Profit
PrEP	Pre-Exposure Prophylaxis
PWD	Persons with Disabilities
PWUD	People Who Use drugs
PWUID	People Who Use and Inject Drugs
RHITES	Regional Health Integration to Enhance Services
RMNCAH	Reproductive, Maternal, New-born, Child, and Adolescent Health
SBCC	Social and Behaviour Change Communication
SCE	Self-Coordinating Entity
SMC	Safe Male Circumcision
SMUG	Sexual Minorities Uganda
SNS	Social Networking Services
SOPs	Standard Operating Procedures
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TASO	The AIDS Support Organisation
TRIPS	Trade-related Aspects of Intellectual Property Rights
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UGANET	Uganda Network on Law, Ethics and HIV/AIDS
UHRC	Uganda Human Rights Commission
UHRN	Uganda Harm Reduction Network
ULRC	Uganda Law Reform Commission
UNCST	Uganda National Council for Science and Technology
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UPHIA	Uganda Population-based HIV Impact Assessment
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASO	Uganda Network of AIDS Service Organisations
UNODC	United Nations Office on Drugs and Crime
UNYPA	Uganda Network of Young People Living with HIV/AIDS

USAID	United States Agency for International Development
UWONET	Uganda Women's Network
VCT	Voluntary Counselling and Testing
VHT	Village Health Team
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation
WLHIV	Women Living with HIV
WONETHA	Women's Organisation Network for Human Rights Advocacy
YAPS	Young People and Adolescent Peer Support
YLP	Youth Livelihood Program

## Foreword

Uganda has made tremendous progress in the fight against HIV and AIDS over the last four decades. During the past decade the national HIV response registered significant progress in reducing new HIV infections as well as AIDS-related morbidity and mortality in most population groups. This achievement is attributed to various factors, including strong and exemplary national political leadership, the implementation of combination HIV prevention strategies with support from our partners, and a multi-sectoral approach that tackles HIV and AIDS as both a public health problem and a developmental challenge affecting all sectors of the economy.

The Government of Uganda remains committed to the goal of ending AIDS as a Public Health threat by 2030. Despite this commitment and the registered successes, the burden of HIV remains huge with some population subgroups affected more than others. Uganda is among three countries in sub-Saharan Africa and 22 countries globally with the highest HIV prevalence. This is attributed to prevalent and significant levels of inequity, with several population groups failing to access and benefit optimally from the national HIV response. As articulated in the National HIV and AIDS Strategic Plan (NSP) 2020/21–2024/25), the factors responsible for the inequity include prevalent stigma, discrimination, or violence against several population groups, including people living with HIV (PLHIV), Key and other vulnerable population groups, in addition to long-standing factors like gender inequality, poverty and harmful cultural norms. Consequently, the pivotal priority of the National HIV and AIDS Strategic plan (NSP) is to identify and address the challenges and needs of the left-behind population groups to ensure the country gets on track to end AIDS as a public health threat. Creating a conducive legal and policy environment for an effective HIV response is one way of addressing the prevailing inequity which is prioritised in the NSP.

Uganda's laws allow equal access to, and provision of, HIV services to all members of the population. However, at the same time, the country's legal landscape has aspects that constrain an effective HIV response, as analysed and presented in this report. The Uganda AIDS Commission is grateful to all stakeholders including the Justice, Law, and Order Sector (JLOS), because, as we slowly learned and shared experiences of the negative effect of some of the national laws and policies on the HIV response, we received support and understanding, and the laws were implemented judiciously to allow for the implementation of a vibrant Public Health HIV response. Consequently, we have been able to provide access to HIV prevention, care, and treatment services to special population groups such as People Who Inject Drugs (PWIDs) or sex worker-groups whose conduct is unlawful under the laws of Uganda. However, relying on the goodwill and understanding of a few government officials or judicial/legal/law enforcement officers is not a sustainable way to guarantee attainment of the national commitment of ending AIDS as a public health threat. Notwithstanding this goodwill, several members of such population groups have been left behind by the national HIV response due to the prevailing legal and policy environment as detailed in this report.

Hence, with less than 10 years to the landmark year of 2030, the national HIV response is committed to employing every feasible evidence-based tool and strategy to get the country on track to realise its commitment of ending AIDS as a public health threat. It is time to take concrete steps to address all causes of HIV-related inequity, including creating an enabling environment for a successful HIV response, with particular focus on addressing the legal and policy barriers to access services for at-risk and vulnerable groups, as articulated in this report.

I call upon our national leaders and all stakeholders whose vision and work has earned us the achievements we boast of today, to support the national HIV response by promoting evidence-informed and human rights-based HIV control programmes, by addressing the identified legal and policy barriers that negatively affect HIV prevention, care, and treatment services, demand access, uptake, and adherence, as presented in this report. It is the only sure way to guarantee an end to HIV-related inequity in Uganda and to get on track to end AIDS as a public health threat by 2030.

Lastly, I take this opportunity to register my sincere and deepest gratitude to all our stakeholders, especially the AIDS Development Partners who have made it possible for us to offer high-quality and dignified services for HIV prevention, care and treatment services for our fellow countrymen and women. I thank the U.S. President's Emergency Plan for AIDS Relief through the United States Agency for International Development for the financial support, and USAID/Uganda Civil Society Strengthening Activity (CSSA) for the technical assistance that enabled this legal environment assessment for HIV and AIDS in Uganda to be conducted.

For God and my country.

A handwritten signature in black ink, appearing to read 'Eddie Mukooya Sofuluya', written in a cursive style.

**Dr Eddie Mukooya Sofuluya**

**CHAIRMAN, UGANDA AIDS COMMISSION**

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# EXECUTIVE SUMMARY

## Introduction and Objectives

This is a report of a Legal Environment Assessment (LEA) for HIV & AIDS in Uganda, conducted by the USAID/Uganda Civil Society Strengthening Activity (CSSA). Uganda is widely credited for its success in reducing the adult HIV prevalence from 18% in 1992 to 6.2% in 2016 and 5.5% in 2020<sup>1</sup>. Yet HIV continues to pose a significant health and developmental threat to the country, with high rates of prevalence among particular groups such as adolescent girls and young women, key, and priority populations, and less than optimal enrolment of people living with HIV (PLHIV) into care and treatment. While the Government of Uganda is committed to the goal of ending AIDS as a public health threat by 2030, there is also increasing recognition that this goal cannot be achieved unless the country addresses structural barriers such as legal impediments, and issues such as human rights, stigma, discrimination, gender inequality and gender-based violence.

This report is based on data collected during the period July 2021 to February 2022.

The main objective of the LEA was to assess the extent to which existing laws, regulations, and policies enable, or constrain, key protections for those affected by HIV in Uganda. The specific objectives were:

- (i) To identify all relevant laws, policies, and strategies that affect, positively or adversely, the successful, effective, and equitable delivery of HIV prevention, treatment, care, and support services to people living with HIV (PLHIV) and HIV-affected persons.
- (ii) To assess the key human rights issues affecting PLHIV, key and vulnerable populations (KVPs) and the extent to which these issues are addressed by the current legal and policy framework.
- (iii) To assess the availability, accessibility, and affordability of interventions that promote rights of PLHIV, and other people affected by, or at risk of, HIV in Uganda and how these are affected by the legal and policy frameworks.
- (iv) To analyse the extent to which PLHIV and those affected by, or at risk, of HIV in Uganda are aware of existing legal frameworks and support systems to access services, as well as mechanisms to enforce their rights.
- (v) To provide recommendations for the creation of an enabling legal, social, and policy framework to eliminate HIV-related stigma, discrimination, and violence against people living with, affected by, or at risk of, HIV in Uganda.

## Conceptual Frameworks and Methodology

This assessment drew from two conceptual frameworks, namely:

- (i) The human-rights approach to HIV response; and

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<sup>1</sup> Ministry of Health (MoH). *Release of Preliminary Results of the Uganda Population Based HIV Impact Assessment (UPHIA)* Kampala, 2022.

- (ii) The Socio-Ecological model that situates the legal and policy environment within the broader Socioecological environment.

The LEA was conducted using a qualitative approach, with data collected through an extensive desk review, 78 key informant interviews, 32 focus group discussions (FGDs), 12 in-depth interviews with PLHIV, and consultative workshops with stakeholders in the HIV and AIDS response and relevant human rights sectors. Primary data were collected from a regionally representative sample of ten districts.

Study participants included policy makers, service managers, service providers, Civil Society Organisation (CSO) leaders, service users (including PLHIV, key and vulnerable populations such as women, teenage mothers, people with disabilities), and staff from AIDS Development Partners (ADPs).

## Key Findings

### ***Laws, Policies, and Strategies that positively or adversely affect the delivery and utilisation of HIV services by PLHIV and HIV-affected persons***

Uganda subscribes to, and is a signatory to, several international human rights instruments that create the legal obligation to respect the various rights of all persons, including specific marginalised and vulnerable groups such as PLHIV.

In addition, Uganda has an extensive legal regime. Ugandan laws, particularly primary laws such as the Constitution of the Republic of Uganda and the HIV Prevention and Control Act of 2014 (HIVPCA), are largely positive and enabling in scope, assuring non-discriminatory and equal provision of, and access to, services for all. Moreover, Ugandan laws do not prohibit anybody from providing or accessing HIV services.

However, at the same time, aspects of the Ugandan legal landscape adversely affect or constrain an effective HIV response. These constraining aspects can be summarised as follows:

- (i) HIVPCA Sections 41 and 43 criminalises attempted transmission of HIV, and intentional transmission of HIV respectively, thus discouraging HIV testing and the disclosure of positive test results. Intention to transmit HIV is difficult to prove in situations where people may not know their HIV status, a point acknowledged by an informant from the Office of The Director of Public Prosecutions. Further, the fact that pregnant women are subjected to routine testing during antenatal visits means that the criminal provisions of the Act are likely to affect women disproportionately. The law also increases HIV stigma and has been unfairly used against PLHIV to deny them a fair hearing or their right to trial. Focus on the HIV status of the accused tends to overshadow other factors that should be taken into consideration when determining the case at hand.
- (ii) HIVPCA Section 18 (2) allows a health worker to disclose HIV test results to a third party without the consent of the affected person, thus violating their right to privacy and potentially discouraging people from testing for HIV if they think their results may be disclosed to third parties without their consent. Releasing HIV test results to another person without the consent of the client may also result in stigma or violence against the client.

- (iii) HIVPCA Section 13 (b) provides for routine HIV testing of a pregnant woman, and Section 13 (c) provides for routine HIV testing of a partner of a pregnant woman. However, health workers routinely make it appear mandatory for pregnant women and their partners to be tested for HIV, with or without their consent. This has the effect of violating their right to privacy and autonomy and discourages people from visiting health facilities.
- (iv) Uganda's Penal Code Act (PCA) Sections 136–139 criminalise sex work and other activities associated with 'prostitution' with the effect of unfairly targeting KVPs and exposing them to arbitrary arrest and mistreatment by law enforcement, while male clients rarely receive the same treatment. The harassment of sex workers has the effect of increasing societal stigma towards them, denying them the livelihood, which is their only source of income, driving them 'underground' and keeping them away from health and justice support services.
- (v) PCA Section 145 criminalises "Unnatural offences" such as (a) "having carnal knowledge of any person against the order of nature;" - generally understood to refer to same-sex conduct, even when consensual. Section 145 permits the persecution, and denial of the human rights of, gay, lesbian, and transgender persons.
- (vi) PCA Sections 167 (Idle and disorderly Persons) and 168 (Rogues and Vagabonds) give law enforcers undue authority to arbitrarily arrest, harass, or violate the rights of PLHIV and KVPs.
- (vii) The Narcotic Drugs and Psychotropic Substances Control Act (2016) criminalises drug possession and use, thereby ignoring the vulnerability of people who use drugs and framing them as criminals. This has the effect of limiting the range of social and medical interventions available to them, discouraging them from seeking care, increasing social stigma towards them, fuelling the likelihood of arbitrary arrest by law enforcers, and perpetuating risky injecting practices such as the sharing of needles, thus contributing to the further spread of HIV.

While Uganda does not explicitly legislate against, or on the basis of gender identity or sexual orientation, Ugandan laws which criminalise sex work, sexual relations between people of the same sex, and drug possession and use, serve to reinforce social stigma and fuel cruel treatment or harassment of the affected persons, either PLHIV or people at risk of HIV infection, depriving them of their human rights to liberty, physical integrity, freedom of association, and good health. In turn, the resulting social stigma discourages these groups from access to HIV prevention, treatment, social support, and justice support services. Some offences under existing laws are either overly broad or, if applied, are likely to be discriminatory against PLHIV and KVPs.

Uganda's current legal situation thus presents a fundamental contradiction in that a primary source of law such as the Constitution guarantees the rights and freedoms of all citizens, while secondary legislation has the effect of annulling those same rights. Uganda has enacted wide-ranging policies and strategies on HIV and AIDS embracing almost every aspect of the epidemic and its associated impacts. These policies and strategies address both the general population as well as specific population groups and include the:

- The National HIV and AIDS Strategic Plan 2020/21–2024/25 (2020)
- Presidential Fast Track Initiative on Ending AIDS in Uganda (2020)
- National HIV Testing Services Policy and Implementation Guidelines Uganda 4<sup>th</sup> Edition (2016)
- National Comprehensive Condom Programming Strategy & Implementation Plan 2020–2025
- Consolidated Guidelines for the Prevention and Treatment of HIV and AIDS in Uganda (2020)

- National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 3<sup>rd</sup> Edition (2012)
- National Action Plan on Women, Girls, Gender Equality, and HIV and AIDS 2016/17–2020/21 (NaWoGGE)
- Leaving No One Behind: A National Plan for Achieving Equity in Access to HIV, TB, and Malaria Services in Uganda 2020-2024 (2019)
- Harm Reduction Guidelines (2020)
- The National HIV Priority Action Plan for Key and Priority Populations 2020/2021-2022/2023
- National Policy Guidelines on Ending HIV Stigma and Discrimination 2020

These policies and strategies are mainly progressive, in theory enabling service delivery and access to all, even the criminalised and outlawed communities of key populations such as sex workers and drug users, excepting policies relating to: (i) consent for HIV testing; and (ii) access to sexual and reproductive health (SRH) services for people under the age of 12 years requiring parental consent, such as the HIV Testing Services Policy (2016).

However, there are also gaps, such as specific policies for provision of HIV services in prison settings. Similarly, existing policies pay little attention to men's issues, give no attention to the increasing number of people aging with HIV (PLHIV get to live longer as a result of ART), and are silent on some KPs groups such as transgender or intersex persons thus creating legal invisibility of such populations in planning and resource allocation.

Other policies, such as the Investment Case/Revised Sharpened Plan for RMNCAH<sup>2</sup> (2016), and the National Adolescent Health Policy (2004), fail to recognise some KVPs such as transgender persons or PWUIDs and their specific vulnerabilities, thus rendering them invisible which prevents their being prioritised for HIV services targeting.

Government policies and guidelines, such as the Sexuality Education Framework and Guidelines for the Prevention and Management of Teenage Pregnancy in School Settings, have yet to be embraced by all and there is a need to build stakeholder consensus around them.

We noted some apparent contradictions between existing laws and policies. Whereas there are very good and well-intentioned policies covering such aspects as 'Test and Treat,' Elimination of Mother to Child Transmission of HIV (EMTCT), or universal access to care and treatment, in practice, the good intentions of these policies are watered down by laws which make it dangerous for the targeted groups to make use of them.

The policies are based on the assumptions of a public health approach that actions such as testing for HIV, knowing one's HIV status, disclosure to the partner, or immediate enrolment for treatment, are good for all. Yet the effect of some punitive laws is that those who suspect they may be HIV positive may fear to test, and those who do test positive for HIV may hesitate to disclose their status to their partners, for fear of being accused of transmitting HIV, losing their relationship or their livelihood.

The result is that some choose not to disclose their HIV status, enrol for treatment, or maintain their care regimen. Thus, in the context of laws currently in force, day-to-day realities may lead some to

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<sup>2</sup> RMNCAH stands for Reproductive, Maternal, Newborn, Child and Adolescent Health.

prioritise their relationships or their livelihoods over HIV testing, disclosure, and treatment with antiretroviral therapy (ART). Many may have no choice but to avoid treatment and other HIV services to safeguard their relationships and their livelihoods in the short to medium-term.

Overall, there has been progress over the last 5-10 years in gaining better recognition and acceptance, both from communities and government institutions, of the KVPs at risk of HIV. This is evident in the fact that many KVPs now associate freely, have formed groups or organisations, and are mobilising their peers. KVPs are invited to, and attend, national and sub-national, and international meetings and events alongside government officials. The harassment they faced from law enforcement a decade ago appears to have reduced. As a result, more KVPs are receiving services, and the services designed for them have expanded in coverage.

The opening of the Medically Assisted Therapy (MAT) Centre in Butabika Hospital, a government national referral hospital in Kampala that treats drug addicts, and the formulation of Harm Reduction Guidelines by the Ministry of Health (MoH) are key milestones in implementing a Harm Reduction approach, despite the continued criminalisation of drug use.<sup>3</sup>

### *Key human rights issues affecting PLHIV and KVPs*

While Uganda has laws and many policies that assure non-discrimination and equality in access to services (as detailed above), some laws contain punitive or restrictive clauses that have the effect of discriminating against certain categories of vulnerable and/or at-risk population groups, thus creating barriers to access services. Both laws and policies generally respect patient privacy and confidentiality in service delivery settings. However, clauses such as HIVPCA Section 18(2) permit health care workers to disclose HIV test results to a third party, eroding patients' rights to privacy and confidentiality.

Respect for personal dignity and autonomy are equally enshrined in Ugandan laws. In practice, however, PLHIV and KVPs such as sex workers, PWUDs, and LGBTI persons, are frequently denied their rights and/or are stripped of their personal dignity, due to police harassment stemming from the criminalising provisions in the Penal Code and other laws.

Despite this, the results of this LEA show that, in line with the human rights-based approach (HRBA) or framework, the overall availability, accessibility, acceptability, and quality of services for HIV and AIDS in Uganda has improved over the last five to ten years. Service coverage has expanded generally, and particularly for KVPs. Differentiated service delivery models have been adopted which have increased the accessibility of services to at-risk population categories such as PLHIV, people with disabilities, and KVPs. This shift in approach has been particularly important during the COVID-19 lockdowns when travel restrictions were in place.

Furthermore, most service providers now actively involve beneficiary groups, while a more systematic mechanism for monitoring services, known as Community Led Monitoring (CLM), is being implemented by a consortium of CSOs, with support from PEPFAR.

However, as yet there is no universal provision of services tailored to particular groups such as adolescent girls and young women (AGYW) or KVPs, as these are often donor dependent, or only exist in some parts of the country. Tailored services are also still lacking in settings such as prisons. The

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<sup>3</sup> Narcotic Drugs and Psychotropic Substances Control Act (2016).



overall quality of services is generally good, though full provision of all services is not yet available. Gaps in provision include inadequate counselling services; unstable supplies for condoms, lubricants and STI drugs; challenges in referral systems; and the inadequacy of services accessible to persons with disability, or school children living with HIV. Access to services is also still hampered by stigma, both external and internal. There are also concerns about sustainability of services given current low levels of financing locally.

### *The Legal and Policy Framework and the availability, accessibility, and affordability of interventions that promote rights of PLHIV and people affected by, or at risk of, HIV*

Uganda has implemented several interventions (and others are ongoing) to promote the rights of PLHIV in their diversity. These have included specific stigma reduction activities, such as community sensitisation, stakeholder dialogue and training sessions championed by government ministries, departments, and agencies, as well as CSOs, religious and cultural institutions.

The success in attracting and mobilising the interest and commitment of these diverse actors to fight HIV stigma and discrimination is commendable. Relevant policies to combat stigma have been developed to guide the work of different actors, exemplified by the launch of 'Policy Guidelines on Ending HIV Stigma' by the Uganda AIDS Commission (UAC) in October 2021.

Government and partners have conducted training of health workers to equip them with necessary knowledge, attitudes, and skills to provide services that are welcoming and accessible to PLHIV, KVPs, and other target groups, such as adolescents and young people. However, more training is required to improve disability-friendly services. Training is also still skewed towards donor-funded programs or specific geographical areas, with only limited activity in non-prioritised areas.

Efforts are ongoing to sensitise and engage law makers and law enforcement officials, as well as political, cultural, and religious leaders. Efforts have also been made to improve legal literacy, human rights awareness, and access to legal to the general community, PLHIV, and diverse key and vulnerable groups such as widows, orphans, sex workers, and persons with disabilities. These are also dependent on donor support, with resulting limits in coverage.

Finally, advocacy for reform of constraining laws is ongoing through the efforts of an active CSO coalition, who have also undertaken strategic litigation, scoring some successes.

### *Awareness of existing legal frameworks and support systems among PLHIV and KVPs*

There is limited awareness among PLHIV regarding their rights and the existing support mechanisms available to them. This constrains individual agency and ability to seek redress when their rights are violated. Awareness is higher among those who have been sensitised, trained, or exposed in other ways, such as those working as expert clients or community health workers.

For many PLHIV, they as individuals lack the knowledge, ability, and resources to defend their rights and to pursue justice when their rights have been violated. Women, girls and KVPs do not have control over resources that could enable them to pay for the services of a lawyer. Issues, such as domestic and intimate partner violence, expose them to great risks of contracting HIV and AIDS with little or no mitigation or redress. The situation is made more difficult for them when violators are family members,

neighbours, or health workers in their community, whom they would not want to antagonise. These vulnerabilities may require greater support from peers or from CSOs to defend and claim their rights.

## Best Practices

The best practices in contributing to a better legal and policy environment in Uganda identified by this assessment include:

- (i) Meaningful inclusion of PLHIV, key populations and vulnerable populations;
- (ii) Engagement with duty bearers<sup>4</sup>, service providers, and other key stakeholders;
- (iii) Assisting with access to legal and justice support services;
- (iv) Working with and/or through community-based volunteer workers;
- (v) Equipping health workers to integrate rights-based approaches; and
- (vi) Integration of medical, legal and psychosocial services.

## Recommendations

	<i>Issue</i>	<i>Recommendation</i>	<i>Responsible (Lead Agency in bold)</i>
<b>I</b>	<b><i>The Penal Code Act</i></b>		
I.1	<p>Sections 136–139 criminalise sex work.</p> <p>Section 145 criminalises same sex relationships.</p> <p>These provisions fuel stigma towards sex workers, MSM, transgender and other LGBTI people, providing a basis for police harassment, and discouraging service utilisation.</p>	<p>Review and repeal these sections of the law to decriminalise sex work and same sex relationships.</p>	<p><b>Uganda Law Reform Commission,</b> Parliament, Ministry of Justice &amp; Constitutional Affairs</p>
I.2	<p>Provisions in Sections 142 and 143 of the Penal Code Act and Article 22 of the Constitution of Uganda present contradictions on the issue of abortion. MoH guidelines on abortion were suspended.</p>	<p>Harmonise the legal provisions on abortion and decriminalise abortion in order to give women access to safe abortion services, guarantee autonomy and decision-making power over their reproductive lives</p>	<p><b>Uganda Law Review Commission,</b> MoH, Parliament</p>

<sup>4</sup> Human Rights Legal Term, of duty-holder, for those with a duty to uphold human rights, usually the government, sometimes individuals or corporations.

1.3	Provisions criminalising idle and disorderly found in sections 167 to 169 are overly broad, vague, and unfairly affect the poor, the marginalised and those castigated as social outcasts and misfits. These unnecessarily crowd prisons and affects PLHIV uptake of HIV services.	<p>Repeal these sections because they are archaic, out-dated, and no longer serve the purpose for which they were created.</p> <p>Uganda Police Force and the DPP should desist from charging and prosecuting individuals with these provisions.</p>	<p><b>Uganda Law Reform Commission, Parliament, Uganda Police Force, The Director of Public Prosecution</b></p>
<b>2</b>	<b><i>The HIV Prevention and Control Act</i></b>		
2.1	Section 41 of the HIV Prevention and Control Act, 2014 criminalises attempted and intentional transmission of HIV. This is being challenged in the constitutional court.	Repeal or expunge this section from the law.	<p><b>Uganda Law Review Commission, Parliament, Ministry of Justice &amp; Constitutional Affairs</b></p>
	This HIV-specific law portrays PLHIV as worse than HIV negative, ignoring vulnerability and having the potential to create bias in legal proceedings. The HIV status of the accused may arouse stigma or overshadow other facts that should be of greater consideration in determining whether there is a case to answer.	Prosecute HIV-related cases such as those relating to intentional transmission of HIV under general criminal law, not HIV-specific laws.	<p><b>Judiciary, DPP, Police</b></p>
2.2	Section 13 (B & C) of the HIV Prevention and Control Act provide for routine HIV testing for pregnant women, which is interpreted as mandatory in some cases, depriving them of their autonomy in decision making, and their right to consent.	Reform the law to make it explicit that pregnant mothers should only be tested upon giving consent, after receiving full information from health care providers.	<p><b>Uganda Law Review Commission, Parliament, MoH</b></p>
2.3	Section 18(2) of the HIV Prevention and Control Act allows a health worker to disclose HIV test results to another person without	Reform the law to remove the provision for a health worker to disclose results to a third party without the consent of the client; instead support the process of disclosure by the client himself/herself.	<p><b>Uganda Law Reform Commission, Parliament</b></p>

	consent of the client, hence eroding their right to consent.		
<b>3</b>	<b><i>The Narcotics Drugs and Psychotropic Substances Control Act</i></b>		
3.1	The Narcotic Drugs and Psychotropic Substances Control Act (Sections 4–6) criminalises drug possession, trafficking, and use, thereby fuelling stigma against people who use drugs, discouraging service utilisation, and relegating them to use of risky injecting practices.	A harm reduction approach to dealing with drug use should be fully embraced, with the provision of a minimum service package for harm reduction as recommended by the WHO. Use Narcotics law to provide preventive and harm reduction services to PWUDs and PWIDs.	<b>UAC, MOH, UN-Human Rights, UNODC, UNDP, ULRC</b>
<b>4</b>	<b><i>Other Access to Justice Issues</i></b>		
4.1	Several pieces of legislation criminalise and punish behaviours of PLHIV and KVPs in a manner likely to fuel stigma and curtail service utilisation.	Parliament should desist from passing laws that do not conform to the standards of human rights in the International Human Rights principles.  Parliament should repeal all provisions that promote stigma against persons living with HIV.	<b>Parliament</b>
		Strengthen advocacy for effective policy and legal reform, and political environment.	<b>CSOs, ADPs</b>
4.2	The enactment of laws takes a very long time.	Fast track the enactment of laws including the National Health Insurance Scheme Bill 2019, and the Public Health (Amendment) Bill, 2021 which seeks to amend the Public Health Act Chapter 281.	<b>Parliament</b>
4.3	Actors in The Access to Justice Programme of Government such as the judiciary, the DPP are well positioned to improve the legal environment and support an equitable and effective HIV response.	The judiciary should cease prosecuting cases under the HIVPCA to eliminate stigma against PLWHIV.  Continue to strengthen the capacity of the judiciary, DPP and other actors to support the HIV response.	<b>DPP, Judiciary, UAC, MoH, MGLSD, Ministry of Justice &amp; Constitutional Affairs, CSOs, ADPs</b>
<b>5</b>	<b><i>Law Enforcement</i></b>		
5.1	Violence and harassment from law enforcement officials towards KVPs violates the latter's personal dignity and has the potential to keep	Police services should ensure that PLHIV, key populations and other vulnerable persons are not subject to harassment, violence, or rights violations by law enforcers; and should ensure that the	<b>Uganda Police, Courts of Law</b>

	them away from service utilisation.	rights of suspects are respected and protected.	
		Law enforcement officials that violate the rights of PLHIV should bear personal liability in addition to vicarious liability by the government for violence and violations of the rights of PLHIV.	<b>Courts of law, Police, DPP</b>
		PLHIV and other vulnerable groups who suffer rights violations should have access to judicial and administrative remedies, which must be adequate, effective, and prompt.	<b>The Judiciary &amp; all courts</b>
5.2	<p>PLHIV arrested under different charges are often denied access to HIV/AIDS treatment, leading to poor adherence.</p> <p>Further, those arrested and charged with sexual offences are automatically subjected to a mandatory HIV testing and anal examination, in case one is gay, MSM or transgender.</p>	<p>Pre-trial detention centres such as police cells should provide an environment for PLHIV to continue with their medication in order to avoid non-adherence or relapse.</p> <p>The mandatory testing in sexual offences related cases increase stigma against PLHIV in circumstances when HIV is an aggravating factor.</p> <p>Desist from subjecting some KVPs to dehumanising anal exams and tests that are of no evidential value.</p>	<p><b>Uganda Police Force, Ministry of Internal Affairs</b></p> <p>Uganda Police Force, Judiciary, DPP</p>
<b>6</b>	<b>Community Norms &amp; Practices</b>		
	Some of the stigma and discrimination as well as violence against PLHIV, KVPs, and vulnerable groups are rooted in community norms and practices.	Scale up engagements in communities with cultural, religious, political, and other community leaders at different levels to create awareness about PLHIV rights, change attitudes, and influence norm transformation.	<b>MGLSD, UAC, CSOs</b>
<b>7</b>	<b>HIV related Policies</b>		
	Some policies, while providing enabling conditions, do not mention all categories of key populations, rendering them invisible.	Undertake policy reform to ensure inclusivity of KVPs using more explicit language that specifies all the vulnerable and key population groups as target groups for HIV and AIDS services.	<b>MoH, UAC</b>
<b>8</b>	<b>Service Issues</b>		
8.1	PLHIV-friendly services are still limited and not accessible to all in need.	Scale up the coverage of friendly and accessible services/practices including differentiated services for adolescents and young people, persons with disability, men	<b>MoH, ADPs, IPs</b>

		living with HIV, and other vulnerable groups.	
8.2	Much of the on-going work to promote and protect the rights of PLHIV is not to scale, dictated by available donor funding.	Invest more resources in building an enabling environment to bring interventions to scale.	<b>UAC, MoH, MGLSD, MoFPED, ADPs</b>
8.3	HIV services in prisons settings are not tailored to existing inmate prison profiles and health burden.	Reform prisons HIV services to include, or link to, services for mental health, trauma management, skin infection etc. Infrastructure and human resources should also be accordingly aligned. Develop guidelines for HIV services provision in prison settings.	<b>MoH, Uganda Prisons Services, ADPs</b>
8.4	HIV has made new demands, and put additional workload on, health workers. There are no counsellors in health facilities and other HIV service outlets.	Upgrade the staffing norms in health facilities to provide for more health workers; include a position of counsellor for all health facilities that provide HIV services, especially those providing ART.	<b>MOH</b>
8.5	HIV stigma is still prevalent in all settings, and in healthcare settings stigma discourages service utilisation by PLHIV and KVPs.	Scale up interventions for stigma reduction in communities, health facilities, workplaces, schools, and all settings.	<b>MGLSD, MOH, UAC, all actors</b>
		Scale up interventions that identify and work with Champions to address stigma and discrimination, SGBV, and other rights violations.	<b>MGLSD, UAC, CSOs</b>
		Provide skills and empower vulnerable communities to demand better services and hold service providers and duty bearers accountable.	<b>MoH, UAC, IPs, ADPs, KP-led CSOs, UKPC, PLHIV-led CSOs</b>
		Continue to train health workers to provide friendly HIV services to KVPs to create a critical mass of HIV-competent health workers.	<b>MoH, UAC, IPs, ADPs, KP-led CSOs, UKPC, PLHIV-led CSOs</b>
		Develop a harmonised and standardised curriculum for training health workers, judicial officers, police officers, and other relevant professionals in providing PLHIV, KVPs, PP, PWUD, and any other vulnerable population, friendly and accessible services. Integrate human rights, gender equality, and stigma reduction into pre-service and in-service curricula of institutions that train these professionals.	<b>MoH, IPs, ADPs, KP-led CSOs, UKPC, PLHIV-led CSOs</b>

8.6	The pre-existing needs and vulnerabilities for PLHIV and vulnerable groups have been worsened by the COVID-19 pandemic and the associated lockdowns.	Scale up provision of comprehensive care packages targeting different PLHIV groups and vulnerable populations, including young mothers.	<b>MoH, IPs, ADPs, MGLSD</b>
		Engage strongly with all school stakeholders to improve the environment to accept and welcome the young mothers to continue their education.	<b>MOES, MGLSD, IPs, CSOs</b>
		Undertake stakeholder engagements to resolve issues around the Sexuality Education Framework, the School Health Policy, and the Guidelines for the Prevention and Management of Teenage Pregnancy in School Settings.	<b>MOES, MGLSD, UNICEF, UNFPA, UNESCO, FBOs</b>
<b>9</b>	<b><i>Stigma and Discrimination in Employment</i></b>		
	PLHIV face discrimination in access to employment as a result of employer policies and practices such as those in uniformed services and other agencies that have mandatory HIV screening during recruitment.	Reform policies and practices in recruitment to remove mandatory HIV screening. Instead, encourage voluntary HIV testing and support this with appropriate counselling.	<b>MGLSD, UAC, Uganda Police, Uganda Prisons, Uganda People's Defence Forces</b>
<b>10</b>	<b><i>HIV Commodities and Supplies</i></b>		
	Procurement and availability of condoms, lubricants, and drugs for treatment of STIs are not stable and dependent on donor funding.	Government should ensure procurement and availability of commodities that reduce the risk of transmission of HIV and other STIs such as condoms and lubricants, as well as harm reduction for PWUD, such as supply of opioid substitution therapy and syringes.	<b>MoH</b>
<b>11</b>	<b><i>Monitoring and Tracking Progress in the Legal Environment</i></b>		
	Implementation of these recommendations and other actions aimed at improving the legal and policy environment should be tracked. Existing M&E systems are not adequate.	Strengthen the monitoring of progress in improving the legal and policy environment; include indicators in the NSP, NPAP, and M&E Framework, and strengthen mechanisms for data collection regarding these indicators.	<b>UAC, MoH, ADPs</b>
<b>12</b>	<b><i>Financing Interventions to Improve the Legal and Policy Environment</i></b>		
	Current HIV financing is inadequate and unsustainable.	Increase donor and in-country funding sources for sustainable HIV financing; and strengthen gender-responsive budgeting.	<b>UAC, MoH, MoLG, MoFPED, ADPs, Districts</b>

		Leverage the Parish Development Model (PDM) as a channel for strengthening the HIV response at the community level.	
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# I INTRODUCTION AND BACKGROUND

## 1.1 Introduction

This report presents the results of a Legal Environment Assessment (LEA) for HIV and AIDS in Uganda. The assessment was funded under the USAID/Uganda Civil Society Strengthening Activity (CSSA) (see *Annex 2 for more on CSSA*) implemented by the East-West Management Institute (EWMI). Data for the LEA were collected between July and September 2021. Data collection was extended during this period due to the COVID-19 travel restrictions within Uganda at the time. This report is organised as follows:

- **Section 1** elaborates the background, objectives, and scope of the LEA and the conceptual framework for the assessment.
- **Section 2** describes the methodology used for executing the LEA.
- **Section 3** presents international-level results on human rights and policy instruments.
- **Section 4** presents national level legal and policy instruments.
- **Section 5** uses primary data to assess the application of national laws and policies.
- **Section 6** presents conclusions and recommendations.

## 1.2 Background: HIV/AIDS and the Legal Environment in Uganda

Uganda has made significant progress in addressing the HIV and AIDS pandemic. Indeed, Uganda is regarded as a success story in the fight against HIV/AIDS in Sub Saharan Africa, having reduced the adult prevalence of HIV from 18% in 1992 to 6.4% in 2005<sup>5</sup>, 7.1% in 2011 (Ministry of Health, 2012), down to 6.2% in 2016 (MOH, 2019), and 5.5% in 2020<sup>6</sup>. This was due, among other factors, to the country's adoption of a multi-sectoral approach to HIV/AIDS in 1992 in recognition that the pandemic was not only a health problem but a multi-sectoral development challenge. Uganda's fight against HIV and AIDS has been greatly aided by the support of leaders across the political, religious, and cultural divide.

Other factors for this success have included: openness about the epidemic; community involvement; use of a combination prevention approach; the work of Civil Society Organisations (CSOs), networks of people living with HIV (PLHIV), and donor agencies.<sup>7</sup> Uganda's government has also supported the HIV response by providing a supportive environment through necessary legislation and policy/planning frameworks.

Notwithstanding these gains, HIV continues to pose a real health and developmental threat to the country, with evidence of high rates of prevalence particularly among married couples, young people, and key populations such as sex workers (35%), fisherfolk (23-35%), and men who have sex with men (MSM) (13.7%).<sup>8</sup> Data from the Uganda Population-based HIV Impact Assessment (UPHIA, 2016-2017) indicates that HIV prevalence was 6.6% among adults who were married or living with a partner,

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<sup>5</sup> Ministry of Health (MoH) & ORC Macro, *Uganda HIV/AIDS sero-behavioural survey: 2004-05* (Calverton, Maryland: Ministry of Health and ORC Macro, 2006).

<sup>6</sup> Ministry of Health (MoH). *Release of Preliminary Results of the Uganda Population Based HIV Impact Assessment (UPHIA)*. Kampala, 2022.

<sup>7</sup> Uganda AIDS Commission (UAC), *Presidential Fast Track Initiative on Ending AIDS in Uganda: A Presidential Handbook—Revised Edition*, December 2020.

<sup>8</sup> Uganda AIDS Commission (UAC) and Ministry of Health (MoH), *Analysis of HIV Prevention Response and Modes of Transmission in Uganda: Final Synthesis Report*, (Kampala, Uganda: 2014).

compared to 1.6% among those who never married: a group dominated by younger segments of the population. In addition, a higher prevalence was reported among females in the 15-34 age bracket than their male counterparts.<sup>9</sup>

While there has been an overall decline in incidence from 0.83% in 2009 to 0.77% in 2013 and 0.40% in 2016, concerns of higher risks of infection persist, especially among key population groups. Some of the key factors often advanced to explain this situation include: (i) high risk sexual behaviours coupled with low knowledge of one's HIV sero-status; (ii) low individual-level risk perception; (iii) low levels of knowledge and understanding of HIV and especially its relationship to perceived personal risk of HIV infection; (iv) low utilisation of antenatal care (ANC) and delivery services; (v) low uptake of voluntary medical male circumcision (VMMC) services; (vi) a considerable number of HIV positive patients not on antiretroviral treatment (ART), constituting about 16% of all people living with HIV as of 2019;<sup>2</sup> (vii) sexual and gender- based violence resulting from gender inequalities; (viii) alcohol consumption; and (ix) poverty.

Furthermore, HIV and AIDS-related stigma and discrimination persist and are compounded by structural barriers that include restrictive aspects in the legal environment, an unfavourable political environment, and cultural and religious values and beliefs which negatively affect access to, and utilisation of, available prevention and treatment services. While the Government of Uganda is committed to the goal of ending AIDS as a public health threat by 2030, there is also increasing recognition that this goal cannot be achieved unless these structural barriers are addressed.

Uganda's Constitution guarantees protection and promotion of fundamental human rights and freedoms,<sup>10</sup> including rights for persons living with or affected by HIV/AIDS. These include the right to equality, freedom from non-discrimination<sup>11</sup>, the right to privacy of a home or other property<sup>12</sup>, access to justice,<sup>13</sup> the right to consent, and the right to confidentiality.

Uganda is also a subscriber and signatory to several international and regional human rights instruments intended to advance the rights and wellbeing of people living with HIV/AIDS, including key and vulnerable populations (KVPs). These include: the Universal Declaration of Human Rights (UDHR); International Convention on Civil and Political Rights (ICCPR);<sup>14</sup> the International Convention on Economic, Social and Cultural Rights (ICESCR);<sup>15</sup> the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW);<sup>16</sup> and the African Charter on Human and Peoples Rights (ACHPR).<sup>17</sup> In many respects, Uganda has made considerable progress in ensuring domestication of the provisions of these instruments within its own legal framework, accompanied by the development of specific policies, guidelines, and manuals on the provision of HIV and AIDS services to the population.

Nonetheless, it is also true that existing provisions in some national laws appear to criminalise the activities of specific population groups, either explicitly or implicitly. This perpetuates discrimination and stigma against members of these groups, which include people living with and/or affected by HIV/AIDS. Implementation of existing laws is often impeded by other socio-cultural and structural

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<sup>9</sup> Ministry of Health (MoH), et.al., *Uganda Population-Based HIV Impact Assessment 2016-2017*, (2019).

<sup>10</sup> Constitution of the Republic of Uganda, (1995), Chapter 4, as amended.

<sup>11</sup> Constitution of the Republic of Uganda, Article 21.

<sup>12</sup> Constitution of the Republic of Uganda, Article 27.

<sup>13</sup> Constitution of the Republic of Uganda, Article 50.

<sup>14</sup> United Nations General Assembly (1966), International Covenant on Civil and Political Rights.

<sup>15</sup> United Nations General Assembly (1966), International Covenant on Economic, Social and Cultural Rights.

<sup>16</sup> United Nations General Assembly (1979), Convention on the Elimination of All Forms of Discrimination against Women.

<sup>17</sup> Organisation of African Unity (OAU) (1981), African (Banjul) Charter on Human and People's Rights, CAB/LEG/67/3.

factors, thus derailing the full enjoyment of the rights and wellbeing of people affected by HIV and AIDS in Uganda, including the right to life, non-discrimination, employment, and equitable access to health and other social services. It is against this background that this Legal Environment Assessment (LEA) for HIV and AIDS in Uganda was undertaken.

### **1.3 HIV & AIDS as a Human Rights Issue**

A solid framework linking HIV and AIDS to human rights started with a political declaration in 2006 at the United Nations General Assembly High Level Meeting on HIV and AIDS, which added further commitments to the Declaration of Commitment on HIV/AIDS adopted by the UNGAS in 2001, containing specific human rights formulations such as the right to health, non-discrimination, and gender equality.

HIV and AIDS is now widely recognised as being more than a medical problem. It is also a development problem, a human rights problem, and indeed a multi-faceted challenge. Human rights violations associated with gender inequalities, violence, stigma, discrimination, and unfair laws and policies are recognised as key barriers to effective HIV responses. Addressing these structural barriers is therefore an emerging priority in HIV responses. The new Global HIV and AIDS Strategy 2021-2026,<sup>18</sup> adopted in June 2021, focuses on ending inequalities in order to end AIDS as a public health threat by 2030. Ending inequalities and other human rights challenges is key to creating an enabling environment for successful HIV responses.

### **1.4 Objectives**

#### **1.4.1 Overall objective**

The overall objective of the LEA was to assess the extent to which the existing laws, regulations, and policies enable or constrain key protections for those affected by HIV and AIDS in Uganda.

#### **1.4.2 Specific Objectives**

- i) To identify all relevant national laws, policies, and strategies that positively or adversely affect the successful, effective, and equitable delivery of HIV prevention, treatment, care, and support services to PLHIV.
- ii) To assess the key human rights issues affecting PLHIV and vulnerable and key populations (KVPs) and the extent to which these issues are addressed by the current legal and policy framework.
- iii) To assess the availability, accessibility, and affordability of interventions that promote the rights of PLHIV, and other people affected by, or at risk of, HIV in Uganda and how these are affected by the legal and policy frameworks.

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<sup>18</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS) (2021). *Global AIDS Strategy 2021-2026—End Inequalities. End AIDS.*

- iv) To analyse the extent to which PLHIV, and those affected by, or at risk of, HIV in Uganda are aware of existing legal frameworks and support systems to access services, as well as mechanisms to enforce their rights.
- v) To provide recommendations for the creation of enabling legal, social, and policy frameworks to eliminate HIV-related stigma, discrimination, and violence against people living with, affected by, or at risk of, HIV in Uganda.

## **1.5 Scope of the Legal Environment Assessment**

The LEA was conducted in recognition that the legal environment in any country can be both an enabler of, and a constraint to, the realisation of the rights and wellbeing of people living with HIV, along with those affected by, or at a high risk of acquiring, HIV. The results of the LEA in Uganda are expected to inform not only CSSA's work but also broadly the work of USAID/PEPFAR, the Government of Uganda, CSOs, and other partners, in an effort to improve the environment for the groups affected by HIV both to access HIV services, and justice support services, and to realise their human rights.

The LEA took a broad scope: reviewing the entire legal and policy framework, rather than focusing on one or more aspects of it. The review considered a wide spectrum of issues related to HIV & AIDS, human rights, and the legal and policy environment with respect to PLHIV, KVPs, as key determinants of the right to the highest standards of physical and mental wellbeing. These included (i) awareness of provisions of laws and policies; (ii) accessibility, availability and affordability of legal and justice support services; (iii) accessibility, availability, and affordability of HIV/AIDS services, including prevention, care and support, and treatment services; (iv) stigma and discrimination; (v) confidentiality and the right to privacy; (vi) informed consent during care seeking; (vii) gender-based violence; and (viii) harassment and brutality from law enforcers.

In terms of geographical scope for primary data collection, the assessment was conducted in a regionally and culturally representative sample of districts to reflect Uganda's social and cultural diversity.

## **1.6 Conceptual Framework**

This assessment drew from two conceptual frameworks, namely:

- (i) the human-rights approach to HIV response; and
- (ii) the socio-ecological framework, which situates the legal and policy environment within the broader socio-ecological environment and maps its possible influences on service access, utilisation, human rights realisation, and wellbeing of PLHIV.

### **a) The Human Rights Approach to HIV Response**

There is increasing recognition that respect for, and realisation of, human rights is essential for the success of the HIV response, and that violations of human rights can be a key barrier to effective national responses to HIV (UNAIDS, 2017, 2019). Human rights-related barriers include stigma and

discrimination, violence and other abuses, legal obstacles, and negative social attitudes (UNAIDS, 2017). In recognition of the importance of human rights to HIV responses, the UN member states in their 2016 Political Declaration on Ending AIDS recommitted to protecting the rights of key and vulnerable populations in the context of HIV and AIDS.

UNAIDS (2017) lists the key human rights principles relevant to the HIV response as consisting of:

- (i) *Availability, accessibility, acceptability, and good quality of services (AAAQ)*<sup>19</sup> in line with the right to the highest attainable standard of health: meaning that relevant HIV services, goods, and information should be available to all who need them in sufficient quantities and coverage, at accessible locations, in forms and modes that respond to their specific risks and needs, for free or at an affordable cost, and should be of a standard that guarantees safety and efficacy.
- (ii) *Non-discrimination and equality*: governments have a duty to protect people from discrimination and to promote equality in access to services and before the law. They have to ensure that services are equitably distributed without discrimination on the basis of socio-economic, cultural, or gender characteristics.
- (iii) *Privacy and confidentiality*: service users are entitled to privacy and service providers have a duty to uphold the confidentiality of service users. Limits on privacy and forced disclosure or disclosure without consent must be restricted to specific compelling circumstances and appropriately provided for in law.
- (iv) *Respect for personal dignity and autonomy*: this requires the free and full cooperation of service users, avoidance of coercive treatment, respect for informed consent, and promotion of client autonomy in decision-making.
- (v) *Meaningful participation and accountability*: people living with, and affected by, HIV and AIDS should be at the centre of the HIV response and should actively contribute either individually or collectively to the design, implementation, and utilisation of HIV-related services. Governments and other implementers also have to be accountable for the resources, decisions, and actions they take in relation to all people's human rights.

These principles are drawn from international human rights laws and standards as enshrined in various international human rights instruments such as the Universal Declaration on Human Rights (1948); the International Convention on Economic, Social, and Cultural Rights (1966); the Convention on the Elimination of all Forms of Discrimination against Women (1979), as well as global commitments on HIV including the 2001 Declaration of Commitment on HIV and AIDS; and the 2016 Political Declaration on Ending AIDS.

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<sup>19</sup> AAAQ: Availability refers to the existence and quantity of health facilities, goods and services; Accessibility refers to the physical and economic access to health facilities, goods and services as well as accessibility on a non-discriminatory basis and with sufficient information; Acceptability refers to the sensitivity of health facilities, goods and services to culture and medical ethics; and Quality refers to the need of health facilities, goods and services to be scientifically and medically appropriate and of good quality.

## ***b) The Socio-Ecology of the Legal and Policy Environment for HIV and AIDS***

The conceptual framework illustrated in the diagram below maps out some possible effects of the legal and policy framework on service access, human rights realisation, and the general wellbeing of PLHIV.

The socio-ecological model examines the interaction between PLHIV and KVPs on the one hand, and the legal environment on the other, whether originating from and/or operating at the individual, community, service, and structural levels. At the structural level, the legal and policy environment includes the nature of laws and policies, the level and mechanisms of law enforcement, and the level, adequacy, and effectiveness of policy implementation. But this legal and policy environment does not operate in a vacuum. Rather, it interacts with, is influenced by, and in turn influences service level, community level, and individual level factors. The socio-ecological framework takes into account the dynamic interrelations between personal and environmental factors, in line with ecological systems theory.<sup>20</sup>

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<sup>20</sup> The Bronfenbrenner socio-ecological model posits that human beings develop according to their environment; that the society, period, and conditions in which they live will impact behaviour and development. It views behaviour and development as a symbiotic relationship. Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press.

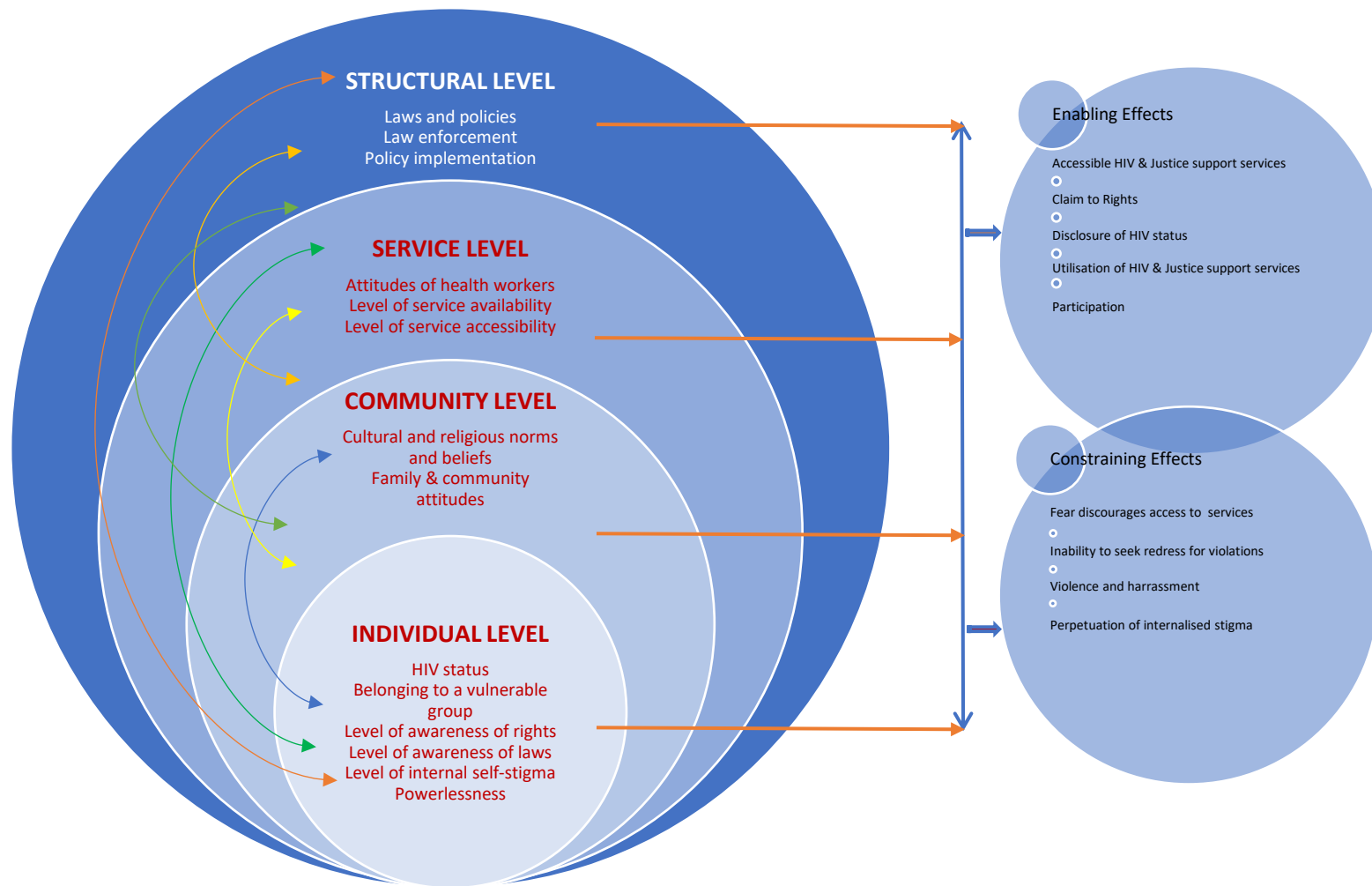


Figure 1: The socio-ecology of the legal and policy environment for HIV and AIDS

Multiple influences from structural and other levels may combine, having both positive/enabling effects and simultaneously, constraining effects on outcomes for PLHIV. If the influences are positive, the outcomes may be accessible HIV and justice support services, high levels of utilisation of these services, claim to rights<sup>21</sup>, disclosure of HIV status, and participation in planning and provision of services by PLHIV. If, on the other hand, the influences are negative, the constraints may be fear to seek services, self-stigma (this may be both an individual factor and an outcome), inability to seek redress against violations, and perpetuation of internalised stigma.

This assessment therefore analysed the nature and influences of the legal and policy environment on access to and utilisation of HIV and justice support services by PLHIV, people at high risk of HIV, and those affected by HIV, as well as their realisation of their rights and overall wellbeing.

## 1.7 Use of Results

The results of the LEA are to be used by GoU, USAID/PEPFAR, Ugandan CSOs, UN agencies and other partners to guide the development, implementation, and enforcement of laws, regulations, and policies that protect PLHIV's rights and promote access to HIV prevention, care, and support services. The results are also expected to inform the work of relevant agencies concerned with law and policy formulation and reform—such as parliament, ministries, and the Law Reform Commission—and those responsible for law and policy implementation and enforcement. The results will also be used to align international support for HIV and AIDS to national priorities with a broader vision of ending AIDS by 2030.

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<sup>21</sup> Claim to Right or Claim-Right is a common legal interpretation of the 'rights' in Human Rights, i.e., a defined benefit to which individuals are entitled with a correlative duty on others, usually a government as "duty-holder" (due to international treaties), in relation to that benefit. It is argued that governments are compelled to fill that duty when individuals are denied/deprived of their rights but sometimes the 'duty holders' are individuals or corporations.



## 2 APPROACH AND METHODOLOGY

### 2.1 Overall technical approach

The LEA was conducted using a qualitative approach. This approach was suited to this kind of assessment as it enables an in-depth scrutiny of the content of existing policy and legal frameworks at different levels, allows for stakeholder reflection on, and analysis of, the existing environment and human rights situation, and allows room for inclusion of case examples, along with stakeholder voices and narratives based on their lived experiences.

The qualitative approach consisted of an extensive desk review; service data reviews; key informant interviews; focus group discussions and consultative workshops with stakeholders in the HIV-relevant sectors and related relevant human rights sectors such as Justice, Law, and Order, Gender and Community Development, the Legislature, and the Law Reform Sector. The approach adopted for the assessment was also highly participatory and consultative. The methodology and tools adopted for this assessment were informed by the manuals for conducting LEAs developed by UNDP (2014) and USAID (2011).

### 2.2 Sampling processes

Study participants were drawn from a sample of Organisations (Government, CSO, ADPs), as well as districts selected on a regional basis. One district was purposefully sampled from 10 regions (as used in the Uganda Population Based HIV Impact Assessment [UPHIA] survey), namely, Kampala, Central 1, Central 2, Mid-Western, South-Western, Mid-North, West Nile, Mid-East, East Central, and Northeast.

Selection of sample districts was based on set criteria, including the presence of US agency operations/support (USAID/PEPFAR, CDC and DOD Walter Reed target districts), districts with high HIV prevalence, districts with a large number of vulnerable and priority populations, and consideration of urban and rural characteristics. Using these criteria, the following districts were included in the sample: Kampala, Kalangala, Buikwe, Bugiri, Mbale, Kotido, Gulu, Yumbe, Kikuube, and Mbarara (See *Annexe 3 for more details on the inclusion criteria*).

### 2.3 Study Participants

Study participants consisted of various stakeholders involved in the HIV and AIDS response and related human rights and legal sectors, including among others: policy makers; service managers; service providers; activists; service users including PLHIV; vulnerable populations (women, teenage mothers, people with disability); and Development Partners. (*Annexe 4 provides a list of Organisations from which key informants were drawn*).

### 2.4 Methods and Tools of Data Collection

This study utilised qualitative methods of data collection, including a desk review, key informant interviews, in-depth interviews, focus group discussions (FGDs), and stakeholder workshops.

### 2.4.1 Desk Review

The study team reviewed international, regional, and national instruments, as well as local government and community ordinances and by-laws relating to HIV/AIDS, human rights, and legal issues. The team also reviewed national policies, strategies, guidelines, program documents, and manuals as well as published and grey literature including case studies, best practices, and reports addressing HIV/AIDS-related legal and human rights issues. (Annexe I lists the documents reviewed).

### 2.4.2 In-depth/Key Informant Interviews

Interviews were conducted with selected key informants as outlined in sub-section 2.3. Key Informant interview question guides were designed for this purpose, tailored to different key informants such as policy makers, law enforcers, CSOs, and service implementers.

In-depth interviews were conducted with individual PLHIV and other vulnerable persons including survivors of HIV-related criminalisation, violence, stigma, and discrimination, other rights violations, or encounters with the law. A total of 78 key informant interviews were conducted with policy makers, service managers, and leaders at different levels; and 12 in-depth interviews were conducted with PLHIV in different categories (women, men, young people, persons with disabilities, key populations, among others).

### 2.4.3 Focus Group Discussions

Focus group discussions (FGDs) were used to collect data from people living with, affected by, or at a high risk of acquiring HIV. FGDs were held separately for different categories of PLHIV and vulnerable populations including men, women, young people, persons with disabilities, teenage mothers, fisherfolk, truckers, refugees, and key populations. A total of 32 FGDs were conducted as listed in Table 1.

**Table 1: Focus Group Discussions Conducted**

Category	Number	Districts where conducted
Male adult PLHIV	4	Gulu, Kampala, Kotido, Mbarara
Female adult PLHIV	4	Bugiri, Kalangala, Kampala, Mbarara
Adolescent girls (12-17) living with HIV	2	Kampala, Mbale
Adolescent boys (12-17) living with HIV	2	Buikwe, Gulu
Mixed boys and girls (12-17) living with HIV	1	Kalangala
PLHIV with disability (Mixed sex)	2	Mbale, Yumbe
Orphans (IM, IF)	2	Buikwe, Gulu
Teenage mothers	2	Buikwe, Mbarara
Refugees living with HIV (IM, IF)	2	Kikuube, Yumbe
Widows	2	Kikuube, Buikwe
Fisherfolk (M)	2	Kampala, Kalangala
Truckers	2	Kampala, Bugiri
MSM	1	Kampala
FSW	2	Bugiri, Buikwe
Transgender	1	Kampala
PWID (M)	1	Mbale

The purpose of the focus group discussions was to gather data on experiences both positive and negative in interacting with the law and accessing services, to identify gaps and implications, and to gather recommendations. Specific focus was on issues of: (i) access to and affordability of, HIV related services; (ii) experiences of stigma, discrimination, and violence; and (iii) awareness and views about existing laws, policies, and guidelines.

FGD participants were mobilised through their respective Organisations and implementing CSOs. Each FGD was facilitated by two persons from the assessment team, one moderating the discussion and the other managing the recording of the discussions. Each FGD had only 6 participants given that the data collection took place during the COVID-19 pandemic and there was need to ensure physical distancing to minimise the risk of spreading the COVID-19 infection. FGDs lasted between 1–2 hours and took place at places recommended by the participants themselves to guarantee their safety and convenience.

#### **2.4.4 Consultative Workshops**

Consultative workshops were intended to facilitate the participation of various stakeholders to generate consensus regarded necessary changes, validate the results, and ensure ownership and utilisation of these results. The workshops included the interagency meeting, the inception/planning workshop, the draft report validation workshop, and a final dissemination workshop. The participants included representatives of the key government, CSO, and Development Partner agencies.

### **2.5 Data processing and analysis**

Data was analysed using a thematic analysis procedure. Raw data from interviews and group discussions was transcribed and typed into Microsoft Word. Thereafter, it was analysed using Atlas Ti (version 9) software. Data were accordingly coded following a code sheet based on the main themes and sub-themes drawn from the data collection tools and from a sample of transcripts. Key broad themes around which data was analysed include:

- Availability, accessibility, and affordability of interventions.
- Key human rights issues affecting PLHIV and vulnerable and key populations (criminalisation of behaviour, stigma and discrimination, violence, privacy, confidentiality, legal invisibility).
- Extent to which human rights issues are addressed by the current legal framework.
- Awareness of existing legal frameworks and support systems to access services.
- Enforcement mechanisms.
- Gaps in existing laws and policy frameworks.

A document review tool/grid was developed which was used to map the contents of documents against the key themes and sub-themes of interest in this study, such as accessibility to services, awareness of laws and policies, utilisation of services, stigma and/or discrimination, violence, and criminalisation.

### **2.6 Ethical Considerations**

Ethics review and approval for this study was sought from the Mildmay Uganda Ethics Review Committee and final approval and registration from the Uganda National Council for Science and Technology. The study team made every effort to adhere to all relevant ethical requirements for undertaking research among human subjects, including informed consent, voluntary participation,

confidentiality, anonymity, and respect for the privacy of the participants along with the obligation to do no harm. These principles were then adapted to the needs of different population categories. Pre-prepared consent scripts were used to obtain consent and an information sheet containing the study information and contact details of the investigators and the Institutional Review Board was left with each participant.

In addition, in an effort to minimise the risk of COVID-19 transmission, most of the key informant interviews were conducted online. Where interviews and group discussions had to be face-to-face, the team adhered to the Standard Operating Procedures (SOPs) for COVID-19 prevention during field studies as issued by the Ministry of Health and the Uganda National Council for Science and Technology (UNCST). These included ensuring that: (i) all team members wore face masks when interacting with other team members and research participants; (2) each team member carried and used a hand sanitiser and frequently washed hands; (3) team members were required to maintain appropriate social distancing while interacting with other team members and study participants; and (4) masks were distributed to study participants from low-income categories.

## **2.7 Quality Assurance Mechanisms and Engaging Stakeholders**

This study benefited from the input and oversight of various technical groups, namely: a Technical Working Group (TWG) consisting of representatives of key government agencies, CSOs, Development Partners, persons living with HIV drawn from the HIV Prevention TWG at Uganda AIDS Commission, and the AIDS Development Partners Group (ADPG). The technical proposal and inception report, including the data collection tools, were presented to these committees as well as to stakeholders in an Inception Meeting for scrutiny and input. The deliverables from the study including draft reports and final reports were also presented to these committees and to wider stakeholders for validation. All deliverables were also reviewed, and feedback was provided by, CSSA and USAID.

Other measures adopted to ensure quality assurance in the implementation of the assessment included: (i) constituting a strong and dynamic team of Research Assistants with experience in conducting interviews and group discussions, to support the core study team; (ii) training the assessment team to ensure common understanding of the purpose, objectives, methods and procedures, ethics, and other essential aspects of the study; and (iii) routine communication within the study team, as well as between the study team and USAID/CSSA.

## **2.8 Team Composition**

The assessment team consisted of two professionals, Dr. Denis Muhangi (Social Scientist) and Ms. Fridah Mutesi (Legal and Human Rights Expert), supported by two Qualitative Data Analysts and 20 Research Assistants.

## **3 RESULTS PART I: INTERNATIONAL LEVEL HUMAN RIGHTS AND POLICY INSTRUMENTS**

### **3.1 International Human Rights Instruments**

International soft law, in the form of an international human rights framework, protects fundamental rights and freedoms through the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR), as well as other key instruments designed to ensure human rights protection for all. The respective Committees that were created to interpret the rights referenced in the various international instruments, made detailed recommendations and comments to address the vulnerabilities of specific groups to HIV infection and stigma, and to develop a human-rights-based approach to HIV prevention and treatment. The following are conventions at the international level that specifically provide for HIV/AIDS.

#### ***Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) Recommendation No. 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of AIDS (1990)***

One of the very first international bodies to make a declaration on HIV/AIDS was the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1990, which aimed to ensure that women and children should not suffer discrimination in the global response to HIV/AIDS. CEDAW's General Recommendation No. 15 stated: "programmes to combat AIDS should give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection".<sup>22</sup> It advised States to "ensure the active participation of women in primary health care and take measures to enhance their role as care providers, health workers and educators in the prevention of infection with HIV"<sup>23</sup> in the fight against HIV and AIDS. The General Recommendation, though limited in reach, was a first step towards international recognition of the fact that different groups within society have different levels of vulnerability to HIV infection and are not affected by HIV and AIDS in the same way.

#### ***Committee on Economic, Social, and Cultural Rights (CESCR) General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) (2000)***

The General Comment references recognition of the broader right to health contained in various international instruments, including Article 25 of the Universal Declaration of Human Rights (UDHR); Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR); Article 12 of CEDAW; and Article 24 of the Convention on the Rights of the Child (CRC).<sup>24</sup> It explains that "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health."<sup>25</sup> The General Comment sets out the four essential elements of the right to health: availability, accessibility,

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<sup>22</sup> United Nations Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW) (1990). CEDAW Recommendation No. 15: Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS), A/45/38, Para. B.

<sup>23</sup> Ibid. Para C.

<sup>24</sup> United Nations Committee on Economic, Social and Cultural Rights (CESCAR) (2000). General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C 12/2000/4, Para. 2.

<sup>25</sup> Ibid, Para. 9.

acceptability, and quality.<sup>26</sup> These four elements are equally applicable to the provision of HIV testing and treatment services in Uganda and should guide the laws, policies and programmes which the state puts in place to ensure they all are met in respect of HIV prevention and care.

General Comment No. 14 Article 12 notes that ICESCR “proscribes discrimination in access to health care” on a broad and inclusive list of grounds, “including health status, (which extends to HIV/AIDS status), sexual orientation, physical or mental disability, and sex. The international framework thus creates an enabling environment for PLHIV and KVPs to access HIV prevention and treatment services.<sup>27</sup>

It goes on to recommend “that States integrate a gender perspective in their health-related policies, planning, programmes and research”<sup>28</sup> addressing the vulnerability of women (as in HIV prevention and treatment policies) and the need for policies to shield them from domestic violence or harmful traditional cultural practices that deny them their full reproductive rights.<sup>29</sup> It addresses the right to health of children and adolescents, along with the need to provide youth-friendly health care, which respects confidentiality and privacy,<sup>30</sup> as well as non-discrimination and respect for the rights of older persons and persons with disabilities (PWD).<sup>31</sup>

General Comment 14 reiterates that the right to health imposes three levels of obligations on States: to respect, protect, and fulfil. The obligation to respect requires States to refrain from interfering with the right to health. The obligation to protect requires States to take measures to prevent third parties from interfering with Article 12 guarantees to the right to health. The obligation to fulfil requires States “to adopt appropriate legislative, administrative, budgetary, judicial and other measures” to fully realise the right to health.<sup>32</sup>

It specifies that States are under the legal obligation to respect the right to health, must refrain “from denying or limiting equal access to health services for all persons”, including prisoners and minorities, and abstain “from imposing and enforcing discriminatory practices”.<sup>33</sup> Legal obligations to protect include “the duties of States to adopt legislation or to take other measures ensuring equal access to healthcare and health-related services”, “to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill, and ethical codes of conduct” and “to take measures to protect all vulnerable groups”, particularly women, children, adolescents, and the elderly from gender-based violence.<sup>34</sup>

In this way the General Comment guides the creation of legal and policy frameworks which give due consideration to the vulnerabilities of PLHIV, as well as HIV-affected groups and those who are most at risk and reminds States of their legal obligation to ensure access to services without discrimination. The Parliament of Uganda was in contravention of these provisions when it passed the HIV Prevention and Control Act in 2014, as the Act contains sections that approach prevention of HIV transmission

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<sup>26</sup> Ibid, Para. 12.

<sup>27</sup> Ibid, Para 18.

<sup>28</sup> Ibid, Para. 20.

<sup>29</sup> Ibid, Para. 21.

<sup>30</sup> Ibid, Para. 22.

<sup>31</sup> Ibid, Paras. 25, 26.

<sup>32</sup> Ibid, Para. 33.

<sup>33</sup> Ibid, Para. 34.

<sup>34</sup> Ibid. Para. 35.

from the standpoint of criminalisation and forced disclosure of test results, approaches which are in opposition to internationally recognised best practice in the fight against the spread of HIV and AIDS.

### ***UN General Assembly Declarations of Political Commitment on HIV/AIDS (2001, 2006, 2011, 2016, and 2021) and the Global AIDS Strategy 2021-2026***

The various United Nations General Assembly (UNGA) declarations of political commitment (2001, 2006, 2011, 2016, 2021) have consistently sought to advance the global HIV response, while promoting and protecting human rights for all, and especially for PLHIV, people at risk of HIV and those made vulnerable by HIV and AIDS.

These declarations and commitments recognise “that women, young adults and children, in particular girls, are the most vulnerable”.<sup>35</sup> They note “that stigma, silence, discrimination and denial, as well as a lack of confidentiality, undermine prevention, care and treatment” initiatives for HIV and AIDS.<sup>36</sup> At the national level, “governments should ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS that (...) confront stigma, silence and denial, address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalisation” while encouraging the participation of PLHIV, vulnerable groups, affected communities, civil society, and the business sector in scaling up national responses to HIV.<sup>37</sup>

The UNGA’s Political Declaration on HIV/AIDS in 2006 reaffirmed the importance of access to medication, the full realisation of all human rights, and the importance of addressing stigma and discrimination in the fight against HIV and AIDS.<sup>38</sup> Over time, key vulnerable and priority groups received increasing attention, e.g., the 2011 Political Declaration noted that many countries do not focus their HIV response on high-risk populations and called on each country to define their own KVPs.<sup>39</sup> That Declaration also recognised the vulnerability to HIV infection of KVPs such as women and girls, young people, persons with disabilities (PWD), and people who inject drugs (PWIDs) and reaffirmed that the realisation of all human rights and freedoms is non-negotiable for HIV response to be effective.<sup>40</sup>

From 2011, the Political Declarations reaffirm that the full realisation of all human rights and fundamental freedoms for all is essential in the global response to HIV and that this extends to HIV prevention, treatment, care, and support.<sup>41</sup> They recognise the importance of adopting national policies and legislation to address stigma and discrimination and to ensure that PLHIV have equal access to healthcare and community support.<sup>42</sup> The Heads of States also commit to create an enabling legal and policy framework, at the national level, in order to eliminate stigma and violence related to HIV as well as discrimination in HIV service delivery.<sup>43</sup>

In June 2021, the High-Level Meeting (HLM) on HIV and AIDS passed the 2021-2026 Global AIDS Strategy, including new commitments to accelerate action to end the AIDS epidemic by 2030 and renewed commitment to promoting engagement of leaders, countries, communities, and partners to

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<sup>35</sup> United Nations General Assembly (2001), *General Assembly Declaration of Commitment on HIV/AIDS*, A/RES/S-26/2, Para. 4.

<sup>36</sup> *Ibid.*, Para. 13.

<sup>37</sup> *Ibid.*, Para. 37.

<sup>38</sup> UNGA (2006) Political Declaration on HIV/AIDS A/RES/60/262 Paras. 11, 12.

<sup>39</sup> UNGA (2011) Political Declaration on HIV/AIDS A/RES/65/277 Para. 29.

<sup>40</sup> *Ibid.*, Paras. 21, 23, 25, 26, 31.

<sup>41</sup> *Ibid.*, Para. 39.

<sup>42</sup> *Ibid.*, Para. 40.

<sup>43</sup> *Ibid.*, Para. 77.

implement a comprehensive universal integrated response to HIV and AIDS.<sup>44</sup> The June 2021 Political Declaration in particular focuses on the enablers and seeks to address inequalities as a foundation to addressing HIV.<sup>45</sup> The new Global Strategy that was launched sets targets of achieving “less than 10%” on key indicators for the enabling environment by 2025, namely: less than 10% of PLHIV and KVPs experiencing stigma and discrimination; less than 10% of PLHIV and KVPs, in particular women and girls, experiencing gender-based inequalities and gender-based violence; and less than 10% of countries having punitive laws and policies. These new targets provide fresh impetus to addressing the structural barriers to HIV prevention, including the legal environment.

### ***The Convention on the Rights of Children (CRC) and the Committee on the Rights of the Child General Comment No. 3 HIV and the Rights of the Child (2003)***

The Convention on the Rights of the Children (CRC) and the CRC General Comment No. 3 recognise that “all children can be rendered vulnerable” to HIV and AIDS, either because they are “themselves infected” or because “of the loss of a parental caregiver or teacher” to the disease.<sup>46</sup> The Objectives of the General Comment include promoting the realisation of human rights of children in the context of HIV and AIDS and formulating child-oriented plans of action, strategies and programmes.<sup>47</sup> It recommends a holistic child rights-based approach to HIV and AIDS and points to the realisation of various key rights as a precondition before adequate measures can be taken to address HIV and AIDS in this KVP. These rights include: the right to non-discrimination; the best interest of the child; the right to life, survival, and development; the right to express views and have them considered. It recommends special measures to protect children who are particularly vulnerable, such as those who have suffered economic or sexual exploitation, violence, and abuse, those who abuse substances or those who have been orphaned due to AIDS-related deaths. The CRC recommends that states allocate financial, technical, and human resources to support national action; to adopt and implement legislation which domesticate the Convention on the Rights of the Child and to reassess HIV-related data collection and evaluation to ensure that children are adequately covered.<sup>48</sup>

### ***Committee on the Rights of the Child General Comment No. 4 Adolescent health and development in the context of the Convention on the Rights of the Child (2003)***

CRC issued General Comment No. 4 to raise awareness about the specific concerns of adolescents as rights holders and to guide States in promoting their health and development, reiterating that adolescents should enjoy all the rights protected under the Convention on the Rights of the Child without discrimination, including on the grounds of HIV status.<sup>49</sup> In order to protect adolescents from HIV and AIDS, States are urged to review and reform their legislation and practice to increase the minimum age for marriage to 18 years, for both girls and boys.<sup>50</sup> States are also urged to: provide adequate access to appropriate and sensitive sexual and reproductive information, including on family planning, the dangers of early pregnancy, prevention of HIV and AIDS, and the treatment of Sexually

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<sup>44</sup> United Nations Global AIDS Strategy 2021-26: End inequalities. End AIDS.

<sup>45</sup> United Nations General Assembly Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 A/RES/75/284.

<sup>46</sup> United Nations Committee on the Rights of the Child (CRC) (2003), *General Comment No. 3: HIV and the Rights of the Child*, CRC/GC/2003/3, Para. 3.

<sup>47</sup> *Ibid*, Para. 4.

<sup>48</sup> *Ibid*, Para. 40.

<sup>49</sup> United Nations Committee on the Rights of the Child (CRC) (2003), *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, CRC/GC/2003/4, Para. 2.

<sup>50</sup> *Ibid*, Para. 20.



Transmitted Diseases (STDs);<sup>51</sup> to develop prevention programmes to protect adolescents from HIV infection; and to adopt legislation which would minimise the marginalisation of young people living with HIV.<sup>52</sup> The General Comment recognises that adolescents who are sexually exploited, including through sex work and pornography, are exposed to significant health risks which include HIV and AIDS and urges States to prohibit all forms of sexual exploitation and related trafficking.<sup>53</sup>

### ***Committee on Economic, Social, and Cultural Rights, General Comment No. 20 Non-discrimination in Economic, Social, and Cultural Rights (2009)***

The United Nations Committee on Economic, Social and Cultural Rights (CESCAR) issued General Comment No.20 to clarify the obligations on States in respect of ensuring non-discrimination.<sup>54</sup> States have a duty to ensure that a person's actual or perceived health status is not a barrier to the realisation of their rights protected under the International Covenant on Economic, Social, and Cultural Rights and it is discriminatory to use a person's HIV status "as the basis for differential treatment with regard to access to education, employment, health care, travel, social security, housing, and asylum" and urges States to adopt measures to address stigmatisation of persons on the basis of their health status.<sup>55</sup>

### ***United Nations Economic and Social Council Resolution on the Joint United Nations Programme on HIV/AIDS (2019)***

The UN Economic and Social Council (ECOSOC) adopted a Resolution on the Joint UNAIDS Programme in 2019 in response to deep concern over the continuing disparities "between and within countries and regions, between men and women, for different age groups and for key populations" which have caused HIV infections to rise in some countries and among some sub-populations.<sup>56</sup> The Resolution recognises "that achieving universal health coverage can be an accelerator to ending the AIDS epidemic through supporting greater access to services, the development and strengthening of health systems (...) and promoting integrated approaches to service delivery". It says that efforts to achieve universal access to health coverage should focus on equity, human rights principles and "the needs of the most marginalised" and address stigma and discrimination.<sup>57</sup> The Council expresses concern about "policies and practices that hinder the efforts to access HIV prevention, treatment, care and support services."<sup>58</sup>

The Resolution calls on Member States, the United Nations system, and other stakeholders to "scale up evidence-based HIV prevention, testing, treatment, care and retention, including access to safe, effective, quality and affordable medicines, including generics" and to ensure that these services reach those who need them the most, including key populations.<sup>59</sup> Member States are urged to work towards gender equality and providing the social and economic determinants of health, while making efforts to end GBV in order to protect adolescent girls and young women from HIV infection.<sup>60</sup> The Resolution recognises the interlinkages between the HIV and AIDS response and the Sustainable Development

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<sup>51</sup> Ibid, Para. 28.

<sup>52</sup> Ibid, Para. 30.

<sup>53</sup> Ibid, Para. 37.

<sup>54</sup> United Nations Committee on Economic, Social and Cultural Rights (CESCAR) (2009), General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights, E/C 12/GC/20, Para. 2.

<sup>55</sup> Ibid, Para. 33.

<sup>56</sup> United Nations Economic and Social Council (ECOSOC) (2019), Resolution on the Joint United Nations Programme on HIV/AIDS, E/RES/2019/33. Page 1.

<sup>57</sup> Ibid. Page 2.

<sup>58</sup> Ibid. Page 2.

<sup>59</sup> Ibid, Para. 4.

<sup>60</sup> Ibid, Para. 4.

Goals and urges UNAIDS to ensure that the AIDS response is positioned as an integral part of sustainable development cooperation between the UN and governments.<sup>61</sup>

### ***The Sustainable Development Goals (2015–2030)***

The Sustainable Development Goals (SDGs)<sup>62</sup> consist of 17 goals adopted by the General Assembly of the United Nations in 2015 to guide global development efforts for the period from 2015 to 2030, building on the Millennium Development Goals, which guided global development from 2000 to 2015. The pursuit of SDGs and the corresponding 169 targets helps create an enabling environment for HIV prevention, treatment, and care, as noted by the Joint United Nations Programme on HIV/AIDS (UNAIDS) which notes the “AIDS response is deeply interwoven with, and dependent upon, progress across sectors covered by the different SDG’s”.<sup>63</sup>

SDG 3 promotes good health and well-being for all at all ages, is aimed at creating an enabling environment for HIV prevention and service uptake. Effective scale-up of quality health services and the promotion of the right of all people to access these services without discrimination can greatly contribute to ending the HIV pandemic.<sup>64</sup> SDG 3 has the key sub-components of universal access to sexual and reproductive health, drug dependence treatment, and harm reduction.

SDG 4 aims to encourage inclusive and equitable education for all, empowering young people and giving them the necessary life skills for informed sexual and reproductive health decisions.

SDG 5 promotes gender equality and the empowerment of all women and girls. This is crucial to increasing increase HIV prevention and service uptake, to strengthen the position of women and girls and allow them agency to make decisions about their own bodies and lives.<sup>65</sup>

SDG 9 incentivises the building of resilient infrastructure, the promotion of inclusive and sustainable industrialisation, and the fostering of innovation. Achieving this goal, interlinked with the HIV and AIDS response of any country, could prioritise the development of infrastructure and innovations to ensure the availability of HIV treatment and prevention services to all.<sup>66</sup>

SDG 10 aims to reduce inequality within and among countries, to increase protection against discrimination and access to justice.

SDG 16 promotes peace, justice, and strong institutions, to enforce an end to violence against PLHIV and KVPs, the promotion of the rule of law, inclusive decision-making, and accountable institutions.

SDG 17 emphasises partnership and strengthening international cooperation, so countries cooperate rather than compete, in order to share expertise and resources. For the AIDS response, revitalisation of the global partnership for sustainable development would ensure efficient allocation of resources,

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<sup>61</sup> Ibid, Para.13.

<sup>62</sup> United Nations Sustainable Development Goals 2015-30 A/RES/70/1.

<sup>63</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS) (2017), *The Sustainable Development Goals and the HIV Response: Stories of putting people at the Center*, page 1.

<sup>64</sup> Ibid, 13.

<sup>65</sup> Ibid, 23.

<sup>66</sup> Ibid, 27.

increase awareness and knowledge, and create a critical mass of power and support to influence policymakers and spur them into action.<sup>67</sup>

Overall, the objective of the SDGs is to ensure that no one is left behind, signifying that they are intended to create room for the inclusion of marginalised and vulnerable groups who are at a high risk of being infected with HIV.

### **UNAIDS HIV Prevention 2020 Road Map: Accelerating HIV Prevention to Reduce New Infections by 75%**

This policy document is described as providing “the basis for a country-led movement to scale up HIV prevention programmes as part of Fast-Tracking a comprehensive response to meet global and national targets and commitments to end AIDS as a public health threat by 2030.”<sup>68</sup> The Road Map emphasises the empowerment of adolescent girls, young women, and KVPs as well as the importance of community peer-led prevention programmes aimed at reducing stigma and discrimination and expanded testing and treatment.<sup>69</sup> It notes that declines in new HIV infections have slowed and targets are being missed,<sup>70</sup> and the reduction of infection among KVPs globally has either stagnated or decreased.

The Road Map proposes a ten-point plan for accelerating HIV prevention at the country level. Point 1 guides countries to undertake a strategic assessment to identify critical policy and programme barriers to progress in reducing HIV incidence. Point 4 recommends legal and policy changes to create an enabling environment for prevention programmes with a focus on most-at-risk populations (MARPs) and key and vulnerable groups (KVPs). Point 5 instructs countries to develop a consolidated prevention capacity-building and technical assistance package for specific key and priority populations; and expanding community-led service delivery.<sup>71</sup>

The Road Map emphasises the importance of additional effort to ensure a conducive policy environment which address the factors that increase vulnerability and limit HIV service access and uptake. It emphasises the need to make sex education and contraception available to adolescent girls and young women and to reconsider punitive laws in respect of sex work, same-sex relations, drug use and possession. Principles endorsed by the Road Map include expanding the coverage of community-based programmes, based on respect for human rights with a people-centred approach which empowers and responds to the differing needs of at-risk people and their communities.<sup>72</sup>

The Road Map focuses on five prevention pillars: (i) Combination prevention programmes for adolescent girls, young women and their male counterparts, including provision of information for HIV prevention, economic empowerment, addressing harmful masculinity and gender norms, and eliminating GBV; (ii) Evidence and Human-rights based combination prevention programmes for all KVPs including community empowerment, peer outreach, condom distribution, harm reduction for PWIDs, and HIV testing and treatment services that are stigma- and discrimination-free; (iii) Strengthened national

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<sup>67</sup> Ibid, 31.

<sup>68</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS) (2017), *HIV Prevention 2020 Road Map: Accelerating HIV prevention to reduce new infections by 75%*, 2.

<sup>69</sup> UNAIDS, *The HIV Prevention 2020 Road Map*, 10.

<sup>70</sup> Ibid 69.

<sup>71</sup> Ibid, 6-8.

<sup>72</sup> Ibid, 13.

condom and behavioural change programmes; (iv) Voluntary medical male circumcision; and (v) Offering pre-exposure prophylaxis to KVPs at substantive risk and experiencing high levels of HIV incidence.<sup>73</sup>

### ***World Health Organisation Global Health Sector Strategy on HIV 2016-2021: Towards Ending AIDS (2016)***

The Global Health Sector Strategy on HIV recognises that major inequities persist in the AIDS response with substantial disparities in access to treatment and care. Progress is insufficient is not reaching many of the populations most at risk. Guided by the SDG 3, the Global Health Sector Strategy's goal is to end the AIDS epidemic as a public health threat by 2030.<sup>74</sup>

“Universal health coverage provides an overarching framework for the Strategy, while the continuum, or cascade, of HIV services provides an organising framework for implementation”.<sup>75</sup> The Strategy is rooted in a public health approach, which “aims to achieve health equity and promote gender equality, to engage communities, and to leverage public and private sectors in the response and also aims to strengthen integration and linkages between HIV and other health services, improving impact and efficiency.”<sup>76</sup>

The Strategy outlines five ‘strategic directions’ that guide priority actions to be taken by countries and by the WHO:

- 1) Information for focused action (know your epidemic and response).
- 2) Interventions for impact (covering the range of services needed).
- 3) Delivering for equity (covering the populations in need of services).
- 4) Financing for sustainability (covering the financial costs of services).
- 5) Innovation for acceleration (looking towards the future).<sup>77</sup>

Countries are guided to prioritise ‘high impact prevention interventions,’ including male and female condom programming, injection and blood safety, behaviour change communication, preventing HIV transmission to infants by providing lifelong ART to pregnant and breastfeeding women, implementing comprehensive harm reduction interventions for PWIDs, addressing GBV, and prioritising combination HIV prevention to adolescent girls and young women (AGYW).<sup>78</sup>

The WHO Strategy's directions and actions have been incorporated into the most recent HIV policies and guidelines adopted by the Government of Uganda through the Ministry of Health, as shown in the section on policy analysis below.

### ***World Health Organisation Consolidated Guideline on Sexual and Reproductive Health and Rights of Women Living with HIV (2017)***

The WHO Consolidated Guideline on Sexual Reproductive Health and Rights (SRHR) of Women Living with HIV (WLHIV), recognises that HIV is driven by gender inequality but also entrenches gender inequality, and as a result, there is need for sexual and reproductive health interventions for WLHIV that are grounded in principles of gender equality and human rights, in acknowledgement of the

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<sup>73</sup> Ibid, 14.

<sup>74</sup> WHO Global Health Sector Strategy on HIV 2016-2021 (2016) WHO/HIV/2016.05: page 11, 22-23.

<sup>75</sup> Ibid, 20.

<sup>76</sup> Ibid, 21.

<sup>77</sup> Ibid, 27.

<sup>78</sup> Ibid, 34.

recognising the multiple and intersecting forms of stigma and discrimination faced by WLHIV.<sup>79</sup> The Guideline covers key aspects of comprehensive SRHR-related service provision to WLHIV, placing emphasis on the creation of an enabling environment that addresses implementation issues and ensures the achievement of gender equality.<sup>80</sup>

It recommends a 'woman-centred' approach to SRHR service delivery, which involves addressing rights-related barriers to SRH, empowering WLHIV, engaging them in the development of policies and programmes that affect them, promoting an enabling legal and policy environment which safeguards the SRHR of WLHIV, supporting access to affordable and quality SRHR-related services, ensuring acceptability of services to WLHIV, strengthening linkages to care, and promoting accountability of health systems.<sup>81</sup>

The Guideline sets out essential strategies for creating and maintaining an enabling environment for SRHR uptake for WLHIV, which includes: psychosocial support, economic empowerment, and resource access; integration of SRHR and HIV services; protection from violence; social inclusion, community empowerment; supportive laws and policies and access to justice.<sup>82</sup> The Guideline makes good practice recommendations in respect of health interventions, including sexual health counselling and support services, Violence Against Women (VAW) services, family planning and infertility services, antenatal care and maternal health services, safe abortion services, and STI and cervical cancer services.<sup>83</sup>

It recommends integrated SRHR and HIV service delivery, decentralisation of services to community levels, and task shifting to address the shortage of health workers to improve access to care.<sup>84</sup> The Guideline includes special considerations for young transgender women living with HIV, considering the severe discrimination and abuse that this group faces in accessing health services.<sup>85</sup>

### **World Health Organisation Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations (2014)**

The WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations combines all the WHO guidance on MSM, PWIDs, sex workers, transgender persons, and people in prisons and other closed settings. The Guidelines set out a Comprehensive Package of Interventions which includes as essential health sector interventions: comprehensive condom and lubricant programming; Post-exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP); Voluntary Medical Male Circumcision (VMMC); harm reduction interventions for substance use; behavioural interventions; HIV testing and counselling; HIV treatment and care; prevention and management of co-morbidities; and SRH interventions.<sup>86</sup>

In terms of strategies for creating an enabling environment, the Guidelines advise decriminalisation of certain KPs, addressing stigma and discrimination, community empowerment, and addressing violence against KPs. The Guidelines recommend the adoption of this package on the basis of both public health

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<sup>79</sup> World Health Organisation (WHO) (2017), *Consolidated guideline on sexual and reproductive health of women living with HIV*, WHO/RHR/17.03, 1.

<sup>80</sup> Ibid, 20.

<sup>81</sup> Ibid, 21.

<sup>82</sup> Ibid, 21-22.

<sup>83</sup> Ibid, 48.

<sup>84</sup> Ibid, 81.

<sup>85</sup> Ibid, 86.

<sup>86</sup> WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014) Ch 4,

and equity considerations which underlie the prioritisation and improvement of HIV services for key populations.

### ***Convention on the Rights of Persons with Disabilities (CRPD), (2006)***

The CRPD<sup>87</sup> and its Optional Protocol were adopted on 13 December 2006 as a core Human Rights Instrument and entered into force on 3 May 2008. The Convention marked a new milestone in the shift from viewing persons with disabilities (PWD) as ‘objects’ of charity, medical treatment, or social protection, towards viewing them as ‘subjects’ with rights, and as productive and active members in their societies.

The CRPD affirms that all persons with disabilities must enjoy all human rights and fundamental freedoms. It clarifies and qualifies how all categories of rights apply to PWD, identifies areas where adaptations must be made for PWD to effectively exercise their rights, and identifies areas where protection of rights must be reinforced.

The CRPD has a set of guiding principles, including respect for the inherent the dignity, individual autonomy, and independence of persons with disabilities; non-discrimination based on disability; participation and inclusion; equality of opportunity; and accessibility, among others.

Under Article 25 which focuses on health, the CRPD puts obligations on States to:

- (a) provide the same range, quality, and standard of services of healthcare to PWD as those provided to other persons;
- (b) undertake early identification and intervention to minimise and prevent further disabilities;
- (c) provide services close to communities; and
- (d) prohibit discrimination against PWD and denial of healthcare to them.

The CRPD provides an enabling instrument for the promotion, protection, and realisation of the right to health of persons with disabilities, including the right to access HIV-related services in a non-discriminatory and friendly environment.

### ***General Comment No.2 of UN Convention on the Rights of Persons with Disability (CRPD)***

General comment No. 2 (2014) offers authoritative guidance on Article 9 of the CRPD on accessibility, which is a prerequisite for persons with disability to live independently and to participate in society fully and equally. Accessibility therefore should not only be understood from the context of non-discrimination and equality but also a societal investment and a critical component of sustainable development agenda (Recommendation 4).

The General Comment reiterates the Convention’s mandate to states parties to ensure access to the physical environment, transportation, information and communication in accessible formats, technologies, systems, facilities, and services available to the public (GC 2 Recommendation 27). States are therefore enjoined to ensure gradual implementation. The right to access is now established as a fundamental right under international human rights legal framework (GC 2 Recommendation 3). This

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<sup>87</sup> United Nations General Assembly (2006), *Convention on the Rights of Persons with Disabilities*, A/RES/61/106.

mandates the removal of technical and environmental barriers that impede access for persons with disabilities. Policies on improved accessibility are only attainable after change of attitudes towards persons with disabilities, stigma and discrimination through communication, awareness raising and cultural campaigns. Recommendation 10 decries the absence of adequate monitoring mechanisms that ensure the practical implementation of accessibility standards and relevant legislation. The General Comment explicitly calls for denial of access to constitute a discriminatory act irrespective of whether the perpetrator is a public or private entity (Recommendation 13)<sup>88</sup>.

### ***Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993)***

The Standard Rules<sup>89</sup>, adopted by the UN General Assembly in 1993 “represent a strong moral and political commitment of Governments to take action to attain equalisation of opportunities for persons with disabilities”.

The Standard Rules consists of 22 rules summarising the message of the World Programme of Action and incorporating the human rights perspective. Of particular relevance to PWD who may also be living with HIV or are affected by HIV are Rule Number 2 on medical care and Rule Number 5 on Accessibility.

Rule Number 2 requires States to ensure the provision of medical care to persons with disabilities; though not specifically mentioned, medical care by its very definition includes HIV/AIDS-related services. The Rule addresses issues of participation, quality, and equity in medical care services, as well as training of health professionals to provide medical care services.

Rule Number 5 requires States to recognise and promote both the physical accessibility of the environment, to remove physical barriers to participation, and to ensure the design of infrastructure facilities provides for easy accessibility. The Rule also requires States to provide access to information and communication services to PWD, including presentation of such information in formats accessible to persons with disabilities such as braille, large print, and sign language, and use of appropriate technologies to make information accessible.

## **3.2 Regional Instruments**

### ***Organisation of African Unity, Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases (2001)***

The Abuja Declaration was adopted by the Heads of States forming part of the Organisation of Africa Unity in 2001 to strengthen continental interventions and strategies to prevent the spread of HIV. The Declaration addresses HIV as a generalised pandemic, affecting the adult population, which was appropriate at the time.

The Declaration recognises the role of poverty, poor nutrition, forced displacement, and underdevelopment in the spread of the disease. The Declaration also recognises the vulnerability of women, youth, and injecting drug users to HIV infection. Importantly, the Heads of State and

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<sup>88</sup> United Nations. Convention on the Rights of Persons with Disability, General Comment No.2, Accessibility. UN Doc. CRPD/C/GC/2, 11 April 2014.

<sup>89</sup> United Nations General Assembly (1993), Standard Rules on the Equalisation of Opportunities for Persons with Disabilities: Resolution adopted by the General Assembly [on the report of the Third Committee], A/RES/48/96.

Government pledged to set a target of allocating 15% of their annual budgets to the improvement of the health sector, and to make the necessary resources available for the improvement of a comprehensive, multi-sectoral response for the fight against HIV and AIDS as well as Tuberculosis and other related infectious diseases.<sup>90</sup> The Heads of States also resolved to enact appropriate legislation on international trade relations in order to ensure the availability of affordable drugs.<sup>91</sup>

### ***The East African Community HIV and AIDS Prevention and Management Act (2012)***

Enacted to provide for the prevention and management of HIV and AIDS within the region and the protection and promotion of the human rights of persons living with or affected by HIV/AIDS, the first of the Act's objects and purposes is to promote a rights-based approach to dealing with issues related to HIV/AIDS<sup>92</sup> The Act further provides for the full protection of fundamental human rights of persons living with HIV/AIDS by extending HIV related services, ensuring quality health care and social services for persons living with HIV and their care givers, safeguarding the right to privacy of the individual, and prohibiting HIV related discrimination It calls on member states to raise awareness of HIV to all populations, prevent and control HIV transmission, and adopt national HIV prevention, treatment and management strategies. Governments are mandated to ensure access to information, goods, and services in a non-discriminatory manner and to create an institutional framework for an integrated and multi-sectoral approach to the prevention and management of HIV and AIDS (S.4a-n).<sup>93</sup>

### ***East African Community Gender Policy (2018)***

The policy reaffirms that the EAC is committed to achieving zero new infections on HIV and AIDS and care for all infected persons through addressing gender inequalities in access and control over basic health care services and facilities<sup>94</sup>. It strives for an inclusive community that guarantees equal opportunities, rights and protection for men and women, and boys and girls. It reaffirms the linkage between sexual and gender-based violence and HIV and calls for the alignment of priorities by member states to ensure gender equality and accountability within EAC. The policy enjoins partner states to strengthen primary healthcare in general and reproductive health services including management of prevention of mother to child transmission (PMTCT), to address stigma and discrimination especially among the youth and children as well as mobilise resources to ensure access to ARV by all infected persons.

It advocates for capacity enhancement for health care service providers to enable the provision of quality gender-responsive services, particularly on sexual and reproductive health. Partner States are obligated to develop and implement gender-responsive communication strategy for sustainable awareness raising programs on the prevention, care, rehabilitation, and treatment of STI's, HIV and AIDS as well as address stigma, including management of prevention of mother to child transmission (PMTCT) and to develop mechanisms for supporting caregivers and encourage men in providing unpaid care work. <sup>95</sup>

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<sup>90</sup> Organisation of African Unity (OAU) (2001), Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases, OAU/SPS/ABUJA/3, Para. 26.

<sup>91</sup> Ibid, Para. 31.

<sup>92</sup> East African Community. The East African Community HIV and AIDS Prevention and Management Act. 2012 (S. 3(1)(a)

<sup>93</sup> East African Community. The East African Community HIV and AIDS Prevention and Management Act. 2012.(S.3(1) (a)-(e). (S.4a-n).

<sup>94</sup> East African Community Gender Policy (2018) Section 2.4, p.16.

<sup>95</sup> East African Community Gender Policy (2018) Section 5.4 (a-e), p.34.



### ***Treaty for the Establishment of the East African Community***

Article 118(a) of the Treaty enjoins partner states to “take joint action towards the prevention and control of communicable and non-communicable diseases and to control pandemics and epidemics of communicable and vector-borne diseases such as HIV/AIDS” (...) “that might endanger the health and welfare of the residents of the partner states”.<sup>96</sup> Member states are urged to cooperate in the facilitation of mass immunisation and in undertaking other public health community campaigns.

### ***Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa (Maputo Protocol) (2003)***

The Maputo Protocol was adopted by the 2<sup>nd</sup> Ordinary Session of the Assembly of the African Union in July 2003. The Protocol urges state parties to combat all forms of discrimination against women through appropriate legislative, institutional and other measures. It also asserts the rights of women, including the right to dignity; the right to respect and freedom from exploitation and degradation; sexual and reproductive rights; and the right to life, integrity, and security. It calls on state parties to condemn and eliminate all forms of harmful practices against women; for women’s access to justice and equality before the law; and special protection for women with disabilities<sup>97</sup>.

### ***Protocol to the African Charter on Human and People’s Rights on the Rights of Persons with Disabilities in Africa – (2018)***

The Protocol calls for special measures of protection for persons with disabilities, consistent with human rights norms and standard setting instruments.<sup>98</sup> Importantly, it provides for non-discrimination of persons with disability on the basis of their disability or any other grounds<sup>99</sup>. It obligates states parties to take measures to eliminate discrimination including affirmative action. Additionally, it recognises the centrality of the right to health for persons with disabilities and obliges states to ensure PWDs have access to health services including sexual and reproductive health<sup>100</sup>. This includes HIV-Related treatment and programmes, in effect a tacit recognition of the susceptibility of persons with disability to sexual violence and the risk of contracting HIV. The Protocol entered into force in January 2018 but had yet to be signed and ratified by Uganda in early 2022. Given the human rights-based approach to disability advocated by this protocol, it would be an important step for Uganda to ratify it, for the improvement of rights of PWDs including those who are HIV positive.

### ***African (Banjul) Charter on Human and People’s Rights, 1981***

This Charter was adopted by States under the Organisation of African Unity (OAU) on 27 June 1981, and it entered into force on 21 October 1986. It states that “every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth, or other status.”<sup>101</sup> The Charter further provides that

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<sup>96</sup> East African Community. Treaty for the Establishment of the East African Community (as Amended on 14<sup>th</sup> Dec, 2006 and 20<sup>th</sup> Aug 2007). Arusha. Art. 118 (a).

<sup>97</sup> African Union. Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa. Maputo, 2005.

<sup>98</sup> African Union. Protocol to the African Charter on Human and People’s Rights on the Rights of Persons with Disabilities in Africa. 2018.

<sup>99</sup> Ibid, (Art 5(1)).

<sup>100</sup> Ibid, (Art.17(2)).

<sup>101</sup> African (Banjul) Charter on Human and People’s Rights, 1981 Article 2.

“every individual shall be equal before the law”, “every individual shall be entitled to equal protection of the law”<sup>102</sup> and “every individual shall have the right to liberty and to the security of his person.” It prohibits arbitrary arrest or detention.<sup>103</sup>

Other rights protected by the Charter include: the right to be heard in case of rights violation; the right to be represented by a lawyer; the right to be presumed innocent until proved guilty; the right to receive prompt and impartial hearing; the right to access information and to express opinions;<sup>104</sup> the right to free association; the right to free assembly; the right to freedom of movement; the right to free participation; rights relating to work and working conditions; rights relating to the best attainable state of physical and mental health; and rights relating to the family, women, children, the aged, and persons with disabilities.<sup>105</sup> It specifies the obligations of States in promoting and protecting these rights, as well as the duties of individuals. These rights apply to all individuals, including PLHIV, who in their diversity may enjoy their rights without interference or violation from anybody.<sup>106</sup>

### ***Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (2005)***

This Protocol was adopted as an addition to the African Charter on Human and Peoples’ Rights, to stand alongside other international human rights instruments committed to eliminating all forms of discrimination against women, since women continue to be victims of harmful practices, notwithstanding the general protective provisions of existing instruments. It places obligations on States to adopt legal, cultural, and policy frameworks that do not discriminate against women and to implement measures which ensure the protection of women from all forms of violence. Such a provision is an enabling factor for protecting women from HIV infection since GBV increases vulnerability to HIV infection.

The Protocol also contains revolutionary provisions in respect of women and HIV and AIDS. Under the provision on sexual and reproductive health, States are to ensure that women have the right to self-protect and be protected against sexually transmitted infections, including HIV. Women also have the right to be informed of their health status and on the health status of their partners—particularly if affected with STIs including HIV—in accordance with internationally recognised best practice.<sup>107</sup>

These provisions are ground-breaking in the sense that they reinforce women’s agency to know their own status and that of their partner and to insist on being protected from HIV infection in their sexual relationships. While the domestication and enforcement of these provisions cannot be without difficulties due to cultural differences and issues around rights to privacy and confidentiality, this regional policy document takes a leap toward the creation of enabling environment with respect to women and HIV prevention.

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<sup>102</sup> Ibid, Article 3 (1-2).

<sup>103</sup> Ibid, Article 6.

<sup>104</sup> Ibid, Article 9.

<sup>105</sup> Ibid, Articles 7, 9, 10, 11, 12, 13, 15, 16, 18, respectively.

<sup>106</sup> Protocol to OAU (1981) on the Rights of Women in Africa, Art. 3(d).

<sup>107</sup> Protocol to OAU (1981) on the Rights of Women in Africa, Art 14(1), (d) & (e).

### ***African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa (2012)***

At the 19<sup>th</sup> Summit of the African Union, held in Addis Ababa in July 2012, a Roadmap was adopted on shared responsibility and global solidarity for AIDS, TB, and malaria response in Africa. It builds on commitments, such as the 2001 Abuja Declaration, and “seeks to leverage the resources, activism and momentum of the AIDS response for progress across health and development through a set of practical African-sourced solutions.”<sup>108</sup>

The roadmap has three strategic pillars:

- 1) More diversified, balanced, and sustainable financing models;
- 2) Access to medicines through local production and regulatory harmonisation; and
- 3) Leadership, governance, and oversight for sustainability.

Priority actions for each of these pillars are to be implemented by Member States. Amongst others, they call on Member States to: develop financial sustainability plans; ensuring development partners align with Africa’s priorities; diversify funding sources; incorporate Trade-related Aspects of Intellectual Property Rights (TRIPS) flexibilities; and ensure that investments contribute to health system strengthening.

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<sup>108</sup> African Union (2012), *Roadmap on shared responsibility and global solidarity for AIDS, TB and malaria response in Africa: Adopted by the 19<sup>th</sup> Summit of the African Union.*

## 4 RESULTS PART II: NATIONAL LEVEL LEGAL AND POLICY FRAMEWORKS

### 4.1 Enabling Aspects in National Laws and Policies

#### 4.1.1 Equality and Non-Discrimination Laws and Policies

The principles of equality and freedom from discrimination for all citizens are enshrined in Ugandan Law, notably in the Constitution of the Republic of Uganda (1995) and Acts of Parliament such as the Equal Opportunities Commission Act (2007). Policy papers, such as the National Policy Guidelines on Ending Stigma and Discrimination (2020) also provide information about rights and entitlements for PLHIV.

#### *Constitution of the Republic of Uganda, 1995*

The Constitution is the supreme law of Uganda and has binding force on all persons and authorities throughout Uganda.<sup>109</sup> Chapter IV lays out in Articles 20 through 58 an extensive bill of rights proceeding from the principle that “Fundamental rights and freedoms of the individual are inherent and not granted by the State.”<sup>110</sup> “All organs and agencies of government” and “all persons” are enjoined to respect, uphold and promote the rights both of the individual and groups.<sup>111</sup> This recognition of fundamental rights and freedoms as inherent to all individuals, is an assurance to minority, key and vulnerable populations of protection against violations.

In the section on National Objectives and Directive Principles of State Policy (NODSPS), Chapter XIV, (General social and economic objectives), the Constitution requires the State to ensure that “all Ugandans enjoy rights and opportunities and access to education, health services...” and other benefits.<sup>112</sup> Constitutional clauses on equality and freedom from discrimination on the grounds of “sex, race, colour, ethnic origin, tribe, birth, creed or religion, or social or economic standing, political opinion, or disability”, offer unequivocal grounds for claims to rights by PLHIV, HIV affected persons and those at risk of HIV from discrimination in HIV prevention and treatment service access.<sup>113</sup>

“The State shall take affirmative action in favour of groups marginalised on the basis of gender, age, disability, or any other reason created by history, tradition, or custom, for the purpose of redressing imbalances which exist against them”<sup>114</sup> is clear in its intent to protect the most vulnerable, enjoining parliament to legislate for an Equal Opportunities Commission to give effect to that obligation.<sup>115</sup>

In the main, these constitutional provisions have been implemented by the Government of Uganda. Legislation such as the Persons with Disabilities Act (2020), the Domestic Violence Prevention Act (2010), the HIV Prevention and Control Act (2015), and the Equal Opportunities Commission Act (2007), among others, establish affirmative and enabling protections for KVPs.

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<sup>109</sup> Constitution of the Republic of Uganda (1995), Article 2(1).

<sup>110</sup> Ibid, Article 20(1).

<sup>111</sup> Ibid, Article 20(2).

<sup>112</sup> Ibid. Objective XIV of the NODPSP.

<sup>113</sup> Ibid. Art 21(1,2).

<sup>114</sup> Ibid, Article 32(1).

<sup>115</sup> Ibid, Article 32(2).

### **The HIV and AIDS Prevention and Control Act, 2014**

The obligations of the State to control HIV are set out: to “ensure right of access to equitable distribution of health facilities, goods and services, including essential medicines on a non-discriminatory basis,” to “provide universal HIV treatment to all persons on a non-discriminatory basis” and to develop and implement a national public health strategy and plan of action for HIV”.<sup>116</sup> Nine clauses tackle issues of discrimination against PLHIV, albeit limiting action for contravention of the provisions to “civil wrong” liability.

### **Equal Opportunities Commission Act, 2007**

Legislation was duly enacted to establish the Equal Opportunities Commission (EOC), as required by Articles 32(3) & (4) of the Constitution, with a “mandate to eliminate discrimination and inequalities against any individual (...) and take affirmative action in favour of groups marginalised on the basis of sex, gender, age, disability, or any other reason created by history, tradition, or custom for the purpose of redressing imbalances which exist against them...” The EOC monitors compliance with the statutory equal opportunities and affirmative action of marginalised groups and has the power of a court to investigate discrimination, marginalisation, and denial of equal opportunities.<sup>117</sup>

The EOC has been operating since it was established in 2010 to enforce the rights of PLHIV, as well as other groups with compounded vulnerabilities (including vulnerability to HIV infection). However, in its original iteration, the Act stipulated that the EOC could not investigate “any matter involving behaviour considered to be (i) ‘immoral and socially harmful’ or (ii) “unacceptable by the majority of the cultural and social communities in Uganda.”<sup>118</sup> This provision undermined the purpose of the EOC by excluding stigmatised groups, including KVPs, most in need of the assistance of the EOC. This issue was resolved when the Constitutional Court struck down this clause in the case of *Adrian Jjuuko v. Attorney General Constitutional Petition I of 2009*.<sup>119</sup>

Many PLHIV and other KVPs interviewed for this LEA were unaware of the existence and role of the EOC, despite it having operated for more than ten years. Those that had heard of it did not know how to access it. Interviews with EOC officials revealed that, to 2022, it had not dealt with any cases of discrimination based on HIV status.

### **National Policy Guidelines on Ending HIV Stigma and Discrimination, 2020**

On behalf of the Government of Uganda, the Uganda AIDS Commission (UAC), recently finalised the National Policy Guidelines on Ending Stigma and Discrimination, which constitute an important addition to the tools and frameworks guiding Uganda’s HIV response. The objective of these guidelines is “to guide national efforts” “to eliminate all forms of stigma and discrimination towards people living with and affected by HIV/AIDS in Uganda.”<sup>120</sup>

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<sup>116</sup> The HIV and AIDS Prevention and Control Act, 2014. Part IV Clause 24.

<sup>117</sup> Equal Opportunities Commission Act (2007), Part III (14.1).

<sup>118</sup> Equal Opportunities Commission Act (2007), Section 15(6)(d).

<sup>119</sup> Human Rights Awareness and Promotion Forum (HRAPF) (2019), *A Guide to the Normative Legal Framework on the Human Rights of LGBTI Persons in Uganda*, 28.

<sup>120</sup> National Policy Guidelines on Ending HIV Stigma and Discrimination (2020) (*Foreword, Objectives at a Glance*).

Recognising that stigma and discrimination are key barriers to effective utilisation of HIV services, the guidelines call for freedom from societal stigma, shame, denial, discrimination, and prejudiced attitudes while also ensuring people's privacy and confidentiality so all may freely access and utilise HIV support services.

The guidelines recommend measures to be undertaken by government and other actors to eliminate HIV stigma and discrimination and contribute to the goal of ending AIDS by 2030.

### ***The Human Rights (Enforcement) Act, 2019***

Legislation to give effect to Article 50(4) of the Constitution of the Republic of Uganda provides the procedure by which rights protected in Chapter Four of the Constitution may be enforced.<sup>121</sup> It sets out the means by which victims of human rights violations can apply for redress, hold public officials personally liable, and hold the state vicariously liable.<sup>122</sup> If the court finds a public official liable for a human rights violation, it can order the official to pay a portion of the compensation or restitution awarded to the victim.<sup>123</sup>

These are significant enabling provisions for PLHIV, and other vulnerable persons affected by HIV, as they enable them to seek direct redress for any violation of their rights. The Act has been invoked in several legal cases seeking to address health and human rights issues and has proven that it can serve to curb rights violations against PLHIV, in turn helping to reduce the stigma and discrimination faced by those affected by HIV and AIDS.

#### ***4.1.2 Laws and Policies that Protect the Right to Health***

### ***Constitution of the Republic of Uganda, 1995***

The NODPSPs iterated in the Constitution include the right to social justice and economic development and oblige the State to ensure that "all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security...".<sup>124</sup> The NODPSPs also require the State to take all practical measures to ensure the provision of basic medical services.<sup>125</sup> The High Court has held that these NODPSPs are justiciable in terms of Article 8A of the Constitution, and together with Uganda's obligations under international law, require the State to act so that the right to health may be realised.<sup>126</sup>

The Constitution thus creates an enabling environment for the enforcement of the right to health, which infers unenumerated rights to HIV prevention and treatment services.

### ***Public Health Act, 1935***

The Public Health Act, enacted under colonial British rule in 1935, is one of the oldest extant pieces of legislation in Uganda, regulating the prevention, control, and management of public health, with provisions for the prevention and management of infectious diseases, a category which includes

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<sup>121</sup> The Human Rights Enforcement Act (2019).

<sup>122</sup> The Human Rights Enforcement Act, Section 10(1).

<sup>123</sup> Ibid, Section 10(2).

<sup>124</sup> Constitution of the Republic of Uganda, Objective XIV (ii).

<sup>125</sup> Ibid, Objective XX.

<sup>126</sup> *The Center for Health, Human Rights and Development (CEHURD) & 2 Others v. The Executive Director, Mulago National Referral Hospital and Attorney General*, Civil Suit No. 212 of 2013.

HIV/AIDS. As it preceded many of the legal instruments on human rights, this act was incapable of incorporating the human rights-based approach into the management of public health and was similarly silent on matters affecting vulnerable and key populations. A revised version is imminent, as the Ministry of Health (MoH) has been engaged in drafting an Amendment.

### **The Health Service Commission Act, 2001**

Legislation establishing a professional code of conduct and ethics for health workers was an important step towards creating an enabling environment for HIV service provision. This Act establishes the responsibility of health workers to “hold the health, safety, and interest of the patient or client to be of first consideration and shall render due respect to each patient at all times and in all circumstances.”<sup>127</sup> Health workers are also required to provide a patient with “relevant, clear and accurate information” about their health.<sup>128</sup> It stipulates that treatment and medical intervention shall not be provided without the “full, free and informed consent” of the patient, except in emergencies.<sup>129</sup> Health workers are also directed to respect the confidentiality of patients and their families and not disclose health information without consent.<sup>130</sup> It further instructs health workers to respect confidentiality: “maximum care shall be taken not to compromise the confidentiality and interest of a patient when carrying out an examination or supplying a report at the request of an authorised person.”<sup>131</sup>

However, while many provisions contribute to the creation of an enabling environment for HIV service uptake, constraint is introduced by permitting health workers disclosure of medical information of a patient, without consent, if it is deemed to be in the best interest of the patient.<sup>132</sup> It may be argued that this undermines the dignity and autonomy of the patient while conferring on the health worker a paternalistic right to decide what is best for their patient, potentially discouraging uptake of HIV testing and treatment services.

### **4.1.3 National Planning Frameworks**

#### **The Second National Health Policy, promoting People’s Health to Enhance Socio-Economic Development (2010)**

Uganda’s Ministry of Health published the Second National Health Policy (NHP II) to prioritise the effective delivery of the Uganda National Minimum Health Care Package (UNMHCP), in line with the UN’s Millennium Development Goals and Uganda’s National Development Plan. Its Mission is defined thus: “to provide the highest possible level of health services to all people in Uganda through delivery of promotive, preventive, curative, palliative, and rehabilitative health services at all levels,<sup>133</sup> guided (*inter alia*) by the social values of equity in health services, respect for cultures and traditions, professionalism, integrity and ethics, and accountability.”<sup>134</sup>

The policy lays out guiding principles of Uganda’s national policy on health including: primary healthcare, decentralisation of health services, evidence-based and forward looking strategy, gender sensitive and

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<sup>127</sup> The Health Service Commission Act (2002), Section 30(1).

<sup>128</sup> *Ibid*, Section 30(3).

<sup>129</sup> *Ibid*, Section 30(4).

<sup>130</sup> *Ibid*, Section 30(5).

<sup>131</sup> *Ibid*, Section 30(8).

<sup>132</sup> *Ibid*, Section 30(5).

<sup>133</sup> Ministry of Health (MoH) (2010), (*NHP II*; 4.2).

<sup>134</sup> *Ibid*, (4.4, Pp.11-12).

responsive health delivery system which is integrated, pro-poor, and sustainable.<sup>135</sup> NHP II policy objectives include: strengthening the organisation and management of the national health system and improving access to quality hospital services at all levels in both the public and the private sectors.<sup>136</sup>

Policy objectives include ensuring “universal access to quality UNMHCP (...) for all prioritised diseases and conditions, to all people in Uganda, with emphasis on vulnerable populations” but these “vulnerable populations” are not specified. Autonomy and agency are encouraged: “Communities, households, and individuals are empowered to play their role and take responsibility for their own health and well-being (*sic*) and to participate actively in the management of their local health services.”<sup>137</sup>

The policy document defines the UNMHCP as consisting of “the most cost-effective priority healthcare interventions and services addressing the high disease burden” and divides this package into clusters: (a) health promotion and community health initiatives; (b) maternal and child health; (c) prevention, management, and control of communicable diseases; and (d) prevention, management, and control of non-communicable diseases. It provides for periodical reassessments of the UNMHCP depending on changes in disease burden, availability and cost-effectiveness of new interventions, and evidence-based availability of resources.<sup>138</sup>

### **Third National Development Plan (NDP III) 2020/21-2024/25**

NDP III is the overarching national planning framework for Uganda’s strategic direction and development goals for the period 2020/21-2024/25. Chapter 16, Human Capital Development of the NDP III notes increase in access to some HIV-related services such as PMTCT over the previous planning period but also acknowledges gaps, such as: inadequate access to child and adolescent-friendly health services; limited disease surveillance; the high teenage pregnancy rate; the HIV/AIDS positivity rate; low access to SRHS; high substance use and abuse; the persistence of harmful cultural practices such as female genital mutilation (FGM); adolescent exploitation; and the continued subjugation of women and girls.<sup>139</sup>

Four objectives are listed for Human Capital Development. Relevant to the HIV/AIDS response, Objective 3 states: “To improve population health, safety and management”<sup>140</sup> and outlines interventions which include: (i) Prevent and control non-communicable and communicable diseases with a focus on high-burden diseases including HIV/AIDS; (ii) Expand community-level health services for disease prevention; (iii) Increase access to family planning services; (iv) Improve the functionality (staffing and equipment) of health facilities at all levels; (v) Expand geographical access to health care services; (vi) Increase access to affordable medicines and health supplies (through local production capacity); and (vii) Implement the national health insurance scheme.<sup>141</sup>

Objective 4 of the Human Capital Development programme is also relevant to the HIV response as its focus is to “Reduce vulnerability and gender inequality along the lifecycle” and one of the tabled

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<sup>135</sup> Ibid, (4.5, Pp.12-13).

<sup>136</sup> Ibid, (6:1, Pp.14-16).

<sup>137</sup> Ibid, (6.7.4.1, P.29).

<sup>138</sup> Ibid, (6.2, Pp. 16).

<sup>139</sup> Third National Development Plan (NDP III) 2020/21 – 2024/25 (Ch. 16: 313, 314, 316, Pp156-158). National Planning Authority, Kampala.

<sup>140</sup> Ibid (Ch16: 321, P.159).

<sup>141</sup> Ibid (Ch16: 322, Table 1, Objective 3: 1,3,4,5,7,8,9. P. 161).



critical interventions is to “Expand scope and coverage of care, support and social protection services of the most vulnerable groups”.<sup>142</sup>

#### 4.1.4 Laws, Policies and Frameworks Specific to HIV and AIDS Services and Related Matters

##### *The HIV and AIDS Prevention and Control Act, 2014*

Nearly 30 years after ‘slim’ disease alerted Uganda to the HIV epidemic, parliament enacted ground-breaking legislation “to provide for the prevention and control of HIV and AIDS”.<sup>143</sup> The HIV and Aids Act, 2014 (HIVPCA) ensures universal access to HIV/AIDS services with specific guidance for prevention, diagnosis, testing, and care as well as defining the rights and obligations of people and of the State.

HIVPCA regulates access to facilities, goods and services related to HIV prevention, testing, counselling, and care. Its provisions embrace equality and discrimination, consent, and privacy issues. It requires the State to ensure the right of access to HIV and AIDS services, including the provision of essential medicines and universal HIV treatment to all persons on a non-discriminatory basis.<sup>144</sup> The State is also under obligation to: promote awareness of the rights of PLHIV; promote and ensure non-discriminatory participation of PLHIV in HIV/AIDS government programmes; provide care and support to PLHIV; and provide adequate funding for HIV and AIDS programmes.<sup>145</sup> One provision established the HIV Trust Fund to “Secure a predictable and sustainable means of procuring goods and services for HIV and AIDS testing, counselling, and treatment”.<sup>146</sup>

HIVPCA fosters an enabling environment to eliminate HIV stigma by prohibiting discrimination on the grounds of actual, perceived, or suspected HIV status in the workplace (including proscribing denial of access to employment for which a person is qualified; transfers; denials of promotions, or termination of employment). The Act specifies that employers may not adopt policies requiring mandatory HIV testing, including pre-employment testing.<sup>147</sup> Discrimination within schools is similarly prohibited. HIVPCA mandates that “an educational institution shall not deny admission or expel, punish, segregate, deny participation in any event or activity, or deny any benefits or services to a person on the grounds only of the person’s actual, perceived, or suspected HIV status.”<sup>148</sup>

Additional protections for PLWHIV include a ban on restrictions to a person’s right to enter, live, and travel within Uganda warns that a person cannot be placed in quarantine or deported on the grounds of their actual, perceived, or suspected HIV status.<sup>149</sup> HIVPCA protects the right to run for public office and gain access to credit and insurance services, regardless of a person’s HIV status.<sup>150</sup> It prohibits any discrimination in health institutions, to ensure that no person can be denied access to healthcare services or charged a higher fee for such services on the grounds of their actual, perceived, or suspected HIV status<sup>151</sup> and requires health institutions and medical insurers to provide services to

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<sup>142</sup> NDP III, (Ch. 16: 322, Table 16.1, Objective 4.2, P.161).

<sup>143</sup> The HIV Prevention and Control Act (2014) (HIVPCA: I. Interpretation).

<sup>144</sup> Ibid. Section 24(1)(a), (b).

<sup>145</sup> Ibid. Section 24 (d-k).

<sup>146</sup> Ibid, Sections 2–28.

<sup>147</sup> Ibid, Section 32.

<sup>148</sup> Ibid, Section 33.

<sup>149</sup> Ibid, Section 34.

<sup>150</sup> Ibid, Sections 35, 36.

<sup>151</sup> Ibid, Section 37.

persons with HIV without discrimination on the basis of their HIV status.<sup>152</sup> There is specific provision for minors, to guarantee that a child living with HIV is also protected from discrimination by their parent, guardian, or person that has custody over them.<sup>153</sup>

HIVPCA's provisions prohibiting discrimination against PLHIV are commendable. However, they do not extend to the most marginalised groups, the KVPs, who face stigma and discrimination based on their actual or perceived HIV status along with their identity as a PWUIDs, sex workers, MSM, or transgender persons. HIVPCA does have a commitment that priority should be given to 'most at risk populations,' but narrowly defines these as fishing communities, prisons, migrant populations and "other areas as may be determined by the Minister from time to time."<sup>154</sup> The majority of specific KVP groups prioritised by UNAIDS: sex workers, PWUID, MSM, and transgender persons are not mentioned at all with no specific provision to making services more accessible to them. This has the effect of rendering these groups invisible within the context of the Act.

HIVPCA has both enabling and constraining aspects, and communities living with or at risk of HIV/AIDS often express frustration that "the government gives with one hand and takes away with another". Constraining aspects of HIVPCA include the criminalisation of attempted HIV transmission (with or without intent)<sup>155</sup> that has the effect of discouraging people from HIV testing and disclosure.

### ***The National HIV and AIDS Strategic Plan (NSP) 2020/21–2024/25***

The National HIV and AIDS Strategic Plan 2020/21–2024/25 (NSP), adopted in 2020, has a central role in Uganda's HIV policy environment. The NSP envisages ending the AIDS epidemic by 2030 by adopting a 'prioritised scale-up scenario' of critical interventions for maximum feasible coverage, to accelerate the decline of new HIV infections.<sup>156</sup> Critical interventions are planned: (i) to reduce new HIV infections by 65% among adults and youth; (ii) to reduce AIDS-related morbidity and mortality by 2025; (iii) to improve social and economic protection; (iv) to strengthen the multi-sectoral HIV/AIDS service delivery and coordination system to ensure sustainable access to the highest quality services for all focus populations; and (v) to support the national HIV and AIDS strategic information management system for improved effectiveness and efficiency.<sup>157</sup>

To provide an enabling environment which maximises access to and use of HIV-related services, these objectives will be effected through a human rights-based and gender-sensitive legal and policy environment. Action will be guided by principles of shared responsibility, inclusion, and non-discrimination; engaging meaningful participation and inclusion of communities, PLHIV, and KVPs; with respect for personal dignity and autonomy.<sup>158</sup>

In its Situational Analysis, the NSP estimated 1.46 million PLHIV in Uganda in 2019, with an incidence of 1.4 HIV+ per 1,000 uninfected people of all ages - but there were wide variations by region, district, and sub-population group. Country performance data measured by UNAIDS against the 90-90-90 target indicated that as of March 2020, Uganda had achieved 89% of all adult PLHIV (93% women, 68%

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<sup>152</sup> Ibid, Section 39.

<sup>153</sup> Ibid, Section 38.

<sup>154</sup> Ibid, Section 24(2).

<sup>155</sup> Ibid, Section 41,43.

<sup>156</sup> *The National HIV and AIDS Strategic Plan 2020/2–2024/25 (Executive Summary, P. xiv).*

<sup>157</sup> Ibid (Section 3.4, Pp. 24 -25). (UAC, 2021).

<sup>158</sup> Ibid, 27.

men) knew their HIV status and 84% (91% women, 77% men) were on ART, of whom 75% (83% women, 68% men) had suppressed viral loads.

Key drivers of new infections were identified as poverty, gender inequality, high levels of stigma, discrimination, and violence against KVPs and AGYW. The low status of women and girls and the prevalence of GBV together limit their ability to adopt and sustain HIV-prevention behaviours.<sup>159</sup> Other equity issues which create barriers to HIV service utilisation, include: HIV-related stigma and discrimination within family and community settings; high levels of stigma, discrimination and violence among KVPs (including from health workers); problematic laws, regulations, and policies which limit the effectiveness of HIV interventions for KVPs; constraints within places of detention; gender inequality and the persistence of GBV; gender norms that influence the health-seeking behaviour of men and boys; poverty; and other forms of social exclusion.<sup>160</sup>

There is acknowledgement that women are disproportionately affected by HIV in Uganda: 60% of PLHIV are women and new HIV infections among young women were more than double those among young men in 2018.<sup>161</sup> The NSP also identifies linkage between HIV infection, sexual and gender-based violence (SGBV), and sexual violence against children. Child and adolescent survivors of sexual violence rarely access post-exposure prophylaxis (PEP).<sup>162</sup>

The (updated and revised) NSP covering the period to 2025 specifies major strategic actions in four thematic areas to be scaled up: 1. Prevention, 2. Care and Treatment, 3. Social Support and Protection and 4. Systems Strengthening (with gender and human rights issues mainstreamed across all four as appropriate).

[1] Prevention. The objective is to better target HIV prevention services to specific (unreached) populations and high-risk age groups that are missed in HIV prevention programming (men, partners of HIV positive individuals, AGYW and their male partners, and hard to reach and at-risk populations). This includes expansion of services for KVPs, such as harm reduction services for PWUIDs (e.g., opioid substitution therapy and clean needle/syringe programmes) as well as services tailored to the needs of sex workers, MSM, transgender people, and prisoners.<sup>163</sup> The Plan also envisages primary prevention of HIV infection for women of child-bearing age, prevention of unintended pregnancies among HIV-positive women, prevention of HIV transmission from HIV-positive mothers to infants, and provision of continuous care and treatment for infected mothers, partners, and their children.

The NSP proposes actions on three planes: (i) Behavioural action to increase adoption of safer sexual behaviours and reduction in risky behaviours among key populations, priority population groups and the general population; (ii) Biomedical action to expand the coverage and uptake of quality biomedical priority HIV interventions; and (iii) Structural action to address underlying socio-cultural, gender, and structural factors that drive the epidemic.

[2] Care and Treatment: the strategic objectives focus on three aspects of the treatment cascade, notably: (i) increase PLHIV starting ART to 95% by 2025; (ii) increase adherence of PLHIV to ART to 95% by 2025 by engaging KPs and priority population peers as distribution agents of PrEP and PEP; and (iii) increase the prevalence of viral load suppression among PLHIV on ART to 95% by 2025. The NSP

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<sup>159</sup> Ibid, 10.

<sup>160</sup> Ibid, 11.

<sup>161</sup> Ibid. 13.

<sup>162</sup> Ibid. 13.

<sup>163</sup> Ibid, (4.2: Prevention. Pp. 28-36).

envisions achieving this by increasing the number of ART-accredited sites, integrating HIV services, and increasing HIV care entry points for HIV-exposed infants, children, adolescents, and men.

Additionally, differentiated HIV testing services will be allocated to high-risk groups, such as pregnant women, MARPs, sero-discordant couples, and children under the age of 15.<sup>164</sup> Expansion of coverage and accessibility of targeted biomedical interventions for key and priority populations is also envisioned, including STI services, HIV testing, VMMC, PrEP, PEP, EMTCT, and harm reduction interventions. The NSP envisages implementing a harm reduction strategy to scale. It also envisages strengthening community health and peer-led platforms to identify, support, and link PLHIV to care, including KPs who remain undiagnosed.

[3] Social support and protection: the strategic objectives include: (i) stigma reduction; (ii) social-economic empowerment of PLHIV and other vulnerable groups; (iii) scaling up psychosocial support for PLHIV and other vulnerable groups; (iv) reinforcing the prevention and response to SGBV; (v) strengthening child protection and the response to violence against children (VAC); and (vi) re-evaluating the HIV/AIDS legal and policy framework to ensure that it is inclusive of all PLHIV, PWD, KPs, and other vulnerable groups.

The NSP further envisions scaling up of ART adherence by leveraging networks of PLHIV and peers of KPs, empowering families and communities to provide support and keep people engaged in care, as well as engaging community structures such as peer-led models for client tracing, care, linkage, referral, and adherence support.

Accordingly, the NSP is enabling in so far as it seeks to address societal factors which perpetuate SGBV, gender inequality, stigma, and discrimination which may prevent people from seeking HIV prevention services. The NSP also envisages developing and/or reforming laws and law enforcement practices on the age of consent, spousal consent, domestic violence, sexual consent, and child marriage.

[4] Systems strengthening building the capacity of service providers to: (i) manage SGBV cases and integrate them into HIV prevention programmes; (ii) deliver integrated youth-friendly HIV and SRH services that include SGBV prevention; (iii) address stigma among health-care workers; and (iv) deliver integrated prevention and mitigation services for HIV, SRHR, and victims of violence (psychosocial, SGBV, and violence against children).

The innovations envisioned also include: (i) scaling up community drug distribution points linked to health facilities; (ii) expanding the scope of differentiated service delivery for older people and PWD, including psychosocial support; and (iii) strengthening both facility and community structures for service delivery using expert clients, peer networks, and lay counsellors to support HIV status disclosure, adherence, retention, and viral suppression. The integration of HIV and TB programming services is envisioned at all levels, including community directly observed treatment (Community DOT) strategy, home-based care, intensified case detection, and TB preventive therapy.

The goal is to apply a human rights-based non-discriminatory and inclusive approach to HIV prevention programmes by working with local civil society advocacy to address legal, policy, and institutional barriers to HIV prevention redoubling efforts against stigma and discrimination by enhancing the

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<sup>164</sup> Ibid, 32.

knowledge, attitudes, actions, and accountability of community leaders, health workers, PLHIV, and family members.

### ***Presidential Fast Track Initiative on Ending HIV & AIDS in Uganda (2020):***

In 2017, President Yoweri Museveni launched a fast-track initiative aimed at eliminating AIDS by 2030 and reaching the 90-90-90 targets for HIV testing, treatment, and viral suppression.<sup>165</sup> The initiative was revised in 2020 with a Five Point Plan: (1) Engage men in HIV prevention to address infection among AGYW; (2) Accelerate the implementation of Test and Treat and attainment of 90-90-90 targets among men and young people; (3) Consolidate progress on EMTCT; (4) Ensure financial sustainability for the HIV response; and (5) Ensure institutional effectiveness for a well-coordinated multi-sectoral response.<sup>166</sup>

The President's Initiative message is targeted at men, youth, parents, and leaders, to involve men in prevention of EMTCT.<sup>167</sup> However it fails to mention that transmission among KPs ought to be addressed as a matter of urgency. It limits its focus on vulnerable populations to young people and pregnant women and omits the vulnerability of uniformed personnel, fishing communities, health workers, elderly people, PWD, MSM, sex workers, and PWIDs to HIV. Furthermore, the vulnerability of women and girls to HIV infection is addressed solely from the viewpoint of men's potential role in prevention of infection.

### ***National HIV Testing Services Policy and Implementation Guidelines Uganda (2016)***

The revised HTS Policy and Implementation guidelines replace the 2010 Uganda HIV Counselling and Testing (HCT) Policy and National Implementation guidelines for HCT (2010), Uganda has since adopted the WHO terminology 'HIV Testing Services (HTS)' to replace (HCT)'. HTS incorporates pre- and post-test counselling, linkage to appropriate HIV prevention, care and treatment services, and coordination with laboratory services for quality assurance and correct results.<sup>168</sup>

The rationale for revising the 2010 HCT Policy was to address the fact that a large group of HIV positive people are unaware of their status and that HIV testing remains low among particular sub-groups, especially key and vulnerable populations: the 'Priority Populations' (including both Key (KP) and Vulnerable populations). KPs include sex workers and their clients, long distance truck drivers, MSM, fisher folk, boda-boda riders, and uniformed forces. 'Vulnerable Populations' refer to discordant couples, infants and young children, sexually abused persons, adolescents, and youth especially girls, young women, emancipated minors, OVC, out of school children, persons with mental illness, pregnant women, PWD, health workers, internally displaced persons, refugees, prison inmates, and migrant workers.<sup>169</sup>

In Uganda sex work and homosexuality are criminalised and therefore people from these sub-populations may not seek health care services. Stigma, discrimination, lack of confidentiality, coercion,

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<sup>165</sup> Uganda AIDS Commission (UAC) (2020). *The Presidential Fast-Track Initiative on Ending AIDS in Uganda: A Presidential Handbook—Revised Edition* (Pp. 1–2).

<sup>166</sup> *Ibid.*, 2.

<sup>167</sup> *Ibid.*, 5–9.

<sup>168</sup> Ministry of Health (MoH) (2016). *National HIV Testing Services Policy and Implementation Guidelines in Uganda (NTS)*, 4<sup>th</sup> Ed. (P. 1).

<sup>169</sup> *Ibid.* P. 5.

fear of repercussions and lack of appropriate services, resources and supplies also deter them from being tested. For the same reasons, KPs do not easily accept linkage to care.<sup>170</sup>

HTS Policy is based on the guiding principle of protection for human rights, requiring ethical HIV counselling and testing, conducted within a supportive environment.<sup>171</sup> The Policy is also guided by the right to dignity, privacy, and confidentiality in testing and treatment. HTS promotes equality for priority populations while recognising and addressing the vulnerable position of women, girls, children, KPs, and PWD. In line with the best interest of the child standard, children's rights and needs are at the forefront of all interventions for HIV prevention, treatment, and support.<sup>172</sup>

There is still an unmet need for HTS among Priority Populations, due to limited access to health services, taking into consideration each group's particular vulnerabilities and concerns about the stigma and discrimination they face, while protecting the privacy and confidentiality of each group. For KPs, key strategies include: a KP peer-led approach; offering services at their convenience; providing services in settings where privacy, confidentiality, and safety can be ensured; using the snowball method to reach peers; and using targeted community-based HTS.<sup>173</sup> Innovative community-based approaches for reaching KPs are advised—such as mobile outreaches, moonlight clinics, and special events in safe environments.<sup>174</sup>

HTS Policy demands delivery of youth and adolescent-friendly HTS, offering convenient services in places where privacy and confidentiality can be ensured, age-appropriate messaging, and special events for adolescents.<sup>175</sup> A mix of facility and community-based approaches is proposed,<sup>176</sup> prioritising HTS for adolescents and young people who are part of KPs. The Policy suggests tailored strategies to reach KPs such as the peer-led approach, moonlight clinics, using mobile vans in hotspots, HTS outreach camps to provide services to fishing communities in the islands, and special clinics in safe spaces.<sup>177</sup>

Adolescents from KPs and vulnerable groups (e.g., adolescents living on the streets or who are sexually exploited, heads of households, orphans, and girls engaged in sex with older men) should be prioritised.<sup>178</sup>

To enable PWDs to access services in a way that meets their specific needs, HTS proposes strategies for integrating disability, include training of service providers in sign language, assessing the capacity of PWD to consent to HIV testing, and remodelling facilities.<sup>179</sup> It offers guidance on the provision of high quality and non-discriminatory HTS to all persons in Uganda based on the '5 Cs' recommended by WHO: Consent, Counselling, Confidentiality, Correct results, and Connection to Care for those who test positive.<sup>180</sup>

The important ethical issue of consent is addressed: HTS allows young people over the age of 12 to give consent for testing services. Consent for HTS is obtained and documented in the appropriate

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<sup>170</sup> Ibid, 24.

<sup>171</sup> Ibid, 10.

<sup>172</sup> Ibid, 11.

<sup>173</sup> Ibid, 24.

<sup>174</sup> Ibid, 19.

<sup>175</sup> Ibid, 20.

<sup>176</sup> Ibid, 53.

<sup>177</sup> Ibid, 75.

<sup>178</sup> Ibid, 20.

<sup>179</sup> Ibid, 22.

<sup>180</sup> Ibid, 28.

patient records with evidence using a signature or thumbprint. Service providers are expected to accommodate persons with hearing, visual, and speech disabilities to enable them to give informed consent for HTS.<sup>181</sup>

HTS also has categories of persons from whom informed consent may not be required in order to prevent transmission, namely: pregnant and breastfeeding women and their spouses; persons who have committed sexual offences; individuals to be initiated on PEP; and donors of blood, body tissue, and organs.<sup>182</sup> The Policy, in waiving the right to informed consent for persons who have committed sexual offences in particular, has the potential to increase stigma associated with HIV and the association of the disease with criminality and wrong-doing.

Disclosure of HIV status may only be done with informed consent except in ‘special circumstances,’ such as: to the parent or guardian of a minor or person of unsound mind; to a medical practitioner where the HIV status of a person is clinically relevant; to a person authorised by the HIV Prevention and Control Act (2014) or any other law; and to a person that may be authorised to receive such results by a court in the context of defilement or rape.<sup>183</sup>

Snowball contact tracing is also suggested for highly stigmatised target groups such as MSM and sex workers.<sup>184</sup> KPs should be given intense post-test counselling combined with follow-up counselling and linkage support by peer leaders, because they may lack social networks and family support to help them deal with a positive diagnosis.<sup>185</sup>

The HTS Policy and Implementation Guidelines create an enabling framework for testing both the general and priority populations for HIV. Guidance for handling priority KVPs is impressive, as are the innovative strategies deployed for reaching left-behind groups. The constraining factor is the use of stigmatising terminology in referring to ‘alcoholics’ and ‘drug addicts,’ contrary to the human rights-focused approaches and terminologies used elsewhere in the Policy.<sup>186</sup> Like the HIV Prevention and Control Act (2014), it also allows for mandatory testing in cases of rape and defilement, which may also constrain some from accessing HTS services.

### ***Ministry of Health Aids Control Program Addendum to the HIV Testing Services Policy & Implementation Guidelines: HIV Self-Testing & Assisted Partner Notification Services (2018)***

The addendum supplements the existing 2016 National HTS policy and implementation guidelines, with new evidence-based information that allows for alternative testing approaches in the hope of improving access for key and priority populations and people who may not otherwise present for HIV testing.”<sup>187</sup> Alternative approaches may assist in persuading people with undiagnosed HIV them to get tested.

The main objective is to implement and scale-up HIV self-testing (HIVST) in a way that is ethical, acceptable, effective, and evidence-based, and to provide guidance on how HIVST should be tailored to specific sub-populations and integrated into existing community-based and facility-based HTS.<sup>188</sup> The

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<sup>181</sup> Ibid, 35.

<sup>182</sup> Ibid, 33.

<sup>183</sup> Ibid, 41.

<sup>184</sup> Ibid, 76.

<sup>185</sup> Ibid, 86.

<sup>186</sup> Ibid, 5.

<sup>187</sup> Ministry of Health (MoH) Aids Control Program Addendum to the HIV Testing Services Policy & Implementation Guidelines: HIV Self-Testing and Assisted Partner Notification), (2018). 21.

<sup>188</sup> Ibid, P. 17.

Addendum is also guided by the 5 Cs of Consent, Confidentiality, Counselling, Correct results, and Connection to Care.<sup>189</sup>

There will be more emphasis on self-testing (HIVST) for people who find it difficult to access health centres. Among the advantages of HIVST are that it ensures discretion, removes the fear of stigma, increases patient autonomy, and still promotes access to HTS.<sup>190</sup> HIVST has proven more acceptable to female sex workers, fishermen, and the partners of pregnant women. It has also been shown to increase overall HIV testing (and repeat testing) among KVPs.<sup>191</sup> Other delivery models also feature, including community-based peer-to-peer delivery, workplace-based delivery models, and the community-based distributor delivery model already in use by community health workers.<sup>192</sup> The target population for HIVST are priority populations, KVPs, emancipated minors, young people (between the age of 18 and 24 years), and men.<sup>193</sup>

Another new development is the increasing recourse to Social Behaviour Change Communication (SBCC) - the strategic use of coordinated messages across diverse communication channels to promote change in knowledge, attitudes, norms beliefs and behaviours. This is proving to increase perception of the HIV risk, address barriers to HIVST demand and utilisation, provide a supportive environment at the family, community, and facility levels for HIVST uptake, and motivate HIV positive clients to start ART.<sup>194</sup>

The Addendum also introduces and sets out Assisted Partner Notification (APN), to be offered as a core component of prevention services for PLHIV. APN can be described as “a process through which HIV-positive index clients (i.e., infected persons who are candidates for APN) are interviewed to elicit information about their sexual partners, who can then be confidentially notified of their possible exposure or potential risk and offered HIV testing services.”<sup>195</sup>

### ***National Comprehensive Condom Programming Strategy & Implementation Plan 2020 – 2025 (2020)***

The people-centred National Comprehensive Condom Programming (CCP) Strategy aims to promote the use of condoms, both for males and females, guided by principles of equity and gender sensitivity. Increased access to free and/or subsidised high-quality female and male condoms and lubricants is viewed as a human right for the sexually active population. Condoms are one of the five critical pillars for HIV prevention and a cost-effective contraceptive device, particularly for the young.<sup>196</sup>

Although CCP aims to reach all sexually active males and females, the specific focus is on the main KP groups: populations at high risk of HIV transmission or acquisition, i.e., adults and young people engaged in multiple sexual partnerships; men and women who engage in transactional sex with clients; adults working away from home such as transport and migrant workers, uniformed personnel, fishermen and boda-boda riders; PWIDs; gay men and other MSM; and transgender people, prisoners and other incarcerated people, people who access family planning clinics and service delivery points, as well as

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<sup>189</sup> Ibid, 23.

<sup>190</sup> Ibid, 17.

<sup>191</sup> Ibid, 18.

<sup>192</sup> Ibid, 28.

<sup>193</sup> Ibid, 24.

<sup>194</sup> Ibid, 36–37.

<sup>195</sup> Ibid, 53.

<sup>196</sup> National Comprehensive Condom Programming Strategy & Implementation Plan 2020 – 2025 (2020) 7.



people who live in HIV concordant and discordant relationships. All these KP sub-groups face marginalisation due to socio-cultural beliefs and norms, and the constraining legal and policy framework, yet they are most likely to engage in risky behaviour that exposes them to HIV.

CCP assesses condom use, motivation, access, and knowledge of how to use them correctly,<sup>197</sup> and projects the condom needs for priority populations for the period of 2020 to 2023 and sets out to define and prioritise targeted population segments which are hard to reach, vulnerable, and in need of equity in access. It envisions exploring alternative distribution channels for free condoms, targeting hard to reach areas and KPs, scaling up coverage of condom dispensers in strategic spots to ensure wider availability, and identifying functional community condom depots. The Strategy also envisions expanding condom availability beyond the traditional channels of public health facilities to non-traditional channels, such as community social and livelihood groups, and to engage private sector actors in condom distribution.

Condom Programming support<sup>198</sup> covers advocacy, behaviour change communication, social and operational research, human and institutional capacity building, integration, strategic information monitoring and evaluation, documentation, and dissemination. It has an advocacy objective of addressing a “mentality of morality in policy setting” at the highest levels in government, advocating for SRHR policies and regulations to create an enabling environment for all sexually active people to access information and services.

### ***The National Policy Guidelines on Post Exposure Prophylaxis for HIV, Hepatitis B and Hepatitis C (2017)***

The National Policy Guidelines provide information on Post Exposure Prophylaxis (PEP) practice, management of exposures and trains health providers on the use of PEP. Its objectives include creating awareness about the dangers of accidental exposure to HIV in occupational and non-occupational settings; advocating for PEP; and managing clients who have had accidental exposure to HIV, the Hepatitis B or Hepatitis C virus.<sup>199</sup>

These Guidelines set out common types of occupational and non-occupational exposures to HIV and how to manage such exposures.<sup>200</sup> Informed consent and confidentiality must be applied at all times, particularly when ascertaining the HIV status of the ‘exposure source’ person.<sup>201</sup>

Child victims of sexual violence are particularly vulnerable to be infected with HIV,<sup>202</sup> However, the guidelines fail to recognise and address the particular vulnerabilities of KPs and MARPs to HIV exposure: there are no particular provisions for ensuring that KPs are aware of the availability of PEP and enabled to access it when accidentally exposed to HIV.

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<sup>197</sup> Ibid, 11-12.

<sup>198</sup> Ibid, 19.

<sup>199</sup> Ministry of Health (MoH) (2007), *The National Policy Guidelines on Post Exposure Prophylaxis for HIV, Hepatitis B and Hepatitis C* (2017), 4.

<sup>200</sup> Ibid, 10–17.

<sup>201</sup> Ibid, 15.

<sup>202</sup> Ibid, 13.

## **Consolidated Guidelines for the Prevention and Treatment of HIV and AIDS in Uganda (2020)**

The Ministry of Health's *Consolidated Guidelines for Prevention and Treatment of HIV and AIDS in Uganda* of 2020 (replacing the 2018 Guidelines) are structured along the continuum of HIV prevention, testing, treatment, and care. They provide guidance on the diagnosis of HIV, the care of PLHIV, and the use of antiretrovirals (ARVs) for treating and preventing HIV infection.<sup>203</sup>

The goal of these Guidelines is to expand access to ART and to optimise treatment. Specific objectives are to provide a standardised and simplified guide for offering HIV testing services, and to provide guidance and updates on other HIV prevention strategies, the use of ARV drugs for HIV treatment and prevention, feeding HIV-exposed infants and children and guidance on key operational and service delivery issues with the aim of increasing access to HIV services and strengthening the continuum of HIV care.<sup>204</sup>

*HIV testing services (HTS):* Testing is the entry point to HIV prevention, care, treatment, and support services. In line with human rights principles, testing must “non-discriminatory and offered in a Public Health approach that observes the 5Cs (Confidentiality, Consent, Counselling, Correct results, and Connection to Care).<sup>205</sup> Providers should ensure privacy and confidentiality; information discussed with clients must not be disclosed without the client's consent. Clients must consent to Assisted Partner Notification Testing (APN) before they can be interviewed to identify their sexual contacts. Quality counselling should be provided before and after testing. HTS providers should adhere to the national testing algorithms and follow SOP for testing to ensure clients receive the correct results. HIVST clients should be provided with clear instructions and graphic illustrations on how to conduct HIVST. Providers should then link HTS clients to appropriate support services.<sup>206</sup>

Targeted or ‘Risk Based Testing,’ (RBT) is the process in which HTS is focused on high-risk KVPs and requires providers to follow a set criterion to determine eligibility. KVPs have specific risk factors that drive the epidemic, but RBT allows for early identification, maximises use of the HTS, allows focus on higher-risk populations and yields a higher positivity rate than routine testing.<sup>207</sup> RBT is encouraged over routine testing within the facility-based model, prioritising TB presumptive clients, malnourished children, clients with an STI, pregnant and breastfeeding women, sexual offenders, and survivors, as well as blood and organ donors.<sup>208</sup>

The community-based HTS model serves KVPs that are unlikely to access facility-based HTS and includes home-based HIV testing and counselling, Social Network Strategy (SNS) for HIV testing, and index client testing. Snowball testing is recommended as a form of index testing to reach sex workers and MSM. Community-based CITC includes workplace HIV testing and HTS outreach targeting priority populations, either through door-to-door campaigns in targeted areas for KPs such as fisher folk or at hotspots where sex workers operate.<sup>209</sup>

HIVST is focused on at-risk individuals who have limited access to facility-based HTS. In the public sector, it is aimed at men, adolescents, KPs, and priority populations. HIVST kits are to be provided for

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<sup>203</sup> Ministry of Health (MoH) (2020), *Consolidated Guidelines for Prevention and Treatment of HIV and AIDS in Uganda* (2020), 17.

<sup>204</sup> *Ibid*, 18.

<sup>205</sup> *Ibid*, 20.

<sup>206</sup> *Ibid*, 21.

<sup>207</sup> *Ibid*, 22.

<sup>208</sup> *Ibid*, 23.

<sup>209</sup> *Ibid*, 23-24.

mothers in Maternal Child Health (MCH) settings whose partners' HIV status is unknown, if they consent. The Guidelines also provide an HIV testing eligibility screening tool for children and adolescents between the ages of 18 months and 14 years.<sup>210</sup> These HIV testing models and approaches are designed to reach the 12% of the population of PLHIV that do not yet know their HIV status and cannot easily access conventional healthcare service facilities. This targeted and risk-based testing is intended to increase uptake of testing and treatment services.

*HIV prevention services:* The HIV epidemic is driven by multiple behavioural, biomedical, and structural factors and therefore a combined prevention approach (behavioural change, risk reduction, biomedical interventions, and comprehensive condom programming) is required for greatest impact. Services for behavioural change prioritise delaying sexual debut, discourage risky sexual or cultural practices and reduce risk by consistent condom use.<sup>211</sup>

The Ugandan government promotes Safe Male Circumcision (SMC) as an important biomedical intervention for HIV prevention as this reduces the risk of HIV acquisition by approximately 60%. Additionally, by providing for PrEP in its policies, the Ugandan government has filled a critical gap in HIV prevention, especially for people who have multiple sexual partners, such as sex workers who cannot guarantee that they will use a condom every time. Condoms are targeted at high-risk populations who may also be targeted for PrEP administration (particularly for sex workers, fisher folk, long-distance truck drivers, MSM, uniformed forces and AGYW. Post exposure prophylaxis (PEP) for HIV (the short-term use of ARVs to reduce the risk of acquiring HIV after potential exposure).<sup>212</sup>

Targeted services for KPs/PPs increase service uptake while also reducing stigma and acknowledge the successes of models which train service providers to provide services which are KP/PP friendly, involve KP communities as peer-educators, and engage duty-bearers.<sup>213</sup> Combined strategies, such as APN, Social Networking Services (SNS), and Differentiated Service Delivery (DSD) approaches along with the development of Drop-in Centres (DICs) increase HIV service access among KPs. Structural interventions are needed to address GBV, which increases the risk of acquiring HIV and negatively affects ART adherence.<sup>214</sup> Provision for the integration of HIV and GBV services is of special importance given the high prevalence of GBV among PLHIV. According to UNAIDS,<sup>215</sup> women who have experienced violence are up to three times more likely to be infected with HIV than those who have not. In Uganda, more than 1 in 5 women aged 15 to 49 experience sexual violence.<sup>216</sup>

Informants interviewed for this study hailed the 'Test and Treat' policy as a significant aspect of HIV treatment because it ensures that people who test positive for HIV are immediately enrolled in treatment, which enables them to suppress the virus and live a healthy life, without worrying about developing AIDS as long as they adhere to their treatment schedule.

*Elimination of Mother-to-Child-Transmission of HIV (EMTCT) and improving Maternal, New-born, Child, and Adolescent Health (MNCAH):* Mother-to-child transmission of HIV accounts to up to 18% of all new infections in Uganda. Current evidence shows that with effective interventions (including use of ART)

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<sup>210</sup> Ibid. 25.

<sup>211</sup> Ibid, 41-42.

<sup>212</sup> Ibid, 42-44.

<sup>213</sup> Ibid, 48.

<sup>214</sup> Ibid, 49.

<sup>215</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS) (2014). *Unite with women - Unite against violence and HIV.*

<sup>216</sup> Ministry of Health (MoH) (2019), *Uganda National Adolescent Health Landscape and Recommendations for Improved Service Delivery Report.*

the rate of transmission could be reduced to less than 5%. The Guidelines recommend the integration of EMTCT interventions and MNCAH services and recognises the specific PMTCT needs of pregnant and breastfeeding AGYW.<sup>217</sup> They set out a minimum package of EMTCT services to be delivered at the community level<sup>218</sup> and provide key information to ensure the health of pregnant women with HIV and to prevent HIV transmission through breastfeeding.<sup>219</sup>

*Care and support for PLHIV:* A minimum healthcare service package has been developed to be offered to all PLHIV, which standardises programming, implementation, and delivery of integrated HIV services.<sup>220</sup> Psychosocial care and support is seen as key to ensuring HIV prevention, care, treatment, and treatment adherence.<sup>221</sup> The Guidelines therefore provide for a psychosocial care and support service package which includes treatment adherence preparation and support, mental health support, GBV care, and support which should be offered to PLHIV with consideration of their vulnerabilities and differences.<sup>222</sup>

Special attention is given to HIV screening for orphans and vulnerable children and adolescents to link them with the appropriate services.<sup>223</sup> Healthcare providers are required to offer Adolescent-Friendly HIV Services (AFHS) to improve uptake of HIV treatment services among this sub-group, including a peer-led approach, walk-in services, age-appropriate information and generating demand for HTS through social media, within a minimum package of services which include information and education, community engagement, favourable facility characteristics, equity and non-discrimination, and adolescent participation.<sup>224</sup>

Strategies for care retention include decentralisation of ART and laboratory services; implementation of differentiated service models including community models of care; strengthening patient appointment and tracking systems; strengthening client counselling and education at health facilities; and implementation of an evidence-based communication strategy.<sup>225</sup> Differentiated service delivery (DSD) is recommended to improve efficiency, address the needs of individuals, and inform targeted interventions.<sup>226</sup> Overall, DSD delivers ART in a way that acknowledges barriers faced by PLHIV and empowers them to overcome these barriers. Target groups to consider for DSD are children, adolescents, pregnant and lactating women, adult men and women, KPs, patients starting ART for the first time, and patients with advanced disease.<sup>227</sup> These groups can be categorised as either 'stable' or 'unstable' after six months of anti-retroviral treatment.<sup>228</sup>

A DSD for adolescents, in particular, is Young People and Adolescent Peer Support (YAPS) which places care givers and family members at the centre of the strategy.<sup>229</sup> The YAPS model increases identification,

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<sup>217</sup> MoH, *Consolidated Guidelines for Prevention and Treatment of HIV and AIDS in Uganda*, 51-52.

<sup>218</sup> *Ibid*, 74–75.

<sup>219</sup> *Ibid*, 77.

<sup>220</sup> *Ibid*, 80.

<sup>221</sup> *Ibid*, 122.

<sup>222</sup> *Ibid*, 123.

<sup>223</sup> *Ibid*, 134-5.

<sup>224</sup> *Ibid*, 135-9.

<sup>225</sup> *Ibid*, 139-140.

<sup>226</sup> *Ibid*, 183.

<sup>227</sup> *Ibid*, 184.

<sup>228</sup> *Ibid*, 189.

<sup>229</sup> *Ibid*, 192.

ART coverage, viral load suppression, and general wellbeing of adolescents and young people through psychosocial support.<sup>230</sup>

Overall, the adoption in Ugandan policies of modern biomedical interventions for HIV prevention and treatment—such as condoms and lubricants, ART, and PrEP—as well as different treatment and care delivery models (such as the Community Client Led ART Delivery—CCLADs) is seen by stakeholders as a positive development that makes it possible for PLHIV and those at risk of HIV to access and utilise HIV services.

### ***The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights Third Edition (2012)***

The National Policy Guidelines have the goal of improving the sexual and reproductive health of everyone in the country.<sup>231</sup> Guidelines for service policy and for service standards provide explicit direction and focus regarding the provision of RH and SRHR services. The document clarifies the roles of Ministries, Development Partners, communities, and stakeholders involved in “planning, implementation, monitoring and evaluation of quality, integrated, gender sensitive and rights-based RH services” to standardise the delivery of RH services in order to “ensure optimum and efficient use of resources for the sustainability of RH services” and to promote SRHR.<sup>232</sup>

The SRHR Policy Guidelines have the objective of improving and ensuring “quality, accessible and equitable RH services” at various levels of service delivery, including the community level.<sup>233</sup> Another goal is the provision of family planning services to everyone who needs them, specifically targeting specific groups including adolescents, individuals and couples infected or affected by HIV, commercial sex workers, and survivors of SGBV.<sup>234</sup> The intention is to integrate family planning services in all health services, which would include HTS. Condom use is promoted as the only family planning method which protects against the transmission of HIV; other family planning methods are considered from the viewpoint of PLHIV or those at risk of contracting HIV.<sup>235</sup>

The Safe Motherhood Programme aims to ensure that no woman or new-born should suffer morbidity or mortality related to pregnancy or childbirth. There is advice on PMTCT and the provision of HTS at antenatal as well as postnatal stages of healthcare, for both women and unborn/new-born babies.<sup>236</sup> An entire chapter is dedicated to adolescent SRH, with the objective of increasing the availability and accessibility of SRHR information and services to adolescents and influencing behavioural change, with HTS included as a component of adolescent SRH.

The guidelines recommend strengthening linkages between HIV and SRH policies and service delivery, since the health needs of sexually active individuals are best met through a ‘package of care.’<sup>237</sup> Such an approach can help address the reproductive health needs of PLHIV while also enabling access to HTS to persons presenting with RH needs. The goal of integrated service provision envisages increasing HIV and AIDS services at health clinics, while also increasing the availability of SRH services at ART clinics

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<sup>230</sup> Ibid.

<sup>231</sup> Ministry of Health (MoH) (2012), *The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (2012)*, 12.

<sup>232</sup> Ibid.

<sup>233</sup> Ibid, 19.

<sup>234</sup> Ibid.

<sup>235</sup> See for example, Ibid. 27, 29.

<sup>236</sup> See Ibid. 36–54.

<sup>237</sup> Ibid.

and developing integrated messages. Priority groups targeted for integrated service delivery include adolescents, commercial sex workers, and homosexuals. As such the Policy Guidelines do not consider the broad range of PLHIV, KPs, and Priority Groups such as PWD, PWIDs, children, or the elderly.<sup>238</sup>

Special attention is given to addressing and preventing SGBV. One of the strategies provided in this regard is to create awareness about the health implications and consequences of SGBV at the community level and to influence behaviour among individuals, communities, and leaders in support of SGBV prevention and response.<sup>239</sup> The objective is to involve males, including adolescents and youth, in SRHR issues, as well as HIV and AIDS and SGBV and to increase access to SRH services for males.<sup>240</sup>

### ***Uganda Family Planning Costed Implementation Plan, 2015-2020 (2014)***

The Uganda Family Planning Costed Implementation Plan (FP-CIP) aims to meet the unmet need for family planning to 10% and increase the modern contraceptive prevalence rate among married women and women in union to 50% by 2020.<sup>241</sup> The FP-CIP recognises family planning as fundamental to SRHR, and the human rights of women and girls. The FP-CIP promotes safer sexual behaviours among young people through its activities to improve knowledge of FP and reproductive health among young people.<sup>242</sup>

The FP-CIP draws a link between family planning and HIV, in the sense that HIV status is recognised as one of the attributes that contributes to a person's vulnerability to exclusion from family planning.<sup>243</sup> As such, the Plan includes PLHIV as a target group to reach with FP services.<sup>244</sup> The Plan acknowledges the gaps in the integration of SRHR and HIV services and that there is a need, at the very least, to strengthen referral systems.<sup>245</sup>

The FP-CIP also provides for the creation of protocols to integrate FP into HIV service delivery in facilities and as such operationalises the HIV NSP objective of integration of HIV services with SRHR and other services.<sup>246</sup> The FP-CIP, in its attempts to empower young people with knowledge and access to FP, can also serve to ensure a greater level of agency among this group in protecting themselves from HIV infection. Involving men in the FP uptake and demand creation may further increase the sense of responsibility among men to avoid unwanted pregnancies by using condoms—while at the same time reducing risks of HIV transmission.

### ***Investment Case for Reproductive, Maternal, New-born, Child and Adolescent Health Sharpened Plan for Uganda 2016/17–2019/20 (2016)***

The Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) Sharpened Plan, referred to as 'the investment case,' has the goal of ending "preventable maternal, new-born, child, and adolescent deaths and improv[ing] the health and quality of life of women, adolescents, and children in Uganda."<sup>247</sup> The investment case focuses on five strategic shifts to address these gaps, namely: (1)

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<sup>238</sup> Ibid, 65.

<sup>239</sup> Ibid.

<sup>240</sup> Ibid, 81-83.

<sup>241</sup> Ministry of Health (MoH) (2014), *Uganda Family Planning Costed Implementation Plan, 2015–2020*, 1.

<sup>242</sup> Ibid, 23.

<sup>243</sup> Ibid, 10.

<sup>244</sup> Ibid, 58.

<sup>245</sup> Ibid, 12.

<sup>246</sup> Ibid.

<sup>247</sup> Ministry of Health (MoH) (2016), *Investment Cas for: Reproductive, Maternal, New-born, Child and Adolescent Health Sharpened Plan for Uganda 2016/17–2019/20*, 19.

emphasising evidence-based high-impact solutions; (2) increasing access to high-burden populations; (3) geographical focusing or sequencing; (4) addressing the broader multi-sectoral context; and (5) ensuring mutual accountability for RMNCAH outcomes.<sup>248</sup>

The investment case recognises that HIV/AIDS, tuberculosis, and malaria exacerbate other RMNCAH problems, and that these diseases are the main cause of death among women and children in Uganda.<sup>249</sup> The investment case states that HIV/AIDS, TB, and malaria strategies should be integrated within “multiple points along the RMNCAH continuum of care” and seeks to address the slow pace of implementation of integrated HIV and AIDS interventions within packages of RMNCAH care.<sup>250</sup> Key entry points for HIV and AIDS strategy integration are: family planning, antenatal care, prevention of mother-to-child transmission of HIV (PMTCT), post-natal care, and the provision of nutrition, as well as psychosocial support to vulnerable women, children, and adolescents.<sup>251</sup>

Three key investment areas for adolescent health are identified, namely: actionable data on adolescent health; meaningful youth participation in policy decisions on adolescent health, especially for the most vulnerable such as adolescents living with HIV or adolescents with disabilities; and promoting school-linked health facilities as adolescent health sites.<sup>252</sup> The envisioned adolescent package of health services is intended to address the increasing HIV incidence among adolescents and SGBV, along with pregnancy timing and psychological wellbeing.<sup>253</sup>

The RMNCAH, if implemented effectively, will create a more enabling environment for HIV service access and uptake for all groups affected by or living with HIV and AIDS. However, the Plan does not make explicit mention of key populations in the LGBTI category.

### ***Ministry of Health Department of Quality Assurance Patients’ Charter (2009)***

The Patients’ Charter was adopted to empower health consumers to demand high quality healthcare, to promote the rights of patients, to improve the quality of life of all Ugandans, and eventually to eradicate poverty nationwide.<sup>254</sup> The Charter sets out particular rights of patients, including the right to impartial access to treatment and emergency medical care and the prohibition of discrimination on the basis of disease, religion, political affiliation, disability, race, sex, age, social status, ethnicity, nationality, or country of birth.

Article 10 of the Charter provides that every patient has the right “to be given adequate and accurate information about the nature of one’s illness, diagnostic procedures, the proposed treatment for one to make a decision that affects any one of these elements.” The Charter protects the right of confidentiality and privacy of patients and provides that information concerning a patient’s health can only be disclosed with informed consent or if required by law or a court order.<sup>255</sup>

These provisions on informed consent and the protection of confidentiality and privacy are enabling factors in respect to HIV testing and treatment service uptake. The Charter, however, allows a health worker to share information about a patient without informed consent where the disclosure of the

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<sup>248</sup> Ibid.

<sup>249</sup> Ibid, I I.

<sup>250</sup> Ibid.

<sup>251</sup> Ibid.

<sup>252</sup> Ibid, 29.

<sup>253</sup> Ibid.

<sup>254</sup> Ministry of Health (MoH) Department of Quality Assurance *Patients’ Charter* (2009).

<sup>255</sup> Ibid, Article 15.

information “is vital for the protection of the health of others or the public, and that the need for disclosure overrides the interest in the information’s non-disclosure.”<sup>256</sup> This provision may serve to deter the uptake of HIV testing and treatment services since a person who suspects that they may be HIV positive would not wish to be in a position where health workers could disclose their HIV positive status to their sexual partners without their consent. The provisions of the Charter also do not have the force of the law and are only applied as guidelines based on the discretion of health workers and managers.

One of the gaps identified in the numerous policies on HIV services is that they do not adequately provide for prison settings. Yet by their nature, prisons may not be suited to the conventional health services that prioritise services for women and children such as maternal and child health services.

#### **4.1.5 Laws, Policies and Frameworks that Protect the Rights of Women and Girls**

##### **Constitution of the Republic of Uganda (1995)**

The Constitution has specific clauses recognising and protecting the rights of women. Firstly, in Article XV of the National Objectives and Directive Principles of State Policy (NODPSP): Recognition of the role of women in society: “the State shall recognise the significant role that women play in society.”<sup>257</sup>

Secondly, Article 33 spells out the full nature of women’s rights and equality with men: and protections for these rights: “Women shall be accorded full and equal dignity of person with men”. It places an obligation on the State to act on women’s behalf, in Clause 2 “The State shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement.”<sup>258</sup> Clause 3 notes women’s “unique status and natural maternal functions” before clarifying equality in Clause 4: “Women shall have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities.” The final assurance of protection comes in Clause 6 “Laws, cultures, customs, and traditions which are against the dignity, welfare or interest of women or which undermine their status, are prohibited by this Constitution.”<sup>259</sup> Women are to be protected by their employers during pregnancy and after giving birth.<sup>260</sup>

##### **The Domestic Violence Act (DVA) (2010)**

Domestic violence is prohibited by the DVA, which provides for the protection and relief of victims of domestic violence and the punishment of perpetrators. It lays down the procedures and guidelines to be followed in court to protect and compensate victims of domestic violence, determines the jurisdiction of courts to handle domestic violence cases and regulates the enforcement of court orders. Sentences for offenders include a fine or imprisonment, as well as payment of compensation to the victim.<sup>261</sup>

The DVA sets out the processes to be followed in hearing domestic violence cases before Local Council Courts as well as the duties of police officers in handling domestic violence cases.<sup>262</sup> It allows

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<sup>256</sup> Ibid, Article 15(ii).

<sup>257</sup> Constitution of the Republic of Uganda, Article XV.

<sup>258</sup> Ibid, Article 33.

<sup>259</sup> Ibid, Article 33(1-6).

<sup>260</sup> Ibid, Article 40(4).

<sup>261</sup> The Domestic Violence Act (2010), Section 4.

<sup>262</sup> Ibid, Section 6, 7.



for protection orders, sets out their contents and the circumstances under which they can be issued.<sup>263</sup> The Act protects women against GBV in the home setting and enables domestic violence to be addressed and eventually, ended. As such, it is an enabling law in respect to HIV as it reduces women's vulnerability to HIV infection that is often perpetuated by domestic and gender-based violence.

### ***The Uganda Gender Policy (2007)***

The Uganda Gender Policy was adopted to guide and direct all levels of planning, resource allocation, and implementation of development programmes from a gender perspective. The goal is the achievement of gender equality and empowerment of women as an integral part of Uganda's socioeconomic development. The priority focus areas of this policy are: improved livelihoods; promotion and protection of rights; participation in decision-making and governance; and recognition and promotion of gender in macroeconomic management.

It prioritises gender inequality in access to justice and addresses issues such as socio-cultural discrimination against women and girls, GBV, high maternal and child mortality and morbidity, low levels of literacy and high levels of fertility.

The Gender Policy is important in creating an enabling environment for women in respect of HIV as it promotes protection from GBV, (a driver of sexual attack and potential HIV infection) enables access to redress for injustices and supports initiatives that lead to economic independence and better services for women.

### ***National Action Plan on Women, Girls, Gender Equality and HIV & AIDS 2016/17–2020/21 (NaWoGGE) (2017)***

The National Action Plan on Women, Girls, Gender Equality and HIV & AIDS (NaWoGGE) acknowledges that women and girls constitute the largest proportion of individuals living with HIV in Uganda and the factors fuelling HIV among women. These include GBV, power imbalances between men and women, HIV stigma and discrimination, early sexual debut, high risk sex, multiple and concurrent sexual partnerships, the low status of women in society, and some unfavourable legal provisions, such as the criminalisation of sex work in the HIV Prevention and Control Act (2014), which discourage HIV testing.<sup>264</sup>

The NaWoGGE acknowledges that Uganda has domesticated global gender normative frameworks and standards and notes the disparities in HIV service access, utilisation, and adherence, among adolescent women in particular.

NaWoGGE is delivered under four thematic areas of the previous NSP (2015/16–2019/20):

- (1) advancement of human rights.
- (2) multi-sectoral gender mainstreaming.
- (3) women's economic empowerment.
- (4) and good governance and accountability.<sup>265</sup>

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<sup>263</sup> Ibid, Section 10–13.

<sup>264</sup> Ministry of Gender, Labour and Social Development (MGLSD) (2017), *National Action Plan on Women, Girls, Gender Equality and HIV & AIDS 2016/17–2020/21* (NaWoGGE), 5–10.

<sup>265</sup> Ibid, 3.

The purpose of the NaWoGGE is to “promote and advocate for prioritised investment and implementation of high impact, gender responsive strategies that will save lives, prevent new infections among both male and female populations while respecting diversity.”<sup>266</sup> The objectives of the Action Plan include scaling up social protection and livelihood support to empower women and girls living with and/or affected by and at risk of HIV; to increase gender equality by addressing the specific needs of women and girls in planning, policy, and program implementation; to scale up services and interventions that reduce gender-related vulnerabilities to HIV infection.<sup>267</sup>

The NaWoGGE sets out specific strategic actions aimed toward creating a supportive legal framework for gender responsive HIV interventions; advancing women’s rights in the HIV and AIDS response through advocacy; improving livelihoods of women and their economic empowerment by improving access to GBV services; providing socioeconomic skills; eliminating harmful practices; and ensuring multi-sector gender mainstreaming.<sup>268</sup>

The NaWoGGE fills an important gap in terms of linking gender inequality to the spread of HIV and AIDS and setting out specific actions for stakeholders to carry out in order to decrease women’s vulnerability to HIV infection and lower the barriers they face in accessing and retaining HTS.

### ***The National Policy on Elimination of GBV 2019***

The aim is to eliminate GBV from all societies in Uganda. This policy seeks to reduce the prevalence of GBV, create an environment for zero tolerance of GBV, and promote comprehensive care and support services for survivors of GBV. It covers physical violence, emotional and psychological violence, sexual violence, economic violence such as denial of assets and livelihoods, and harmful practices such as female genital mutilation (FGM) and forced marriage.

The policy creates an enabling environment for implementing interventions that address GBV in its various forms, and in different contexts such as communities and workplaces.

#### ***4.1.6 Laws, policies, and Frameworks that Protect the Rights of Adolescents and Young People***

Uganda’s Constitution and Penal Code Act (PCA) both offer specific protections for adolescents and young people. Protection for the rights of all people, including adolescents and children, are enshrined in the Constitution’s Bill of Rights. The PCA sections 124 and 128 criminalise rape and indecent assault, while section 2 of the Penal Code Amendment (2007) Article 129, criminalises defilement and aggravated defilement. This law on defilement protects both boys and girls. Additional protections are found in the policies outlined below.

### ***National Adolescent Health Policy (NAHP) for Uganda (2004)***

This Policy provides direction and focus on the provision of adolescent health services by different stakeholders and provides a framework for planning, implementing, and evaluating adolescent health services. It recognises the critical roles adolescents can play in promoting their own health and development and emphasises the need to include them as participants in planning, implementing, and monitoring development programmes.<sup>269</sup> It also seeks to eliminate gender bias and promote an

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<sup>266</sup> Ibid, 14.

<sup>267</sup> Ibid.

<sup>268</sup> Ibid, 8-6.

<sup>269</sup> Ministry of Health (MoH), *National Adolescent Health Policy for Uganda (2004)*, 8.

enabling social and legal environment for the provision of high quality, accessible adolescent health services.

The NAHP defines adolescents as people between 10 and 19 years of age and recognises categories of adolescents who are particularly vulnerable, such as street children, refugees, those engaging in sex work or substance abuse, those with disabilities, orphans, pregnant adolescents and mothers, and adolescents living with HIV and AIDS.<sup>270</sup>

Adolescents, and female adolescents, are especially vulnerable to reproductive health issues such as early and unwanted pregnancy, unsafe abortion, STIs, HIV and AIDS, as well as psychosocial problems and substance abuse.<sup>271</sup>

The overall goal is to mainstream adolescent health concerns in the national development process to improve the quality of life and standard of living of young people in Uganda. Its objectives include creating an enabling legal and socio-cultural environment that promotes provision of better health and information services for young people; the promotion and protection of the rights of adolescents to health, education, information, and care while encouraging health-related positive behaviour. The Policy also aims to protect girls from harmful traditional practices and all forms of abuse while re-orienting the health system to better meet the special needs of adolescents.<sup>272</sup>

The Policy sets extensive reproductive health targets for adolescents, including increase of contraceptive use and safe sex; delay of age at first sexual intercourse; the provision of post abortion care; increase of knowledge about STIs and AIDS; integrated HIV counselling, home-based care, and support to orphans with HIV; increased ARV access by adolescents; and the incorporation of reproductive health curricula in schools.<sup>273</sup>

It recommends the integration of health services for adolescents into existing services and the implementation of a minimum adolescent health package at different levels of care.<sup>274</sup> The participation of communities as well as adolescents themselves in adolescent health programmes is encouraged.<sup>275</sup>

### ***The National Adolescent Health Strategy 2011–2015 (2011)***

The high prevalence of HIV among adolescents is acknowledged and their vulnerability to health challenges is in part attributed to their willingness to take risks and to the lack of access to information, in the context of socio-ecological circumstances such as poverty, the absence of formal employment opportunities, and their dependence on adults.<sup>276</sup>

The National Adolescent Health Strategy is intended to provide a framework for addressing the health-related needs and problems of young people and to provide strategic direction to government, NGOs, and other collaborating agencies for developing and implementing adolescent health programmes.<sup>277</sup>

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<sup>270</sup> Ibid, 9.

<sup>271</sup> Ibid, 10.

<sup>272</sup> Ibid, 14.

<sup>273</sup> Ibid, 16.

<sup>274</sup> Ibid, 21.

<sup>275</sup> Ibid, 22.

<sup>276</sup> Ministry of Health (MoH) (2011), *The National Adolescent Health Strategy 2011–2015*, 1.

<sup>277</sup> Ibid, 18.

From the perspective of the role this strategy document may have in promoting HTS uptake among adolescents, it first addresses the broad factors which may increase youth vulnerability to HIV infection while decreasing their access to and uptake of HTS.

The Strategy also points to actions that can help create an enabling policy and legal framework to promote the rights and health of adolescents, to increase resources for adolescent health programmes, and to increase access to quality adolescent-friendly health services.<sup>278</sup> A further objective is to enable positive behavioural change among young people and promote their meaningful participation in adolescent programmes, to increase adolescents' uptake of HTS.<sup>279</sup>

### ***The Adolescent Health Policy Guidelines and Service Standards (2012)***

These guidelines aim to provide a minimum package of adolescent-friendly services and set standards in line with the national service standards with the aim of reducing the risk of HIV infection in this age group.<sup>280</sup> Its primary objectives are to increase the supply of information and health services to adolescents to influence positive behavioural change, to create a socio-cultural environment that promotes better health and information services to young people; to protect and promote the rights of adolescents and to train healthcare providers to offer adolescent-friendly services.<sup>281</sup>

Guiding principles aim to ensure community involvement and parental support for adolescent health, encourage the participation of adolescents in health programmes, and promote gender equality in adolescent RH services.<sup>282</sup> It recommends that adolescent-friendly health services include HIV counselling and testing<sup>283</sup> and provides guidance on harmful traditional practices, protection against child abuse, substance abuse, and health and sexuality education adolescent for adolescents, to help reduce the vulnerability of this group to HIV infection.<sup>284</sup>

The chapter dedicated to adolescents and HIV and AIDS, provides adolescent-friendly service standards, education and information on HIV tailored to the 10-19 age group, and aims to ensure that adolescents living with HIV do not suffer discrimination in schools.<sup>285</sup> The Policy Guidelines also provide for adolescent-focused health service access points, such as youth desks in schools, youth desks for out-of-school youth, outposts for hard-to-reach young people, and youth corners in health facilities.<sup>286</sup>

While the Policy Guidelines are comprehensive in their approach to health services for adolescents and the integration of HTS with other health services, they do not provide for particularly vulnerable categories of adolescents, such as orphans, PWD, sex workers, MSM, and transgender adolescents and do not contain any mention of special measures to reach these particular groups with adolescent-friendly health services.

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<sup>278</sup> Ibid, 38–40.

<sup>279</sup> Ibid, 19.

<sup>280</sup> Ministry of Health (MoH) (2012), *Adolescent Health Policy Guidelines and Service Standards*, 9.

<sup>281</sup> Ibid, 8.

<sup>282</sup> Ibid.

<sup>283</sup> Ibid, 12.

<sup>284</sup> Ibid, 14–17.

<sup>285</sup> Ibid, 19–20.

<sup>286</sup> Ibid, 50–58.

### ***The National Sexuality Education Framework (2018)***

Uganda's Ministry of Education and Sports (MoES) drafted a National Sexuality Education Framework which was finalised and launched in 2018, after many years of debate and controversy about the provision of sexuality education in schools, seeking to set uniform standards for the provision of sexuality education.

The authors of the Framework intended this to provide a comprehensive and useful set of guidelines for the provision of age-appropriate information and life skills to in-school children of all ages, as a necessary step to protect children from the risks of sexual violence and exploitation, early sex and teenage pregnancy, and exposure to HIV. However, the Framework was not embraced by all stakeholders. Some religious bodies, responsible for more than half of the schools in Uganda, presented strong objections to the provision of sex education for children, with the result that the Framework may not be successfully implemented in all schools.

The religious objections focussed on two areas: first, the inclusion of the term 'sexuality education' in the name, which some interpret to mean the same as 'sex education' under the misapprehension that this would teach children how to perform the act of sex; and second, the intended inclusion of issues such as sexual diversity and orientation, which are perceived by some as inconsistent with their moral values and those of the country as a whole.

### ***The Uganda National Parenting Guidelines (2018)***

Uganda's Ministry of Gender, Labour, and Social Development (MGLSD) formulated the National Parenting Guidelines to empower parents, the family and community structures to effectively nurture children so that they can realise their full potential. The Guidelines recognise the family as the basic unit of any society, and that good parenting are the foundation for healthy and responsible children and citizens.

The Parenting Guidelines aim to fill critical gaps left by the weakening of traditional systems of raising children and omissions in previous policies, while including out-of-school children into the framework and assigning key roles to parents and caregivers. The MGLSD has undertaken some dissemination of the guidelines, but they have yet to reach all targeted stakeholders.

### ***Guidelines for the Prevention and Management of Teenage Pregnancy in School Settings (2020)***

The Ministry of Education and Sport along with partner stakeholders drew up guidelines to reduce and manage teenage pregnancies, to ensure that school age girls are not denied an education due to early pregnancy. The Guidelines are based on the recognition that the right to education is guaranteed by the constitution irrespective of age, sex, social economic standing, and other characteristics. They aim to promote a change in attitudes towards schoolgirls who get pregnant to allow for their reintegration into schools to continue their education.

Despite government approval and acceptance of the guidelines, their implementation will meet with stiff opposition, in particular from schools owned and run by religious bodies, due to traditional and retrograde attitudes, values, and beliefs about moral standards and strong opinions on whether it is appropriate for teenage mothers to attend the same schools as girls considered sexually 'innocent', who are perceived to be at risk of emulating 'bad' behaviour. The guidelines, by promoting information that might help schoolchildren abstain from early sexual experience, would have an enabling influence

but, unless all stakeholders are persuaded of their benefit, they are unlikely to be implemented in the short term.

### ***The National School Health Policy (Draft, 2018)***

A National School Health Policy would provide clear guidance on the provision of SRHR services to in-school adolescents and young people, but the draft prepared in 2018 has yet to be approved by the Ugandan government. The policy as drafted seeks to promote the integration of life skills-based education at all levels and improve access to and utilisation of SRH services among young people. It promotes linkages between schools with health facilities to ensure access to services for those in need. Stakeholders should call for the finalisation and approval of this policy.

#### ***4.1.7 Laws and Policies that Protect Children's Rights***

The rights of children in Uganda are protected under the Constitution and special protection is accorded to orphans and other vulnerable children.<sup>287</sup> It is prohibited for children to be deprived of medical treatment or any other social or economic benefit by reason of religious or other beliefs.<sup>288</sup>

### ***The Children's Act (as amended in 2016)***

The Children's Act encompasses the principle that the welfare of the child (the child's best interest) is paramount in determining the upbringing of the child.<sup>289</sup> It sets out the specific rights of children, which include the right to "safety, privacy, information and access to basic services" and to be treated without discrimination of any kind on grounds including race, gender, disability, social origin, or any other condition.<sup>290</sup> Section 9A established a National Children Authority, whose functions include advising government on the formulation of child protection policies and child rights programmes, raising awareness generally about children's rights, and monitoring the implementation of laws and policies designed to protect children.

The Act makes failure to report child abuse a criminal offence and prohibits harmful traditional and cultural practices.<sup>291</sup> It also sets out parental duties and responsibilities.<sup>292</sup> It offers protection to children from sexual exploitation and from all forms of violence, including sexual abuse, trafficking, child marriage, and female genital mutilation.<sup>293</sup> It also places a legal obligation on Local Councils to safeguard and promote the welfare of children<sup>294</sup> and provides that a family and children's court can order that a child should be medically examined if there is reason to suspect abuse that may require appropriate examination.<sup>295</sup>

The Children's Act therefore creates an enabling environment for children to be protected from HIV infection and to access HIV testing and treatment services.

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<sup>287</sup> Constitution of the Republic of Uganda, Article 34(7).

<sup>288</sup> Ibid, Article 34(3).

<sup>289</sup> The Children's Act (as amended in 2016), Section 3.

<sup>290</sup> Ibid, Section 4(g), 4(j).

<sup>291</sup> Ibid, Section 4(5), 4(6), 7.

<sup>292</sup> Ibid, Section 5, 6.

<sup>293</sup> Ibid, Section 8A, 42A.

<sup>294</sup> Ibid, Section 11.

<sup>295</sup> Ibid, Section 42(1).

### ***The Sexual Offences Bill (2021)***

This bill was initially approved by the Ugandan parliament on 3<sup>rd</sup> May 2021 and sent to the President for assent<sup>296</sup>. It sought to strengthen protections for children from sexual violence and addressed exposure to sexual material, sex tourism, and child ‘prostitution.’

However, President Yoweri Museveni declined to assent to the Bill in the form submitted and sent it back to parliament for review. The Speaker of the 11<sup>th</sup> Parliament then made a ruling that all business of the previous parliament would not proceed to the new term as the business of the house. Accordingly, the Sexual Offences bill was discarded. Although it does not form part of Uganda’s legal regime, some people are under the misapprehension that its provisions may still be valid, and this has disadvantaged KVPs, such as sex workers, transgender, and sexually diverse persons.

#### **4.1.8 Laws that Protect People with Disability**

### ***The Constitution of the Republic of Uganda (1995)***

Respect and protections for the rights of PWD are enshrined in the Constitution of the Republic of Uganda, which places a legal obligation on the State to take affirmative action “in favour of groups marginalised on the basis of gender, age, disability or any other reason created by history, tradition or custom, for the purpose of redressing imbalances which exist against them.”<sup>297</sup> The constitution also explicitly requires that the State is establish an Equal Opportunities Commission to give effect to that obligation to take affirmative action in favour of marginalized groups.<sup>298</sup>

The Constitution also protects minorities and provides that they have the right ‘to participate in decision-making processes and their views and interests shall be taken into account in the making of national plans and programmes.’<sup>299</sup>

### ***The Persons with Disabilities Act (2020)***

Approval of the Persons with Disabilities Act implemented the International Convention on the Rights of Persons with Disabilities (ICRPD), to ensure protection for respect of the rights and human dignity of PWDs, as provided for in the Constitution, and ensure the State takes appropriate measures for PWDs to realise their full mental and physical potential.<sup>300</sup>

Although the existing legal frameworks and policies call for provision of infrastructure and facilities that are friendly and accessible to PWDs, and some progress has been made in adapting physical infrastructure to this end, much remains to be done. Persons with other forms of disability (e.g., visual, hearing, mental, or speech) still face numerous access barriers, including lack of accessible IEC materials, lack of sign language translators, and unfavourable attitudes and stigma towards them.

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<sup>296</sup> See: Human Rights Awareness and Promotion Forum (HRAPF) (2021), *Sexual Offences Act, 2021* (Constructed on the basis of the 2019 Sexual Offences Bill and decisions made on floor of Parliament).

<sup>297</sup> Constitution of the Republic of Uganda, Article 32(1).

<sup>298</sup> Ibid, Article 32(2).

<sup>299</sup> Ibid, Article 36.

<sup>300</sup> Ibid, Article 35(1).

#### 4.1.9 Laws, Policies and Frameworks that Protect the Rights of Key Populations and their Access to Services

##### *Leave No-One Behind: A National Plan for Achieving Equity in Access to HIV, TB and Malaria Services in Uganda 2020-2024 (2019)*

This National Action Plan sets out a comprehensive response to remove human rights and equity-related barriers to HIV, TB, and malaria services.<sup>301</sup> It defines ‘health equity’ as follows: “that all individuals have fair opportunities to avoid infection or to live with their disease in full health and dignity in the absence of barriers or other limits based on avoidable, unfair or remediable differences.”<sup>302</sup>

Barriers to HIV services include: poverty and social exclusion; HIV-related stigma and discrimination; high levels of stigma, discrimination, and violence against KVPS; problematic laws, regulations, and policies; challenges with places of detention; GBV; as well as gender inequality and harmful gender norms.<sup>303</sup>

The ‘Leave No-One Behind’ Plan prioritises the following key and vulnerable populations: PLHIV; key and vulnerable populations (KVPs); uniformed services personnel; inmates and other detainees; AGYW; PWD; older persons; and people affected by ethnic, geographic, religious, or cultural barriers.<sup>304</sup> The Guiding Principles of the Plan are: (1) equality and non-discrimination; (2) do no harm; (3) privacy and confidentiality; (4) meaningful participation of PLHIV, vulnerable populations, and KPs; and (5) respect for personal dignity and autonomy, which is encompassed by various international human rights standards and extends to persons in prison and other closed settings.<sup>305</sup>

The objective is to eliminate violence, discrimination, and stigma in the context of HIV, TB, and malaria, with success measured by a reduction in the percentage of PLHIV experiencing discriminatory attitudes and HIV-related discrimination, as well as the percentage of KPs and vulnerable populations experiencing physical violence based on their real or perceived membership to a KP group.<sup>306</sup>

Results are to be achieved through a package of specific actions: targeted anti-discrimination messaging; violence- and discrimination-reducing interventions aimed at young people; up-scaling DICs for KVPs and empowering DICs to form partnerships with local stakeholders; up-scaling of interventions to address self-stigma; and up-scaling of collaborative interventions in communities to increase treatment uptake and to routinely measure HIV-related stigma, discrimination, and violence.<sup>307</sup> The Plan aims to achieve health services which are inclusive, non-discriminatory, and which protect the health and safety of all patients and staff.<sup>308</sup>

The plan aims to inform and engage stakeholders, in particular the judiciary and cultural leaders, while strengthening the capacity and role of law makers and the justice sector to promote human rights-informed, gender sensitive public health responses to HIV, malaria, and TB, including appropriate training

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<sup>301</sup> Ministry of Health (MoH) (2019), *Leave no-one behind: A national plan for achieving equity in access to HIV, TB and Malaria services in Uganda 2020-2024*, 5.

<sup>302</sup> *Ibid.*, 2.

<sup>303</sup> *Ibid.*, 3.

<sup>304</sup> *Ibid.*, 7.

<sup>305</sup> *Ibid.*, 8.

<sup>306</sup> *Ibid.*, 9.

<sup>307</sup> *Ibid.*, 9–11.

<sup>308</sup> *Ibid.*, 12.



in these issues for the Uganda Police Force and the Uganda Prisons Service.<sup>309</sup> The plan further aims to ensure that communities and individuals are equally knowledgeable about their rights and responsibilities for health and that legal information and services are accessible and responsive.<sup>310</sup> Resolution of gender-related health inequities is contemplated by scaling up efforts to address GBV, as well as harmful gender norms at the community level, and end stigma and discrimination against pregnant adolescents.<sup>311</sup>

One of the goals is to address health-related equity barriers for specific KVPs. The Plan discusses specific interventions for PWD, people in closed settings, refugees, asylum-seekers, and other displaced populations.<sup>312</sup> While these detailed interventions aimed at specific KVPs are a positive step towards reducing stigma and increasing HIV service uptake for these three groups, the Plan does not provide detailed interventions for other KVPs, including those listed as ‘prioritised’ such as uniformed personnel, elderly persons, or persons affected by ‘ethnic, religious, or cultural barriers’, nor does it make any mention of KPs such as fisher folk, long-distance truck drivers, MSM, transgender persons, sex workers, or PWIDs and thus does not fully succeed in its attempts to fulfil the country’s commitments with respect to the international HIV framework.

It is particularly unfortunate that a plan with the phrase ‘leave no-one behind’ in its title, a significant number of KVPs are left out of the otherwise-detailed interventions and actions to address barriers to health equity.

### ***The Harm Reduction Guidelines (2020)***

The Ministry of Health’s Harm Reduction Guidelines have enabled the establishment of the first Medically Assisted Therapy (MAT) centre for the treatment of people who inject drugs (PWIDS). The centre was launched in December 2020 and is based at Butabika National Mental Health Referral Hospital. These guidelines set a benchmark opportunity to ensure that PWUID are included in the national HIV/AIDS response despite a punitive legal environment that criminalises them.

### ***The Key Populations Priority Action Plan (2020)***

The Key Populations Priority Action Plan details specific services that should be provided to priority populations, along with how, and when they are to be provided. It also details measures to improve KPs’ to services.

## ***4.1.10 Laws that Protect the Right to Work and Terms of Employment***

### ***The Employment Act (2006)***

The Employment Act prohibits discrimination in employment defined as “any distinction, exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin, the HIV status or disability which has the effect of nullifying or impairing the treatment of a person in employment or occupation, or of preventing an employee from obtaining any benefit under

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<sup>309</sup> Ibid, 14–15.

<sup>310</sup> Ibid, 16, 18.

<sup>311</sup> Ibid, 21, 23.

<sup>312</sup> Ibid, 24-28.

a contract of service.”<sup>313</sup> The Act thus explicitly protects PLHIV from workplace-related discrimination on the basis of their HIV status.

### ***National Policy on HIV/AIDS and the World of Work (2007)***

This policy recognises that the age 18-64 population group, the working age or economically productive population group, is also the one most affected by HIV/AIDS and aims to provide a basis for the development of specific HIV/AIDS workplace policy guidelines and promote access to decent work for PLHIV in the face of the epidemic.<sup>314</sup>

Policy objectives include: provision of guidelines for employers, workers, and the government on the management and mitigation of the impact of HIV/AIDS within the world of work; provision of guidelines for the elimination of HIV-related stigma and discrimination in the world of work; provision of care, treatment, and support for PLHIV within the world of work; provision of a framework for monitoring the impact of HIV and AIDS in the world of work; and the effectiveness of measures taken to combat HIV.<sup>315</sup>

Guided by principles of non-discrimination and equality, the Policy provides guidance on the development of a workplace HIV programme to educate and raise awareness of HIV and AIDS among both employers and employed to eliminate discrimination in the workplace on the basis of real or perceived HIV status and to enable appropriate access to all appropriate HIV and justice services to HIV-affected workers.<sup>316</sup>

The Policy makes it clear that termination of employment on the basis of real or perceived HIV status amounts to discrimination and is prohibited by law. It stipulates that PLHIV should be protected from stigma within the world of work.<sup>317</sup> It emphasises that compulsory HIV testing for recruitment, promotion or career development is prohibited by law and that workers have the right to privacy and the right not to disclose their HIV status.<sup>318</sup> The Policy provides that employers should be sensitive to the care-giving roles placed on women within their families and accommodate this role in their HIV programmes and policies.<sup>319</sup>

This is an important document in terms of removing stigma and discrimination and normalising HIV/AIDS and PLHIV. It enables all people of working age to access HIV services, since fear of job loss or forced disclosure of HIV status within the workplace have been constraining factors discouraging people of working age from testing from HIV.

A review of the legal and regulatory frameworks on HIV and SGBV in capital projects in Uganda<sup>320</sup> showed that labour issues were not adequately linked to HIV and SGBV at the technical or financial level. To date there are no laws or policies that require a percentage of project investments to be set aside for HIV services.

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<sup>313</sup> The Employment Act (2006), Section 6(3).

<sup>314</sup> Ibid.

<sup>315</sup> Ibid, 7.

<sup>316</sup> Ibid, 17–18.

<sup>317</sup> Ibid, 8.

<sup>318</sup> Ibid, 8–9.

<sup>319</sup> Ibid, 10.

<sup>320</sup> Nyirankindi, U. (n.d), *Review of the Legal and Regulatory Framework on HIV and SGBV in Capital Projects in Uganda*.

Stakeholders who participated in this study observed that most government policies formulated since 2015 are enabling and seek to be inclusive and protective of all categories of PLHIV and KVPs in their diversity. This was attributed by some informants to the fact that the policies are drafted by technocrats, whose awareness and appreciation of the public health importance of ensuring inclusivity and universal access to HIV services, contrasts with the attitudes of some parliamentary law makers, whose actions and behaviour may be guided by political or other expediency.

*Conclusion:* Uganda has a very extensive set of laws and policies relevant to the provision of HIV services and protection of human rights. The laws have both enabling and prohibitive aspects as far as utilisation of HIV services and realisation of rights by PLHIV and other vulnerable groups is concerned. The constitutional framework prohibits discrimination based on personal attributes and membership to particular groups. However, a number of provisions in the Penal Code Act, the HIV Prevention and Control Act (2014) and in the proposed Sexual Offences Bill (2021) are counter-productive to a human rights-based approach to addressing HIV. Further, the Constitution does not explicitly protect adolescents, youth, or the elderly, nor does it make specific provision for the protection of PLHIV and KPs such as transgender persons, PWID, and MSM.<sup>321</sup>

Uganda's policies and action plans are, in the main, enabling and most stakeholders have no concerns about them. Existing policies enable service delivery and access even to outlawed population groups, except those that relate to consent for HIV testing for adolescents aged 12 years and below and which require parental consent for access to HIV and SRH services for those aged 18 and below. Most of the policies and planning frameworks address a wide range of aspects of service provision targeting various clientele and stakeholder groups. As one key informant stated:

*... we have policies which are public health oriented, and they seek to support and ensure equitable access to services, for all populations. I have not seen policies saying don't serve particular group X or Y. No, the policies are for all Ugandans and emphasise equitable access to services (Interview, Senior Official, ADP-I).*

Some of those canvassed, however, disagreed that the environment had improved, pointing to efforts by government over the last 10 years to punish PLHIV and key populations through legislation.

Some gaps in policy are yet to be addressed: some are silent on KVPs such as transgender and intersex persons and greater attention needs to be paid to men's issues, to people in closed settings such as prisoners, and to the increasing number of people aging with HIV as ART extends the life expectancy of PLHIV.

It is therefore evident that Uganda still has work to do to upgrade legal instruments and as the HIV/Aids epidemic continues to unfold, to update, revise or amend policies in accordance with the emergence and availability of evidence-based data or technological advance to assist the national HIV/AIDS response.

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<sup>321</sup> Constitution of the Republic of Uganda, Article 21.

## 4.2 Prohibitive and Restrictive Aspects in National Laws, Policies and Strategies

### 4.2.1 Laws that Criminalise HIV Transmission

#### *The HIV Prevention and Control Act (2014)*

The HIV Prevention and Control Act (PCA) makes attempted transmission of HIV a criminal offence with punishment by fine, a prison sentence of up to five years, or both.<sup>322</sup> Additionally, intentional transmission of HIV is a criminal offence, punishable by fine, or a prison sentence of up to ten years, or both.<sup>323</sup> The broad and vague terminology used to define these criminal offences has the effect that law enforcement and Courts may find it hard to determine “attempt or intention” considering that many people may be unaware of their HIV status.

#### *The Penal Code (Amendment) Act (2007)*

Section 2 of the Penal Code (Amendment) Act (amending article 129 of the PCA) establishes two related criminal offences of ‘defilement’ and ‘aggravated defilement.’ ‘Aggravated defilement’ occurs when the victim is less than 14 years of age, and the offender was aware of their HIV/AIDS infection. While the intent of this amendment was to protect young girls and boys, it criminalises HIV transmission in contravention of international guidelines and discourages people from testing for HIV and/or disclosing their HIV status. In particular, it unfairly discriminates against young people born with HIV, who as young adults, are trying to build relationships with the opposite sex.

#### *The Sexual Offences Bill (2021)*

The Sexual Offences Bill, although passed by Parliament and forwarded to the President for assent in May 2021, was not signed into effect but returned by the President to Parliament for further scrutiny.<sup>324</sup>

Analysed in its unrevised state, the bill would increase punishment for sexual offenders as a deterrence to crime, while offering greater protection to victims of sexual offences.<sup>325</sup> It would address sexual harassment and prescribe penalties for rape and sexual assault, while strengthening protection for children from sexual violence. It would also address exposure to sexual material, sex tourism, and the sexual exploitation of children in what is sometime referred to as child ‘prostitution.’

However, the Bill omitted to increase protections for women and other vulnerable groups from GBV and also fell short on inclusion of international standards for protection against sexual violence. It also contains a number of provisions which may reinforce stigma against vulnerable groups and KVPs.

The offence of “aggravated rape,” could carry the death penalty as the Bill requires the court to consider HIV and AIDS status as one of the aggravating factors, even if the perpetrator were unaware of that status. Criminalisation of HIV status and the creation of different punishments for PHLIV as compared to other people convicted of the same crime, is discriminatory and thus unconstitutional and against public policy. It also entrenches stigma and discrimination against PLHIV. It could also be

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<sup>322</sup> The HIV Prevention and Control Act (2014), Section 41.

<sup>323</sup> Ibid, Section 43.

<sup>324</sup> See: HRAPF, *Sexual Offences Act, 2021* (Constructed on the basis of the 2019 Sexual Offences Bill and decisions made on floor of Parliament).

<sup>325</sup> Long title of the Act.

possible in cases where HIV status is an aggravating factor, that lack of knowledge of status could be used as a defence, potentially discouraging people from testing and accessing treatment in a bid to escape criminal liability. The unintended effect could be to exacerbate the spread of HIV and AIDS.

The clause related to the offence of “aggravated rape” would also sanction mandatory testing without consent of individuals accused of or charged with rape, to ascertain their “health status, including HIV status,” which would single out and victimise HIV-positive persons that come into conflict with the law in circumstances yet to be proven in court. The forced HIV testing of persons charged with rape (at a stage where the accused is legally innocent until found guilty) is discriminatory and an affront to their bodily integrity. It has the potential to subject PLHIV to cruel and inhumane treatment even when innocent of any crime. The international standard requires freely given consent before a person can be subjected to medical checks.

Further, the Bill’s definitions of rape are flawed. It defines “sexual organ” as vagina or penis and construes rape, “performing a sexual act on a person without that other person’s consent, or when that other person is incapable of consenting” as occurring only by penetration of a vagina by a penis without consent. This ignores internationally accepted definitions of what legally constitutes sexual assault amounting to rape, which may involve other objects or other parts of the body of a male, female or otherwise gendered perpetrator or male, female, or otherwise gendered victim. This flawed definition of rape (as in the equally flawed Section 123 of the Penal Code Act, Cap 120) also defines rape as an offence that can only affect females, which is factually incorrect and discriminatory.

The bill’s flawed legal terminology negates the possibility of other assaults amounting to rape, such as the forceful, unconsented penetration of other body parts such as the mouth or anus, whether by a sexual organ, other part of the body, or object, or that an assault, while not penetrative may still cause harm or injury and expose the victim to HIV infection by transmission of bodily fluids. This is inconsistent with the equal protection of all persons by the law.

In addition, the clause on rape does not consider factors such as the withdrawal of consent previously given at any stage, thus essentially denying victims of sexual violence redress if they consented to any part of the act of which they seek to complain. The removal of the right to withdraw consent during a sexual act effectively subjects the person seeking to withdraw consent to sexual acts in which they no longer wish to participate, thus violating their dignity and their right to freedom from cruel and inhumane treatment. It is also noteworthy that the bill is discriminatory in failing to recognise marital rape as an offence, thus denying victims of rape who are married to their assailants equal protection of the law. Considering the heightened vulnerability of women, girls, and other marginalised persons within the domestic setting, the prevalence of domestic violence in Uganda, and the intricacies involved in escaping from an abusive spouse, this omission increases the vulnerability of the victim and risk of exposure to HIV/AIDS.

The Bill would reintroduce criminalisation of consensual relations between persons of the same sex. It would also criminalise anyone found to have made “false accusations of a sexual crime,” which would certainly discourage many victims of sexual crimes from reporting their cases to the police for fear that if the offence is not proven at trial for any reason, the victim will be doubly harmed, first by the assault and then again by criminal prosecution and its consequences. This would have the effect of contributing to the culture of impunity in Uganda towards GBV, to the detriment of the protection of

women and other vulnerable groups from HIV.<sup>326</sup>The Bill also has a vague provision which creates the offence of obstructing any activity related to the implementation of the provisions of the Act.<sup>327</sup>

*Analysis of the Criminalisation of HIV Transmission:* As previously mentioned, the HIV Prevention and Control Act (2014) created the crimes of attempted transmission of HIV, and intentional transmission of HIV, both of which may be impossible to prove. Interviews conducted for this LEA pointed to the difficulties:

*“...how do you know someone was attempting to give you HIV deliberately?” “... this would mean that you must be able to know the status of the other person. So, that this person you know, okay, they told you that I am HIV positive, and then you say this person knew and he is giving me HIV.”* (Interview, Leader of a PLHIV Network-2).

This was indeed acknowledged by an informant from the Office of the Director of Public Prosecutions, who confirmed that the burden this provision places on the prosecution.

Criminalising HIV transmission runs contrary to the globally accepted public health approach to HIV and serve to increase silence and stigma while discouraging those who are living with HIV from learning their status and making choices to enrol on treatment and prevent transmission to others:

*“So, it means that for us who are fighting stigma and we are saying 'open up' and be supported, people are not going to open up, and that drives the epidemic underground. If people realise that in case I open up and something happens, then it can be used against me, then the person will keep quiet and will not even access the services”* (Interview, Leader of a PLHIV Network-2).

*“If you look at those clauses you realise that, in one way or another, they don't encourage someone to come out and say, 'let me be open and speak to my partner or colleague about my status'. Instead, they would just encourage that particular person to go into hiding because of the fear to disclose their status.”* (Interview, Senior Official, ADP-2)

The fact that pregnant women are routinely subjected to HIV testing also means that the criminal provisions of the Act are likely to disproportionately affect women.<sup>328</sup> The Act is currently subjected to a challenge before the Constitutional Court.<sup>329</sup>

The Penal Code (Amendment) Act (2007) earlier established two related criminal offences of 'defilement' and 'aggravated defilement,' the latter of which was defined as including circumstances where the victim is under 14 years of age and where the offender to his or her knowledge is infected with HIV/AIDS. It is concerning that provisions of this kind presume a person living with HIV to be a worse criminal than one who is HIV negative. Participants in this study argued that sexual offences such as defilement and rape should be condemned irrespective of the HIV status of the perpetrator:

*“So, if you have defiled a young girl, definitely that's wrong enough and therefore if there is going to be any punishment for that it should really be that. But because somebody is HIV positive and maybe*

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<sup>326</sup> See HRAFP (2016), *Legal analysis of the Sexual Offences Bill 2015 and its implications on LGBTI persons, sex workers and persons living with HIV/AIDS*, 13.

<sup>327</sup> *Ibid*, Section 44.

<sup>328</sup> Human Rights Watch, “Uganda: Deeply flawed HIV Bill approved,” 13<sup>th</sup> May 2014.

<sup>329</sup> Constitutional Petition No. 24 of 2016 instituted on 24<sup>th</sup> July 2016 by UGANET, ICWEA, Prof. Ben Twinomugisha and 60 civil society organisations. See: Human Rights Awareness and Promotion Forum (HRAWPF) (2017), *A quick scan of the laws and policies affecting the HIV response among Men who have Sex with Men in Uganda*, 12.

sometimes they don't even know [that they are HIV positive], then you know like the other one becomes a better defiler than the one who is HIV positive and therefore it makes even defilement look like its ok if you are not HIV positive but if you are HIV positive then that is too bad" (Interview, Leader of a PLHIV Network-1).

The Penal Code (Amendment) Act law in its current form also has the potential to drive a conclusion that a person living with HIV defiled a young girl because he is HIV positive: 'He knew he was HIV positive and deliberately wanted to infect the girl.' The other danger is that the HIV status of the accused is likely to overshadow other facts that should be considered in determining a case. The example of a court case regarding Rosemary Namubiru, a nurse, who was accused for intentionally transmitting HIV to a child under her care illustrates these concerns (See Text Box 1).

In her analysis of the Namubiru case, one respondent had this to say: "Rosemary Namburi's conviction was a complete miscarriage of justice, driven by HIV stigma and criminalisation," said the Executive Director at one of the advocacy CSOs.

Another informant narrated the events and her analysis of them:

*"I used to attend the court sessions where Rosemary was accused for intentionally transmitting HIV to a child under her care... I can assure you that the magistrate was not even looking at the details of what was being presented, she already had that mind, like a pre-set mind of a nurse and this is a child she intended to give HIV... that word alone that you are HIV*

**Box 1: Uganda Vs Rosemary Namubiru (HCT-00CR-CN00502014):**

Rosemary was initially accused of attempted murder but was convicted of committing a negligent act likely to spread infection of disease contrary to section 171 of the Penal Code Act cap 120. She worked as a nurse at a Clinic in Kampala.

On 7 January 2013, she was administering intravenous antibiotics to a two-year-old boy. In the process of inserting the cannular into the hand of the child, Rosemary mistakenly pricked her own index finger and drew blood.

The story goes that she put the cannular back on the tray and administered treatment on her injured finger. She thereafter removed the cannular from the tray and inserted it into the vein of the boy. Rosemary was asked by the mother of the child why she was re-using a contaminated cannular, but she gave no satisfactory answer.

Later in the day, the mother of the child reported the incident to the management of the clinic. Rosemary was asked to take a blood test for HIV, and it was discovered that she was HIV positive. She had known that she was HIV positive at the time of the incident.

With the media frenzy and circumstances surrounding the case, she was convicted by the trial magistrate and sentenced to three years imprisonment. On appeal, the judge found that her initial three-year sentence was excessive and ordered her release after she served 10 months in prison. In her own narration, she asserts stigma and discrimination that she faced;

"I struggled a lot because I was associated with being a murderer, a killer, and society shunned me." I was discriminated against and stigmatised" ... "I now know first-hand that stigma, especially among healthcare workers, is real..."

*positive cuts the entire analysis and detailed understanding of 'did this person have an intention?' Rosemary was paraded by the police, the media and what we saw the following day in the media, was a 'killer,' a 'nurse killer,' you know like these headlines could not allow anybody on the bench deal with the real issues, to the extent that even lawyers were fearing to defend her, so it is that bad. We are not saying that there are no criminals, but we are saying that the fact that the first thing we are looking*

*at is: 'is this person positive?' So, the judgment is already made that because you are positive you had an intention to transmit the virus and therefore nobody looks beyond that to ascertain: 'was there intention?', ...and by the time Rosemary was found not guilty, she had spent a lot of time in Luzira [prison] and her life had never been the same since then just because of how she was painted." (Interview, Leader of a PLHIV Network -1).*

The lesson learned from the Namubiru case was that the course of justice was affected by discrimination and stigma, fuelled by media reports which in turn influenced the minds of the public, the lawyers, the magistrates, and judges. The right to a fair trial and to justice overall can be difficult for a person living with HIV because they are already stigmatised. The presumption of innocence as required by the constitution was negated by their HIV status.

There is concern that the motive of the framers of the clauses in the HIV Prevention and Control Act that criminalise HIV transmission was to punish PLHIV for transmitting HIV to other people, incidentally, punishing the CSOs that work with and support PLHIV, including KPs.

*"... it is clear that the intention [of the framers of the law that criminalises HIV transmission] was that 'we must prevent by all means; we must make sure that there are no new HIV infections and the only way to do that is to make sure that those who are HIV positive are punished if they are to be transmitting HIV.' And that's how we end up getting the clauses we have in the HIV Act, but also that's how we come up to use those clauses in the Penal Code and then of course it speaks the fact that you talk about people living with HIV who are key populations who are sex workers, yeah, and that's how we come up ... then we must deal with the CSOs, yeah, we must deal with sex workers and that's how we are ending up with all these other Acts and laws. When we were advocating for removal of some of those clauses, like criminalisation clauses, like intentional transmission in the HIV Prevention and AIDS Act, one of the things that they kept on saying is 'they must be punished, especially men must be punished because they transmit to women,' but the cases I have heard so far, I haven't heard of men, am hearing women" (Interview, Leader of a PLHIV Network -1).*

The potential magnitude of this effect can be seen in the context of young people who were born with HIV and are now young adults. The effect of such laws may be to stop them from declaring their HIV status for fear of being accused of transmitting HIV to others.

*"So if we are now getting at the level where we are saying we must punish people because of their HIV status ... we are talking about a situation where you have young people who were [born] with HIV, now they are growing into adults but they are fearing because, one, they don't know how to deal with the current situation where you have a law that for example, if today they chose to declare their status they don't know what happens tomorrow, they don't want to be known that they are HIV positive and so we are having a situation where people are limited in terms of access to services. If people are fearing to come out because of the laws and policies that are discriminative in nature, then we are not helping to address the epidemic ..." (Interview, Leader of a PLHIV Network -1).*

HIV-positive young people may also have grounds to sue their parents if they have evidence that they conceived them knowing that they had HIV and therefore intentionally transmitted it to them.

There is also evidence of internal contradictions in some of the laws. For instance, while stakeholders hailed the Sexual Offences Bill as a largely progressive piece of legislation intended to protect women and girls, it was watered down by the clauses which criminalise HIV transmission. The intentions of the



framers of these clauses were called into question given that the controversial clauses were sneaked in at the last minute without informing the different stakeholders who had participated in the formulation of the law, as one informant explains.

*“We were not anticipating a re-introduction of HIV criminalisation in this bill, ... it really protects women and girls, and that is what we thought it should have been, but then especially in the last few weeks of parliament working on the bill, it took a different shape altogether, and we were really surprised”* (Interview, Leader, Women’s HIV focused CSO-1).

Some apparent contradictions also emerge between the existing laws and policies. Whereas there are very good and well-intentioned policies on test and treat, on EMTCT, and on universal access to care and treatment, in reality, the good intentions of these policies are watered down by the laws which make it dangerous for the targeted persons to take advantage and make use of these policies. The policies are based on the assumptions of a public health approach that testing for HIV, knowing one’s status, disclosure to the partner, and starting on treatment immediately are good for all. Yet the effect of the punitive laws is that those who test HIV positive may fear to disclose their status to their partners for fear of being accused of transmitting HIV, and they may as such, not disclose, not enrol for treatment, or return to the health facility.

*“...for example, you have a policy on universal access to care support and treatment, on EMTCT, on test and treat [test and treat everybody found HIV positive] which is very, very good as a policy, but the danger here is that if for example there is a person who is fearing that if I know my status, if they know my status, it’s not going to be good for me...”* (Interview, Leader of a PLHIV Network -1).

Some young persons living with HIV fear losing their relationships, support, and their peers if it emerges that they are HIV positive because of the stigma attached to HIV and AIDS and the punitive laws that may end up accusing them of intentionally transmitting HIV due to the knowledge of their status.

*“...and I give you an example, you have young people who are HIV positive, and like any young person who would like to have a full sexual reproductive health life realised, maybe this young person is in a relationship with another young person who is HIV negative, so their fear would be that if this person who is negative, even though they may be using protective measures, her fears or his fears are: ‘if this person knows my status, one, maybe they would leave me; two, maybe they would take me to court. So, what they do is to probably say am not going to access services for the fear of losing my partner, losing this relationship. So, for us with our policies we are thinking that everybody who is HIV positive must be interested in knowing their status and starting on treatment, that is for their good, that is a public health approach, but for the person in question, probably treatment is not their immediate priority...”* (Interview, Leader of a PLHIV Network -1).

In such cases, their immediate priority is the relationship, and probably their source of support.

*“... this woman who is pregnant, she goes to the facility, they tell her you are HIV positive, so what goes in her mind is not, unlike the health worker who is thinking ‘this woman must be started on treatment for her own good and the good of the child,’ but for this woman she is fearing, ‘if my husband or partner knows, they are going to get me out of the house, I don’t have anywhere else to go,’ maybe ‘they are going to say that am the one who brought the infection.’ So, for her she is dealing with the immediate and for us here with our policy we are looking at the long term for your good and the good of the child, but this woman is looking at what happens to me when I tell this man that I have been*

*tested positive? What happens when this man sees the medicine? So, she has to make a decision as an individual probably to hide the drugs or even to throw away the drugs and she goes back home and she will never come back to the facility” (Interview, Leader of a PLHIV Network -1).*

Some were not concerned that the laws might necessarily interfere with the implementation of policies and delivery of services.

*“We don’t find it difficult because we fear that the law will catch up with us, no. We only have difficulty accessing or providing services to them (KPs) because we need to reach them through their networks. If you don’t work with them, you may not be able to reach them because they understand best their networks and how they operate” (Interview, Senior Manager, Implementing Partner).*

Another concern is that with provisions in the law which criminalise transmission of HIV, women are more likely to be disadvantaged or victimised by these unfair laws compared to men, by virtue of the fact that they are more frequently tested for HIV due to their reproductive roles, and their HIV status is therefore more likely to be known.

Some informants also called for the revision of the clauses in the HIV Prevention and Control Act that criminalise intentional transmission of HIV and apply harsh penalties, given that with technological and medical advances, getting HIV is no longer a life sentence, and people who get HIV can avoid getting AIDS and still live long, healthy, and productive lives.

#### **4.2.2 Laws that Criminalise Sex Work**

##### **The Penal Code Act (1950)**

Sections 136–139 of the Penal Code Act (PCA) criminalise different aspects of sex work in Uganda. Section 138 defines ‘prostitute’ as “a person who, in public or elsewhere, regularly or habitually holds himself or herself out as available for sexual intercourse or other sexual gratification for monetary or other material gain.” Section 139 prohibits prostitution for which the maximum penalty is seven years in prison. The Act also prohibits other activities associated with sex work, including operating a brothel, which under section 137 attracts a maximum sentence of seven years; and an offence in respect of living on the earnings of prostitution, which criminalises any person other than a prostitute that survives off earnings derived from prostitution, with knowledge of the origins of the earnings. The Sexual Offences Bill (2021) seeks to expand the criminalisation of sex work and criminalises operating a brothel, engaging in prostitution, and engaging in a sexual act with a prostitute. Apart from the use of the outdated terms of ‘prostitute’ and ‘prostitution,’ the Act repeats the provisions from the Penal Code Act which have been the subject of challenges for a long time.<sup>330</sup>

The laws that criminalise sex work are discriminatory in nature and unfairly target a vulnerable subgroup who may have no other means of support and already face discrimination due to social status and stigma. Reports by HRAPF show that sex workers generally face arbitrary arrest and mistreatment by the police, and this is rooted in their criminalised status.<sup>331</sup> Further, the lived realities of sex workers demonstrate that in practice female sex workers are more targeted and arrested whereas their male clients are allowed to go free. Thus, these laws drive sex workers underground. Consequently, many

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<sup>330</sup> Human Rights Awareness and Promotion Forum (HRAPF) (2021), *Analysis of the Sexual Offences Act, 2021 and its implications on the human rights of criminalised minorities*, 11.

<sup>331</sup> Human Rights Awareness and Promotion Forum (HRAPF) (2016), *Legal regulation of sex work in Uganda: Exploring the current trends and their impact on human rights of sex workers*, 43–45.

shun HIV testing, or HIV and AIDS care, treatment, and prevention services due to fear of being exposed to stigma or prosecution.

The definition of prostitution and related offences fail to recognise sex work as a commercial activity from which a large number of vulnerable people derive a living. This omission violates the constitutional human rights of liberty, privacy, and the right to work and earn a living. This criminalisation is also applicable to other key populations such as transgender persons since sex work is a common source of income and often a very last resort. HRAPF reports also show that transgender sex workers are often the victims of the worst human rights abuses.<sup>332</sup>

Overall, the criminalisation of sex work increases the stigma and discrimination which sex workers and other key populations such as transgender persons already face and may push them away from accessing health services, legal aid services, or public complaints mechanisms. Decriminalisation of sex work would reduce stigma and discrimination, remove the basis for arbitrary arrest and encourage take up of HIV and legal support services.

### **4.2.3 Laws against Unnatural Offences / Same Sex Relationships**

#### **The Penal Code Act (1950)**

Section 145 of the Penal Code Act criminalises the act of “having carnal knowledge against the order of nature.” This is generally understood to refer to same-sex conduct, even if it is consensual, and has been used to persecute gay, lesbian, and transgender persons. People presumed to be gay, lesbian, or transgender persons can easily be accused of engaging in same-sex conduct even if not engaging in sexual activity. This provision of the law fuels social stigma against these persons in diverse community, workplace, and healthcare settings, which discourages them from HIV services. This vulnerable group is also deterred from accessing legal aid services or from seeking legal redress when their rights are violated, due to the fear of stigma, discrimination, and exposure. This legislation is also sometimes used by law enforcement officials to justify arbitrary arrest.<sup>333</sup>

#### **The Sexual Offences Bill (2021)**

Clauses 16 and 17 of the Sexual Offences Bill would replace section 145 of the Penal Code Act, which criminalises what are termed ‘unnatural offences’ with a provision that prohibits anal sex and sex between persons of the same gender. This both criminalises and stigmatises MSM and transgender persons and discourages them from accessing HIV prevention and treatment services. Criminalisation of same-sex sexual conduct reduces MSM and transgender persons to second class citizens who constantly fear arrest and human rights violations at the hands of law enforcers.<sup>334</sup> The provision further infringes on the personal liberty and freedom of expression of consenting adults, which increases stigma around sex and sexuality and discourages a culture of confidentiality and respect for bodily integrity and autonomy in which people are comfortable to receive HIV testing and treatment services.

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<sup>332</sup> Human Rights Awareness and Promotion Forum (HRAPF) (2019), *The Impact of the Legal and Policy framework on access to justice for transgender persons in Uganda*, 44.

<sup>333</sup> Human Rights Awareness and Promotion Forum (HRAPF) (2020), *Consolidated Human Rights Violations against Key Populations in Uganda 2019*, 9, 26, 31.

<sup>334</sup> HRAPF, *Analysis of the Sexual Offences Act, 2021*, 10.

### ***The Anti-Homosexuality Act (2014)***

Despite its nullification by the Constitutional Court, the Anti-Homosexuality Act represents one of the most egregious attempts by the Ugandan government to criminalise same sex conduct and marriage. The Act also criminalised HIV transmission, and “the promotion of homosexuality.” This law would intentionally violate the human rights of gay people, including their right to privacy and to freedom from discrimination. The law would have discouraged this vulnerable and high-risk group from HIV testing, disclosure of HIV status, and the utilisation of HIV services.

#### **4.2.4 Laws that Criminalise Drug Possession, Trafficking, and Use**

### ***The Narcotic Drugs and Psychotropic Substances Control Act (2016)***

The Narcotic Drugs and Psychotropic Substances (Control) Act of 2016 (NDPSCA) criminalises not just the trafficking of narcotic drugs and psychotropic substances, but also their possession or use. Vulnerable people who use and/or inject drugs (PWUIDs) are a key high-risk population group who need to be encouraged to access HIV prevention, testing, and other services in the interest of public health. By criminalising individual drug use and possession, and imposing heavy penalties for transgression, the Act forces PWUIDs into hiding and secrecy, contrary to the harm reduction approach to addressing drug use.

The consequences of this law were constraining, limiting the range of medical interventions available and accessible to PWUIDs, and discouraging this group from openly seeking healthcare services, including HIV and AIDS-related services. Emphasis on criminal approaches to drugs use worsens the stigma and discrimination against PWUIDs and increases discrimination by some health service providers which makes PWUIDs more vulnerable to dangerous practices, such as needle sharing, which increases the risk of their being exposed to and/or infected with HIV.

Reports by HRAPF show that this law has served to further marginalise PWUIDs, to push them away from accessing HIV services, and to impede realisation of their rights.<sup>335</sup> Furthermore, the social stigma created in large part by the criminal approach to drug use, has further entrenched their isolation and related suffering and depression, making them one of the most vulnerable cohorts to HIV and AIDS.

There is a need to fully embrace the harm reduction approach to drug use. This would involve services such as needle exchange and MAT. Law makers should decriminalise individual drug use and possession that involves small amounts. Experience from other countries shows that decriminalisation of drug use and possession for personal use reduces the stigma and discrimination that hampers access to health care, harm reduction and legal services. People who use drugs need support, not incarceration.

There is also a need to ensure the principle of proportionality is applied for drug-related crimes, and to put in place public health-based alternatives to incarceration, administrative penalties, and other forms of corrective action.

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<sup>335</sup> Ibid, Sections 4, 6. See Human Rights Awareness and Promotion Forum (HRAPF) (2016), *The Narcotic Drugs and Psychotropic Substances (Control) Act, 2015 and the legal regulation of drug use in Uganda: Analysing the tension between Criminal Law, Public Health and Human Rights*, 36–46.

## 4.3 Laws on being Idle and Disorderly, Rogue, and Vagabond

### *The Penal Code Act (1950)*

Sections 167 and 168 of the Penal Code Act create broad and vague ‘vagrancy offences’ by criminalising ‘being idle and disorderly’ and ‘being a rogue and vagabond.’<sup>336</sup> These provisions are overbroad and vague and they criminalise a very wide range of actions such as “being found wandering” in a public place at such a time and under such circumstances which would “lead to the conclusion that such person is there for an illegal and disorderly purpose.”<sup>337</sup> The offences are applied subjectively and have often been used to arbitrarily arrest and detain ‘undesirable’ persons and groups, including KPs such as sex workers, PWIDs, MSM, and transgender persons.<sup>338</sup>

The effect of these provisions is to drive KP groups away from HIV prevention, testing, and treatment services. Such provisions affect mostly the poor and marginalised who are more likely to be considered ‘undesirable’ and who do not conform to the gender norms of society. Transgender persons in Uganda have sometimes been arrested under these provisions where police officers suspect that they engage in ‘unnatural offences,’ mainly on the basis of their appearance, even where there is no evidence to convict them.<sup>339</sup> These provisions are thus used to unfairly discriminate against key populations and other minorities and carry the potential to keep these groups away from HIV and justice support services. A subsection of Section 168 is currently the subject of a legal challenge before the Constitutional Court of Uganda.<sup>340</sup>

## 4.4 Laws that Restrict Personal Freedoms

### *The Public Order and Management Act (2013)*

The Public Order and Management Act (POMA) came into force on October 2, 2013 and was designed to “...provide for the regulation of public meetings; to provide for the duties and responsibilities of police, organisers and participants in relation to public meetings; [and] to prescribe measures for safeguarding public order.”<sup>341</sup> In its earlier version, the POMA barred three people from holding a meeting without police permission, reflecting its intention to tighten the grip of security forces on public gatherings or assembly. It should be noted that the Act was formulated in the aftermath of the 2011 Presidential elections and was intended to restrict the activities of political protestors.

The timing was also in the aftermath of the ‘Arab Spring’ during which sitting presidents in North Africa were overthrown through mass protests. The current law requires the organiser of a public meeting to give written notice to police at least three days before the date of the proposed meeting. It also gives authority to police authorities to prevent the holding of a public meeting or disperse such a meeting if it is deemed not to meet the provisions of this law.<sup>342</sup> While the POMA primarily targets protestors of a political nature, the law has been used by police to disperse any gatherings.

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<sup>336</sup> Penal Code Act, Sections 167, 168.

<sup>337</sup> Ibid, Section 168(1)(d).

<sup>338</sup> Human Rights Awareness and Promotion Forum (HRAPF) (2016), *The implications of the enforcement of the Idle and Disorderly Laws on the human rights of marginalized groups in Uganda*, 34-35.

<sup>339</sup> HRAPF, *The Narcotic Drugs and Psychotropic Substances (Control) Act. 2016*, 51-52.

<sup>340</sup> Francis Tumwesigye Ateenyi v Attorney General, Constitutional Petition No. 36 of 2018.

<sup>341</sup> Public Order and Management Act (2013). Long title of the Act.

<sup>342</sup> Ibid, Sections 8, 9.

Meetings of population groups considered undesirable - such as key populations or KP-led CSOs - are therefore a likely target for dispersal and/or the arrest of anyone deemed to be an organiser or participant of a gathering. The Act contradicts the basic premise on which the right to freedom of peaceful assembly is based and restricts the space for citizens to participate in the governance of the country<sup>343</sup> or to publicly discuss matters of importance to them. It also gives police authorities an excuse to curtail people's freedoms and human rights.

### **The Anti-Pornography Act (2014)**

The Anti-Pornography Act made involvement in pornography a criminal offence and established a Pornography Control Committee.<sup>344</sup> The Act imposes severe penalties for the production and publication of child pornography.<sup>345</sup> Pornography is defined as “any representation through publication, exhibition, cinematography, indecent show, information technology or by whatever means, of a person engaged in real or stimulated [sic; ‘simulated’] explicit sexual activities or any representation of the sexual parts of a person for primarily sexual excitement.”<sup>346</sup> This definition uses terms that are vague and overbroad, which means that they can be applied subjectively with unjust consequences. The passing of the Act served to legitimate public violence and the imposition of moral standards on women: 44 cases were reported where mobs of men attacked women whom they considered to be improperly dressed and tore off their clothes.<sup>347</sup>

Overall, the Act is interpreted as an attempt by the state to regulate personal morality, infringing on personal freedom and choice and violating freedom of expression. In terms of access to HIV services, the moralising tone of the Act contributes to a culture of stigmatisation of sexual behaviour which is considered socially unacceptable, which in turn discourages the uptake of HIV testing and treatment services. The Act has been subjected to a challenge before the Constitutional Court.

### **Laws on Personation**

Section 381 of the Penal Code Act creates the offence of personation. This means a person falsely representing himself or herself with the intent of defrauding another. Even though transgender persons who express their gender identity are not trying to represent themselves *as another person*, there have been cases in which transgender persons were arrested and prosecuted under this provision.<sup>348</sup> Law enforcement officials apply this law in such a way as to further marginalise transgender persons and alienate them from health and justice support services.

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<sup>343</sup> Human Rights Awareness and Promotion Forum (HRAPF) (2015), *The Human Rights Advocate*, Second Issue.

<sup>344</sup> The Anti-Pornography Act (2014). Long title of the Act.

<sup>345</sup> Ibid, Section 14.

<sup>346</sup> Ibid, Section 2.

<sup>347</sup> Strategic Initiative for Women in the Horn of Africa (SIHA), “Anti-Pornography Act – Human Rights Activists and Civil Society Organisations Challenge the Legality of the Act in the Constitutional Court – Uganda,” 7<sup>th</sup> May 2021.

<sup>348</sup> Human Rights Awareness and Promotion Forum (HRAPF) (2020), *How laws that promote human rights impact on access to HIV and TB services for key populations in Uganda*, 9.

## 4.5 Law Provisions that Restrict Reproductive Health Rights

### *The Constitution of the Republic of Uganda and Penal Code Act*

Abortion in Uganda is a crime except in certain circumstances as permitted by law<sup>349</sup>. Sections 142 and 143 of the Penal Code Act define the crime and punishment by a custodial sentence of up to seven years. Sections 205 and 217 of the PCA allow the performance of abortion to preserve the life of a mother. These contradictory provisions are confusing and deter women from seeking professional medical services. Vulnerable women and girls faced with unwanted pregnancy, e.g., due to sexual abuse or rape who seek alternative means of ending the pregnancy are thus exposed to unsterile environments that put them at a higher risk of contracting HIV. Guidelines on abortion proposed by the Ministry of Health were suspended some years ago with the result that there is no protocol on abortion or monitoring of the impact of illegal abortions on HIV infection of women and girls.

## 4.6 Laws that Restrict Forming and Registering Organisations

### *The Non-Governmental Organisations Act (2016)*

The Non-Governmental Organisations Act was intended to provide a conducive and enabling environment for the NGO sector and to strengthen and promote the capacity of NGOs and their mutual partnership with Government.<sup>350</sup> The Act places special obligations on NGOs, including the requirement to register with the NGO Bureau, apply for a permit, keep accounting records, submit periodic reports to the Bureau, and maintain high standards of governance, transparency, and accountability.<sup>351</sup>

However, the NGO Act has two provisions which present constraining factors to service access and the realisation of rights of PLHIV and people at risk or affected by HIV. The first is under section 44(d) and (f) which stipulates that an organisation shall not engage in any act that is prejudicial to the security and laws of Uganda or the interest of Uganda and the dignity of the people of Uganda. The terminology used in these two subsections is overly broad and the terms are not properly defined in the Act, which allows for unfair limitation to freedom of association of KP organisations in an arbitrary manner.<sup>352</sup> It is possible that organisations providing services to KPs may be deemed as undertaking activities “prejudicial to the laws of Uganda,” since conduct associated with many KPs (such as drug use, sex work, and same-sex relations) are criminalised.<sup>353</sup>

The other constraining provision is section 30(1) of the Act, which empowers the NGO Bureau to refuse the registration of an organisation if the objectives of the Organisation are in contravention of the laws of Uganda. Organisations providing services and support to KPs who engage in criminalised conduct (such as drug use, sex work, and same-sex sexual relationships) may be refused registration on the basis of this provision. There is a precedent to this, when in 2015, the Uganda Registration Services Bureau (URSB) refused to reserve and register the name of a KP-led organisation, ‘Sexual Minorities Uganda’ (SMUG), on the grounds that “the proposed name was undesirable and un-

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<sup>349</sup> Article 22 of the Constitution provides that no person has a right to terminate the life of an unborn child except as might be permitted by law permitted unless authorized by law.

<sup>350</sup> The Non-Governmental Organisations Act (2016). Long title of the Act.

<sup>351</sup> Ibid, Sections 29, 30, 32, 39.

<sup>352</sup> Human Rights Awareness and Promotion Forum (HRAPF) (2016), *Position Paper on the Non-governmental Organisations Act, 2016*, 3.

<sup>353</sup> Ibid.

registrable because the proposed organisation was to be formed to advocate for the rights and wellbeing of lesbians and gay persons among other LGBTIs, which persons are engaged in activities labelled criminal acts under Section 145 of the Penal Code Act.”<sup>354</sup>

The refusal of registration of KP organisations leads to an increase in stigma against the constituencies involved and constrains access to services and realisation of rights to PLHIV and HIV affected groups. Participants in this study noted that these provisions in the NGO law create fear among PLHIV and KP-led Organisations and restrict their ability to organise and mobilise resources and their members. As a result, some operate informally or underground, which limits their scope and reach. It is recommended that the terms used in this provision should be adequately defined in the Act, in accordance with the Constitution, to ensure that they are not open to abuse.

This law and others framed in the same spirit have also been used to close down organisations which are deemed to be either serving KPs or alleged to be inclined to some political party positions. In early 2021, 54 CSOs were suspended in unclear circumstances over allegations of failure to comply with financial regulation laws, the NGO law, failure to renew their annual operating licences in time, failure to file annual tax, financial and company returns in time, and other flimsy grounds that should not warrant closure. Some of these organisations were beneficiaries of financial support from the Democratic Governance Facility (DGF) (a funding mechanism by European countries). Leaders of some of the organisations in question were arrested on trumped up charges and placed under investigation on unclear grounds, putting great strain on the human rights advocacy work they were engaged in. Many stakeholders interpreted this as an attempt by the government to punish and restrict the activities of CSOs deemed to be less than supportive of government positions on many issues including democratic processes, human rights, and the running of the economy. CSOs who had been vocal on human rights issues including those affecting key populations were most affected.

#### **4.7 Local/Community By-Laws, Norms, and Practices**

Local community by-laws, norms, and practices sometimes adversely affect the prevention of HIV, access to and utilisation of services, and the broader environment for addressing the HIV and AIDS epidemic.

Community level participants in this study from Mbale district for instance reported how there are persistent beliefs that unprotected sex with a person who has a disability cures HIV. As a result of such beliefs, HIV positive men have infected women with disabilities (or vice versa). If both parties are HIV positive, it leads to co-infection.

Mistaken beliefs often intersect with the poverty and vulnerability of women with disabilities who, as one informant explained, may embrace any opportunity to have a sexual encounter given they do not have much choice over sexual partners or the timing of sexual activity. Already highly vulnerable women feel obliged to accept whichever man comes along and accept his terms. Interviewees also reported the existence of beliefs in witchcraft, and that some people with HIV are encouraged to seek the services of traditional healers rather than professional medical services.

The role of religion and religious belief, norms and values present another emerging issue that constrains the effectiveness of the HIV/AIDS response. Findings show that many religious institutions

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<sup>354</sup> Letter by URSB, dated 16<sup>th</sup> February 2015.



in Uganda still consider HIV infection to be a moral issue. People who live with HIV are therefore likely to be judged as having been ‘sinners’. Where such religious beliefs are prevalent, PLHIV may be reluctant to disclose their HIV status or to seek services, lest they be judged or condemned. In other cases, it was reported that some born-again religious sects and/or churches direct their followers living with HIV to stop taking ARVs and rely solely on prayer for miracle healing, actively discouraging recourse to professional medical services.

Another major issue of concern is the high incidence of violence against women and girls, including intimate partner violence condoned as a result of cultural or traditional custom. Many traditional Ugandan sub-cultures normalise male-on-female violence. The potential for violence is heightened when a woman is known to be HIV positive and can be accused of bringing HIV to the man or to the family. Sexual violence in marriage is not viewed as abuse or a crime and women living with HIV or whose partners are living with HIV may not be given the opportunity to protect themselves.

*“There is a lot of concealing especially when it comes to violence against children because of the gender norms within the communities. For a girl to be pregnant at 14 years it is assumed normal, and they marry her off. We see such things in the fishing communities. So, when she comes in, she will even lie about her age to conceal”* (Interview, Manager, HIV Programme Implementing Agency-1).

Child marriage is another form of violence that is culturally sanctioned in many Ugandan communities. In many instances, parents are involved in identifying suitors and negotiating bride wealth to be paid for under-age girls. The motivations for this are both cultural and economic. Cases of child marriage are reported to have increased during the COVID-19 lockdown period, i.e., during 2020 and 2021 when schools were closed and girls spent months at home. Schools provide an avenue for HIV interventions targeting children and young people and the prolonged school closure from March 2020 affected over 15 million schoolchildren and heightened their vulnerability to abuse, including teenage pregnancy and child marriage. A report by FAVE estimates the increase in pregnancies among girls aged 10-14 years at 367% (i.e., from 290 to 1,353) between March to September 2020<sup>355</sup>. An analysis of teenage pregnancy trends for the last two years shows year-on-year increments in pregnancies in general (11%) with relatively higher increments among women aged 19 years and below (14%).

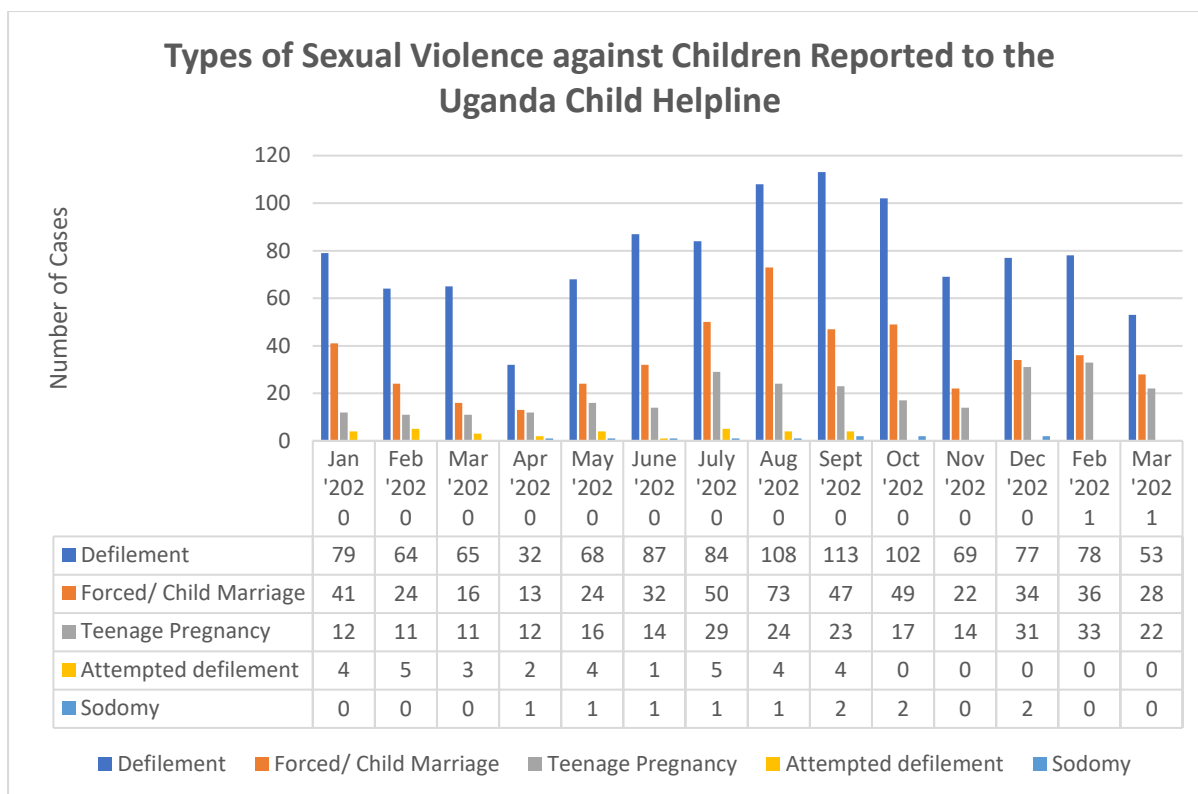
Relatedly, the 2018 National Violence Against Children survey showed that among 13 to 17-year-olds, 25% girls and 11% boys reported experiencing sexual violence during the past year.<sup>356</sup> The rise in cases of child abuse and violence against children, is largely attributed to the COVID-19 lockdowns, which resulted in children staying at home with family members and losing the protections enjoyed at school.

The Uganda Police Annual Crime Report for 2020 showed that defilement cases increased by 3.8% between 2019 and 2020, from 13,613 cases to 14,134 cases. Relatedly, a total of 5,383 cases of violence against children were reported to the Uganda Child Helpline (UCHL) between July 2020 and June 2021 alone. Of these, 708 were cases of defilement, 345 were of forced or child marriage, and 200 were of teenage pregnancy.

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<sup>355</sup> Forum for African Women Educationalists Uganda Chapter (FAWE Uganda) (2021): Newsletter. 1<sup>st</sup> Edition, 2021.

<sup>356</sup> MGLSD (2018): Uganda Violence against Children Survey. Kampala.



**Figure 2: Types of sexual violence reported to the Uganda Child Helpline 2020/21**

The increase in the level of teenage pregnancy, child marriage and defilement points to the high prevalence of unprotected sex, which is likely to result in a surge of new HIV infections. It is also feared that many girls have not returned to school following the re-opening of schools in January 2022, which in the long-term will worsen gender inequality.

Yet these figures do not reflect the full picture, given the limits of awareness and reporting to the child helpline. Many cases go unreported. The toll free 116 Uganda Child Helpline and the sister U-Report platform at the MGLSD have helped to improve access for children to report violence, and have their cases followed up. Interventions in response to VAC have been provided by CSOs, district local governments, health facilities, the police and the MGLSD, but in general services are inadequate to prevent and respond to cases of VAC.

CSOs have provided shelters, legal aid, and psycho-social support, while District Action Teams consisting of Social Workers and Probation and Social Welfare Officers undertake follow-up of cases and provide the necessary support and referral. Through the efforts of the responsible ministries, partners and CSOs, there has been improved follow up and handling of cases of violence against children, for instance through special court sessions. Increased awareness about issues of VAC has also led to increased demand for contraception and PEP services for girls that have been sexually abused. While the police have helped to arrest some of the perpetrators, and to undertake investigations and support prosecutions in courts of law, data from the Child Helpline shows that on average, only about 36% of the suspected perpetrators of defilement are arrested.

Some information emerges from health facilities that provide medical services to victims of sexual abuse. Data from the Uganda Child Helpline shows that on average, only 30.7% of the children that suffered violence between July 2020 and June 2021 for whom it was a requirement to get HTS were

able to access the service. In addition, only 20% of those who were supposed to get PEP were confirmed to have received it between July 2020 and June 2021. The reasons included late reporting of sexual violence beyond the 72 hours within which PEP can be given, failure by the responders to trace the survivor in cases where the reporter did not have a phone number, lack of resources for follow up and case management, and the family of the abused children lacking money for medical examinations.

Moreover, access to services for violence were curtailed due to movement restrictions during the COVID-19 lockdowns. Another constraint to provision of PEP to victims of sexual violence, and to attaining justice, is that the girl or woman victim bears the burden of proof in sexual abuses cases. In the case of married women, proving sexual violence such as rape is almost impossible as the concept of 'marital rape' is inconceivable in many Ugandan socio-cultural settings. In some contexts, the female victim may even be blamed for the sexual violence inflicted upon her.

This study found very few enabling by-laws passed by local governments. Overconsumption of alcohol in Amudat was reported to have affected PLHIV prescribed ARVs, thus it was helpful that Amudat district passed a by-law in 2019 aimed at curbing rampant alcohol abuse, which restricted the hours for drinking alcohol. In other districts of Karamoja sub-region there are helpful by-laws against other harmful practices such as courtship rape. Mityana district has passed a by-law requiring clients utilising HIV services to pay a service fee of UGX 1,000 (about 28 US cents) intended to facilitate community health volunteers – the effect of this on take-up of services has not been established.

## **5 RESULTS PART III: APPLICATION OF THE NATIONAL LEGAL AND POLICY FRAMEWORKS AND THEIR IMPACT ON THE HIV&AIDS RESPONSE**

### **5.1 Introduction**

This section of the report draws mainly from primary data and uses it to analyse the impact of the legal environment on the rights of PLHIV and those at risk or affected by HIV. The section is organised along specific objectives two to four of the assessment.

### **5.2 Key Human Rights Issues Affecting PLHIV, Vulnerable and Key Populations and the Extent to Which these Issues are Addressed by the Current Legal Framework**

One of the objectives of this LEA was to assess the key human rights issues affecting PLHIV, vulnerable and key populations and the extent to which these issues are addressed by the current legal and policy framework. To address this study objective, we have used the Human Rights Based Approach (HRBA) framework as outlined in Section One of this report. The five principles of the HRBA are used here as the analysis framework, namely: (i) availability, accessibility, acceptability, and quality of HIV services; (ii) non-discrimination and equality; (iii) privacy and confidentiality; (iv) respect for personal dignity and autonomy; and (v) meaningful participation and accountability.

#### **5.2.1 Availability, Accessibility, Acceptability and Quality of HIV Services (AAAQ)**

##### **Availability of HIV services**

As previously reviewed, a number of Ugandan laws and policies call for the provision of various HIV services to address client needs. These laws and policies include:

- The HIV Prevention and Control Act (2014).
- The National HIV and AIDS Strategic Plan 2020/21–2021/25.
- The Presidential Fast Track Initiative on ending AIDS in Uganda (2020).
- National HIV Testing Services Policy and Implementation Guidelines in Uganda (2016).
- The Addendum to the HIV Testing Services Policy & Implementation Guidelines: HIV Self-Testing and Assisted Partner Notification (2018).
- National Comprehensive Condom Programming Strategy & Implementation Plan 2020–2025 (2020).
- National Policy Guidelines on Post Exposure Prophylaxis for HIV, Hepatitis B, and Hepatitis C (2007).
- Consolidated Guidelines for Prevention and Treatment of HIV and AIDS in Uganda (2020).
- National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (2012); and several others.

Some of these laws and policies focus on family planning and sexual and reproductive health services but all of the laws and policies follow the guiding principle that services should be made available to reach all populations in need without discrimination. They also lay out strategies for expanding service

coverage. As can be seen from this long list, Uganda has done well in terms of establishing a firm legal and policy foundation for HIV services provision. Whether, in practice, these policies are implemented to make services available is discussed below.

In practice, the coverage of basic HIV services as well as those targeting different population groups has expanded over the last 10 years, and participants in this study reported that most HIV-related services are readily available in the country. The MoH has for instance accredited extra health facilities to reach more than 1,800 sites to provide comprehensive HIV services including ART.

ART coverage has increased with the roll-out of the test and treat policy. ART, for instance, is available in all Hospitals, Health Centres–Level four (HCIVs), as well as most Health Centres–Level Three (HCIIIs), and in some cases, even some Health Centres–Level Two (HCII) are accredited and provide ART. About 1.2 million Ugandans out of 1.4 million who live with HIV are on antiretroviral treatment. This is a key achievement of the second 90 in the HIV treatment cascade targets. Other HIV-related services such as HIV testing, Safe Male Circumcision (SMC), condoms, Sexually Transmitted Infections (STI) screening, and Elimination of Mother to Child Transmission of HIV (EMTCT) services were also reported to be readily available up to HCIII level. Fairly comprehensive HIV services also exist in police, prison, and army settings where government runs a network of health facilities and outreach posts such as community drug distribution points. Such services include laboratory services, CD4 count, viral load testing and others. Services in these uniformed service settings are in many cases also accessible to the civilian population that live in and outside the barracks. However, in the case of prison settings, HIV services are not aligned to existing inmate prison profiles and health burden. They require more mental health, trauma management and skin infection units rather than the standard health facility services with a maternity ward and contraceptive services.

The coverage of HIV services in Uganda has also expanded through the adoption of innovative models such as outreach visits, home-to-home HIV testing, HIV self-testing, drop-in centres (DICs) for key populations, and other differentiated service delivery (DSD) models, which allow stable clients to make less frequent visits to HIV clinics. HIV self-testing, for instance, has been rolled out targeting mainly men and key populations (KPs). The number of DICs has increased from fewer than 20 in 2018 to more than 30 in 2020, as more than 10 DICs were opened in government Regional Referral Hospitals across the country. The number of DICs is set to reach 54 with 15 more being established by one of the faith-based institutions, the Uganda protestant Medical Bureau (UPMB).

One key informant who works with a major implementing agency had this to say:

*“Prevention services have improved, especially for key populations. I remember in 2014 we could not even get data around key populations or priority populations because there was hardly any partner supporting their services. We are now able to extend services to reach even populations that could not be reached because of their criminalisation. Now there is a policy, there are guidelines, and we are now seeing data on key populations in our reports as a country. We are tracking progress on the access and coverage for these populations and that is good progress because we know that is where new infections were concentrated”* (Interview, Manager, Programme Implementing Agency-1).

The use of DSD models has helped to maintain service continuity during the COVID-19 lockdown period, which was characterised by constrained access to health facilities.

Another landmark development in the provision of HIV-related services is the recent opening of a Centre for Medically Assisted Therapy (MAT) for the treatment of people who inject drugs (PWUID) at Butabika National Mental Referral Hospital in Kampala. These expansions in services targeting key populations have clearly been enabled by the favourable policies passed by government over the last five to eight years.

Overall, the space for KP-led organisations to participate in service delivery has expanded, and there are dozens of KP-led CBOs and NGOs actively engaged in mobilising their members, conducting advocacy, delivering services, and sitting at the same tables with government ministry officials talking about policies and services for key populations. The KP-led organisations are also coordinated through various umbrella organisations such as the Uganda KP Consortium (UKPC). This was not the case about 12 years ago, and therefore constitutes an improvement in the environment for these actors.

However, in other cases implementers are not able to provide a comprehensive package of services. Either the clients only get what is available or referrals are made to other service providers who may be some distance away. For instance, most government health facilities at the level of Health Centre II (HCII) do not provide full EMTCT services. Mothers who attend antenatal care (ANC) services at these facilities therefore may miss out on HIV testing during pregnancy, and if they are HIV positive, they will have missed the EMTCT package essential to protect their babies from infection. Districts with a high coverage of HCII are more likely to face this challenge. HIV services in prisons settings do not include condoms and KP-tailored services such as lubricants. According to key informants from the Prisons Services, sex is illegal within prisons settings (among inmates) and therefore there is no justification to provide commodities such as condoms and lubricants. The availability and suitability of HIV services in school settings is also an issue of concern, and little information about this is available.

Another example is that MAT services for treatment of PWUIDs are only available at the centre in Butabika, Kampala. Whereas implementers may identify and screen PWUIDs in the districts, they can only provide them a few other services, then refer them to the main centre in Kampala for MAT. Yet referral systems are also affected by issues of long distances and cost of transport, as well as lack of a unique identifier system which would help to track referral completion.

Another issue of concern is that where comprehensive services exist, they are largely donor dependent, calling into question their long-term availability and sustainability. For instance, most of the programmes targeting AGYW and KPs are donor funded, and not mainstreamed into government health systems. Many HIV services that are delivered in a vertical manner from national level (e.g., ART, PrEP, HCT, VMMC, etc.) are largely pursued separately, thus missing out on synergies that could support delivery of comprehensive integrated packages that would address beneficiary needs across, for instance, the HIV/SRH/GBV continuum. There is still a long way to go to achieve equity especially for SRH/HIV prevention services.

The differentiated geographical targeting means there is especially poor coverage for adolescents and young people (e.g., the Determined, Resilient, Empowered, AIDS-free and Safe [DREAMS] initiative in selected districts) and for adults 25-48yrs in districts that are not considered hotspots, translating into a large population of the very vulnerable who cannot access services. Targeting for some vulnerable groups, such as persons with disabilities, is also weak. Some key informants interviewed for this study argued that unless HIV services are fully integrated into routine public healthcare services, it will remain extremely difficult to achieve equitable access to HIV services for all from a human rights perspective.

Centralised approaches coupled with externally driven programming cannot assure universal coverage, sustainable accessibility, and availability of services.

Coverage of the programs is still inadequate, and thus not all populations in need of services are reached. Some of the areas where coverage is still low include the North-Eastern region of Karamoja. For instance, programme implementers of interventions targeting AGYW, orphans and other vulnerable children (OVC), and pregnant women reported that they are reaching only 30-50% of the target populations in need in the catchment areas. Most health facilities are also missing out men living with HIV because the services are not designed to meet the needs of men. Moreover, men are more likely to remain unreached as they do not have similar entry points into care as do women. There are also other emerging groups such as people aging with HIV who are not being targeted or prioritised, yet they are on the increase given the longevity that ART has enabled.

Prevention services, especially for key populations, did not increase in coverage as much as treatment services. This was partly due to lack of size estimates for KPs. On the other hand, while HIV prevention and treatment services may be fairly available, there is a dire lack of social support services. Given that most PLHIV are also vulnerable economically, the need for services such as food and material support or economic empowerment interventions cannot be over-emphasised. The magnitude of the unmet needs among PLHIV was illustrated by women refugees from one of the refugee settlements visited during this study.

*“The experience is hard, besides being a refugee, I am HIV Positive, and I have so many thoughts making me believe that any time I am dying. At times we fail to get what to eat. I do not work, I have no money, I have children to look after, so it becomes hard for me to have a meaningful life. It is really a bad experience what I am going through... At times, I even develop a bad heart towards those who are HIV negative, I wonder ‘why me?’, going through all these challenges, at times I even think of killing myself’... [sheds tears] ... it is really a hard experience being a refugee. In the camp, we receive inadequate food ...”* (FGD, Refugee Women Living with HIV, Kyangwali Refugee Settlement).

The situation in the refugee settlements should also be understood in the context that the support agencies do not meet all the needs of refugee households and expect them to grow their own food and work towards self-sustenance. Refugee study participants also reported that the monthly cash stipends they receive were reduced from UGX 32,000 to UGX 15,000. PLHIV who may not have the energy to grow their own food or who have large families continue to face challenges meeting their food and other basic needs.

In prison settings, prisoners are tested for HIV on entry, and those who are found to be HIV positive are immediately enrolled for ART. Key informants reported that, nevertheless, some opt to defer treatment until they have completed their prison sentence, and others who have been on treatment opt to suspend treatment for different reasons. Some challenges to adherence to care within prisons settings include stigma and poor diet (a standard daily menu of posho (maize meal), beans and porridge). There is lack of access to medicines outside the essential care package. Referral linkages are poor, as prisoners living with HIV are often arrested or brought with no referral from their usual service outlets. Similarly, those released from prison may not want to mention to care providers elsewhere that they were on treatment, in prison. With support from CDC, Uganda Prisons services is developing a referral information system using a phone-based SMS platform.

While there has been improved coverage for HIV treatment interventions through the pursuit of the 90:90:90 targets, the weak focus on structural and behavioural factors makes such gains fragile, as individuals may fail to sustain access due to factors that could have been addressed as part of a package. For instance, there are weak linkages on the PMTCT platform to SRH services resulting in high numbers of unintended pregnancies for HIV positive women who are already in care and creating a burden on the system to manage more exposed babies.

Overall, therefore, there are concerns that while the country has put much attention on treatment targets (and indeed performed well on these) other accompanying needs of PLHIV such as food, safe water, hygiene and sanitation, shelter, childcare, transportation to pick ARV refills, and psychosocial support, have not been as adequately met. While there are several on-going government economic empowerment programmes, the extent to which they target or reach PLHIV in their diversity is still limited.

The Youth Livelihood programme (YLP) reports that about 2.8% of its beneficiaries are living with HIV. Other programmes do not seem to have data regarding how they have reached PLHIV. Integration with GBV and legal issues is still weak, and HIV service providers may not look beyond the ARV refill. Treatment protocols also focus narrowly on the medical issues, missing the bigger picture of the socio-ecological context in which a person living with HIV operates.

Policies and codes of particular religious institutions also have an impact on the provision of particular HIV services. The Catholic Church, for instance, does not promote the use of condoms for either HIV prevention or for contraception. The Anglican Church and other denominations do not accept homosexuality and sex work, and therefore may not target these persons or may only do so reluctantly. On a positive note, the Uganda Protestant Medical Bureau (UPMB), the health arm of the Church of Uganda, is opening drop-in Centres to provide medical services to key populations.

In conclusion, there is no national law and no policy provision that prohibits the provision of any HIV-related services to any category or group of persons. Indeed, service implementers reported that there is no particular provision of the laws and policies which has constrained their establishment and provision of HIV services to any population category or group. The gaps in the availability of services are more to do with inadequacy of resources and infrastructure, as well as bottlenecks in implementation.

### **Accessibility and utilisation of HIV services**

Ugandan laws and policies make extensive provision for accessibility to HIV services. The HIV Prevention and Control Act (2014), for instance, places obligations on the State to ensure the right of access to equitable distribution of health facilities, goods, and services, including essential medicines and the provision of universal HIV treatment to all persons on a non-discriminatory basis.<sup>357</sup>

Government has also promoted access to and utilisation of HIV-related services, and accessibility of services has improved over recent years not only for general populations but also in particular for marginalised groups such as AGYW and previously excluded groups such as KPs. The accessibility of HIV services is partly reflected in the utilisation rates, as demonstrated by the fact that Uganda is one of 14 countries that achieved the 90-90-90 targets by 2020, i.e., getting at least 90% of the people living with HIV tested and aware of their status; at least 90% of those who are HIV positive being enrolled

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<sup>357</sup> The HIV Prevention and Control Act (2014) Section 24(1)(a), (b).



in treatment; and at least 90% of those in treatment having their viral load suppressed. The country has since adopted the 95-95-95 targets for epidemic control.

Through the 'Test and Treat' policy, all people who test positive for HIV are enrolled for treatment immediately. ART and other services such as HIV testing and viral load testing are provided free of charge in all government health facilities. However, those who opt to seek these services elsewhere due to stigma may end up in private health facilities where they have to pay. TB treatment is also free.

Nevertheless, access to and utilisation of services remains a challenge in some locations and for some groups. Some of the factors limiting access and use include: distances to health facilities (91% of the population live within a 5km radius of a health facility<sup>358</sup> but with variations across regions); inadequate health staff; lack of competent health workers to provide counselling and friendly services to different categories of PLHIV and those at risk of HIV; and issues of stigma (both internal and external) and discrimination. Because of high levels of stigma, there are reports that many PLHIV go to access ART from distant outlets, skipping those that are nearest to them where they are likely to be known by health workers and other patients. COVID-19 and the associated lockdowns have made access even more difficult.

*“COVID-19 has greatly affected people because as you know, we are in a lock down and people are not able to access the usual modes of transport and because some people are in different places. So, that has become a huge hindrance because someone tells you ‘**How can I take my medicine when I have no food?**’ So, it’s either you take the medicine and feel pain, or you don’t take the medicine and still you will be sick. We are doing badly because people can’t really take the medicines on an empty stomach”* (Interview, Leader of a KP Consortium).

Retention rates for the PLHIV enrolled into care remain low (at 71.5% for the general population of PLHIV compared to a target of 95%) and are particularly lower for key populations (28% compared to a target of 60%).<sup>359</sup> These low levels of retention in care have been attributed to various reasons including health-related, social, and structural factors including stigma.

Actors in the HIV response have put in place some strategies to mitigate some of the limitations in access and utilisation of services. They work through peers, expert clients, linkage facilitators, and champions who escort PLHIV to access services, make follow up visits to clients in their homes, support disclosure, and provide psycho-social support.

Some of the provisions in the existing legal and policy frameworks were found to have negative effects on access and utilisation of services by PLHIV, at-risk, and other vulnerable groups. Provisions of the law that criminalise sex work have been used by police to arrest women suspected to be sex workers and any other people found in their company. As a result, women engaged in sex work fear reporting any crime or injustice committed against them to police or other authorities, in the belief that they will be adjudged guilty of criminal behaviour. Women who are known to be sex workers, or whose appearances fit a stereotypical mental image of sex workers, risk being judged unfairly, stigmatised, or discriminated against if they become the subject of a police case or made to appear in court.

The Human Rights Awareness and Promotion Forum (HRAPF) has documented cases of sex workers being harassed and arrested by police, and sometimes being paraded before the media and subjected

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<sup>358</sup> Uganda Bureau of Statistics (UBOS) (2020), *Uganda National Household Survey*.

<sup>359</sup> Uganda AIDS Commission (UAC) (2021), *Joint Annual Review Report 2020/2021 (Draft)*.

to public humiliation.<sup>360</sup> The sex workers arrested in such a manner reported suffering scorn, harassment, and humiliation. In other cases, those arrested spent days in police custody or in prison and missed taking their ARVs. Such cases of sex workers and other KPs being arrested on flimsy charges and being denied the opportunity to adhere to their HIV treatment are a demonstration of a violation of their rights.

It is highly recommended that pre-trial detention centres such as police custody centres emulate prisons in providing an environment for PLHIVs in order to avert situations in which non-adherence to drug treatment causes a relapse. (Interview with a Member of Parliament and Chairperson of the HIV Committee).

Asked if a member of the key populations who is HIV positive would feel comfortable disclosing their HIV status to a health worker, one key informant from a KP network Organisation had this to say:

*“It’s a yes and no. It’s the issue around stigma. You question yourself, how I am going to be treated after this. I am a sex worker, and then I am HIV positive, like how are you going to be seen or even just someone when they are getting services and you mention that you are HIV positive, you will see the attitude by health workers for instance ‘Oh my God, let me get the gloves,’ you know those things.”* (Interview, Leader, KP Network Organisation-1).

Some arguments have been made that KPs do not have to disclose that they are sex workers or MSM when attending a health facility, and therefore they should be able to access services just like anybody else. These arguments miss the reality of the situation, that punitive laws have criminalised some categories of people and so wherever they go, the criminal label hangs around their necks, as one key informant explains:

*“If people are a subject, if their identity is a subject of criminality, they don’t want to be known anywhere, they cannot present themselves as truly the people they are. If I am a sex worker, I will not say that I am a sex worker, I will go to a health facility and I will not say that I am a sex worker; my needs will not be like any other person, I will need more screening for infections, I will need more support, etc., so the fact that I cannot tell you that I am a sex worker, I will not have the attention I deserve. And just the same with the gay men and transgender, they will have specific needs that are not the usual needs, then the differentiated service model that is championed by the Ministry of Health will mean nothing because, if you cannot have differentiated services for people who are at high risk, then there is something you are missing”* (Interview, Leader, Women’s HIV focused CSO-1).

The human rights approach of availability, accessibility, affordability, and quality (AAAQ) requires that services to the beneficiaries served be acceptable from their perspectives. From this standpoint, it is imperative that clients such as members of KPs are respectfully consulted on service packaging and approaches for delivering them. The essence of differentiated services can only be achieved if the unique needs of different clientele groups are served.

Overall, while there is no law that explicitly prohibits PLHIV and other affected populations from accessing HIV services, the fact that some of the groups and their behaviours are criminalised means that they do not feel free to access services when and where they want. There are also unresolved issues regarding access to services by particular categories of the population, such as young people.

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<sup>360</sup> HRAPF, *Legal Regulation of Sex Work in Uganda*.

### **Access to HIV and SRH services for adolescents and young people**

As elaborated in the previous sections of this report, whereas various Ugandan policies and strategies provide for interventions aimed at adolescents and young people, (such as through the NSP, the FP-CIP, the Adolescent Health Strategy, and others) gaps and unresolved issues remain in both policy design and implementation of the HIV response targeting young people.

#### *Contraceptives for Adolescents?*

Existing policies provide for the provision of information to adolescents and young people but do not provide for the provision of contraceptives to this target group. There are divided opinions amongst stakeholders as to whether young people below the age of 18 should be allowed access to contraceptives. On one hand some argue that given that a large number of young people are already sexually active and are therefore at risk of HIV, other STIs, and teenage pregnancies, it makes sense to allow these young people access to contraceptives as well as information. On the other hand others argue that it would send a bad signal to other young people that it is all right to be sexually active at that young age because you can be protected through condoms and other contraceptives. These contending views show that opinion remains sharply divided, and further strategies of engagement and conversation are needed before Ugandans can find common ground.

#### *Youth Corners and Youth Friendly Services/Practices*

One of the strategies used in the past to ensure that young people could access HIV and SRH services was the youth-friendly services, or youth corners. Youth corners would be a designated space in one part or corner of a hospital or health facility where tailored services are available for young people. Many policies suggest that there is provision for youth-friendly services, but there have been inconsistencies in following through. At one time there was an effort to establish youth corners in most government health facilities but the initiative soon lost momentum, in part due to lack of financial support. Even where youth corners had been established, they became dysfunctional, and consequently many were abandoned. Uneven youth-friendly services continue to be provided in various parts of the country, depending on availability of funding from external sources and the work of CSOs.

#### *The YAPs Model*

Recent programmes focusing on AGYW and those under the Young People and Adolescent Peer Support (YAPS) programme have re-energised the provision of youth-friendly services. The Comprehensive HIV Prevention and Treatment Guidelines (2020) provide for DSD models targeting different groups, including adolescents and young people. A DSD for adolescents, in particular, is the YAPS model which places care givers and family members at the centre of the strategy.<sup>361</sup> The YAPS model increases identification, ART coverage, viral load suppression, and the overall well-being of adolescents and young people through psychosocial support.<sup>362</sup> This strategy has been implemented under the leadership of the MoH and is being rolled out. However, programmes so far cover only a few parts of the country, and young people in unprioritized districts remain unreached.

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<sup>361</sup> MoH (2020). Consolidated Guidelines for Prevention and Treatment of HIV and AIDS in Uganda, 192.

<sup>362</sup> Ibid.

### **Access to HIV services for people who use drugs**

It is estimated that there are more than 7,000 people who inject drugs (PWUIDs) in Uganda,<sup>363</sup> and over 3,000 in Kampala alone,<sup>364</sup> as well as an estimated HIV prevalence rate of 17% among these PWUIDs.<sup>365</sup> There is an unquestionable need for services that can mitigate the transmission of HIV and other infections through sharing of injecting needles.

Access to HIV services for people who use drugs (PWUD) and those who inject drugs (PWUID) has improved in the recent past through the opening of the first ever MAT Centre in Uganda at Butabika National Mental Health Referral Hospital in Kampala. Health workers at the Centre have received appropriate training and protocols have been developed. The hospital has already enrolled close to 100 PWUIDs. The opening of this service came about thanks to the formulation of the Harm Reduction Guidelines (2019)<sup>366</sup> by the Ministry of Health. These guidelines represented a fundamental shift from the previous approach that treated PWUIDs as criminals, to a harm reduction approach which seeks to reduce the negative consequences of drug use, policies, and laws. Harm reduction is grounded in social justice and human rights and focuses on achieving positive change among drug users without subjecting them to judgement, coercion, discrimination, or criminal prosecution.

### **Access to HIV services for key and priority populations**

To overcome the barriers that tend to dissuade key populations such as sex workers, MSM, and truck drivers from accessing conventional HIV services, drop-in centres (DICs) have emerged as a popular model. In Uganda, DICs were initially introduced to target long distance truck drivers and were established along major highways in Bugiri-Naluwerere (Bugiri district), Migyera (Nakasongora district), Rubaare (Ntungamo district), and at Mbuya in Kampala. These were followed by the Most-at-Risk Populations Initiative (MARPI) clinic established by the Ministry of Health in old Mulago Hospital, which targeted mainly sex workers and MSM.

In recent years, more DICs have been established, targeting different types of key and priority populations. These have been set up both in community settings and health facilities, including government-owned Regional Referral Hospitals. More DICs are being established by the Uganda Protestant Medical Bureau (UPMB), the medical arm of the Anglican Church in Uganda. DICs are expected to offer tailored services such as HIV testing, female condoms, lubricants, STI screening, PrEP, and ART; and to offer them in a friendly setting and welcoming manner, with service provided by health workers who have been trained to work with key and priority populations. DICs are free of the bureaucracy that often characterise other service centres and the stigma attached to attending them. DICs provide an accessible alternative for those who cannot (or will not) go to a government health facility for various reasons and for those who cannot afford to pay for services in private facilities. Community-based DICs run by KP-led organisations coordinate and mobilise access to antiretroviral therapy by linking the DICs to government health facilities. The community DICs also work with MARPI, which supports regional clusters/specialised clinics in 13 government Regional Referral Hospitals across the country. These developments have made considerable progress towards providing responsive services to key and priority populations, and reflect support from the government, CSO,

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<sup>363</sup> Byamukama (2020). Synthesis, Consolidation and Building Consensus on Key Population Size Estimation Numbers in Uganda. Power point presentation, PEPFAR Uganda Science Summit, January 13-14, Kampala.

<sup>364</sup> Doshi, et al., 2019.

<sup>365</sup> Uganda AIDS Commission. Fact Sheet. 2021

<sup>366</sup> Ministry of Health (MoH) (2019). Technical Guidelines for Universal Access to HIV Prevention, Treatment and Care for People who use Alcohol, Drugs and Other Substances.

and religious sectors who accepted the public health approach in dealing with KPs and priority populations.

In addition, other new DSD models of service delivery such as HIV self-testing have also made it possible for particular groups, such as transient or mobile populations (including sex workers and LDTDs), to have the flexibility to use the service when and where they want, and where they feel safe. The presence of private clinics and pharmacies where anybody can walk in and pay and get a service (e.g., for STI treatment) is also a valuable aspect of HIV services in Uganda.

Some of the challenges with the DIC model, especially the community-based ones, is that they may not provide all the essential services and thus they have to refer clients elsewhere. This is also often compounded by other challenges, leading to losing track of some clients.

*“The other barrier is around the referral system. Sometimes, the drop-in centres, do not provide all the services. So, people are sometimes referred but unfortunately, in that referral process we lose people and it’s hard to know whether they made it to the other facility ‘A’ or not” (Interview, Leader of a KP Network Organisation -I).*

It is evident, from our research, that while progress has been made in easing access for some of the hitherto unserved groups, some access challenges remain.

### **Affordability of HIV services**

In accordance with existing policies, HIV testing services and ARVs are provided free in government health facilities, including in prisons, police, and military settings. Some of the private not-for-profit facilities also charge only a token fee for consultation but then provide free or subsidised services in terms of tests and drugs.

However, there are additional costs that PLHIV have to incur beyond the tests and drugs. These include, for instance, the transportation costs to reach the location where services are provided. The cost of transportation is higher for some PLHIV who, because of stigma, do not collect their medicines from the outlet nearest to them but have to travel a long way to another outlet. This is a common phenomenon as has been reported in other studies. PLHIV on treatment also need to eat appropriately, and yet some may not have adequate access to food. PLHIV are also advised to undergo certain tests to check the functionality of their vital body organs at least once a year, for which they have to pay.

While it is true that most HIV-related services are offered for free in public health facilities, it is also the case that many people in Uganda start by seeking care from private facilities or continue to seek care from both private and public facilities, in which case they have to pay for services when they visit private facilities. These patterns of care seeking are often due to the constraints associated with accessing care in public health facilities, such as long queues and long waiting time.

### **Quality of HIV services**

The quality of HIV services is a broad subject area and entails a number of parameters such as the comprehensiveness of services, the availability of drugs and other supplies, the friendliness of health workers, the waiting time, aspects of confidentiality and privacy, along with safety, and equity.

A dispassionate but critical examination of the quality of HIV services in Uganda reveals a mix of both good quality and not-so-good quality aspects. Stakeholders report that, for instance, the availability of ARV stocks has improved over the recent years and there are far fewer instances of stock depletion

or unavailability of ARVs which characterised the HIV service landscape a few years ago. This makes it possible for PLHIV to readily access treatment as needed. One exception is for stocks of lubricants which had previously been imported thanks to donor funding alone. To date government has not included lubricants on the essential commodities list. Another advance is that PLHIV are accessing better treatment regimens that are friendlier to take, such as dolutegravir (DTG). Whereas long queues still exist at some HIV clinics, DSD models have helped to decongest health facilities to some extent, and most PLHIV can access their drug refills without long waits.

Some study participants described what they termed as ‘structural violence,’ a form of violence that is embedded in the structures and institutions of government, manifesting in different forms of government failure to fulfil its duties and obligations to PLHIV and other vulnerable groups of citizens. These structural violations include, for instance, running out of stock of ARVs, shortages of condoms, shortages of testing kits for HIV and other associated illnesses, lack of counselling services, long waiting times, stigma and discrimination from health workers, lack of privacy and confidentiality in healthcare settings, and poor-quality services in general. It was found, for instance, that whereas all pregnant mothers find they have to buy some essentials that should have been provided by the health facility, such as gloves, a plastic sheet, etc., a mother who is HIV positive has an additional shopping list by virtue of her HIV status, and hence an additional financial burden.

Participants in this study also highlighted the lack of professional counsellors at HIV service clinics. Despite many years of advocacy on this issue, government has not yet established positions of counsellors in the human resource structures of health facilities.

While not all outlets are able to offer a comprehensive service, efforts are made to refer clients to places where they can get them. Weaknesses in the referral system present challenges for client follow-up, to obtain feedback, and monitor referral completion. A system of unique identifier numbers is to be initiated to improve this.

Health worker attitudes towards clients and the level of client care varies widely across health facilities, and even amongst health workers within the same facility. Substantial work has been done to train health workers and to equip them to provide PLHIV, KP, and youth-friendly services. However, training is mainly donor/project supported and has only reached some of the districts and health facilities, not all. As a result, there are still widespread complaints from PLHIV, KPs, and vulnerable persons about the conduct of some health workers.

*“I am not satisfied with the counselling services because you may go to the counsellor with a high viral load. The counsellor will tell you that you are not adhering (**tomila ddagala**) without listening to you. She will judge you right away. She needs to understand me before judging me. For them, when you go to them, they will tell you that you don’t adhere well and you will die. Things have changed, this is not how it was before, they seem to be tired of counselling us. Before, they used to receive us well, welcome us, give us stickers, put them in the books if you adhered well, and would give us gifts and would appreciate you, but now if you don’t adhere they will judge you and tell you go back adhere or die. They don’t seem to listen to you.”* (FGD, Adolescent Girls Living with HIV, Mengo, Kampala).

The comfort of clients while at health facilities has been improved through the increasing role of client peer workers such as HIV expert clients, who smooth the relationship between clients and health workers, assist health workers in registering and triaging clients, and provide some psycho-social support.

In terms of safety, there have also been some improvements, especially for KPs who had previously been subjected to arrest and/or torture by police. The increase in the number of DICs and other DSD models has increased the provision of HIV services in 'safe spaces' for key populations.

A Community-Led Monitoring (CLM) initiative is now being rolled out after a two-year pilot, which - amongst other things - seeks to monitor the quality of HIV and other health services. Under the CLM, client satisfaction feedback is collected and analysed through a score card approach. Results from the first Score Card report (2020) indicate that most HIV services were of good quality; these included services for EMTCT, HIV testing services, VMMC, ART, paediatric HIV care, adolescent services, viral load monitoring, and the integration of services. Areas of poor-quality services identified included limited privacy for HIV testing and counselling in some health facilities due to space shortages, stigma towards PLHIV when seeking services at some facilities, slow response to reported/referred cases of GBV, and inadequate education about VMMC. Results from the scorecards are being used to develop action plans to improve services.

As part of the effort to ensure high quality services that are responsive to client needs and expectations, government formulated the Patients' Charter in 2009. Copies of the Patients' Charter have been translated into major languages and distributed to all government health facilities. Despite this, the CLM Score Card study found low levels of awareness among patients about their rights. Without knowing what they are entitled to, and what level of service to expect, clients are not in position to demand better quality services. Other service providers have used suggestion boxes, telephone hotlines, and social media to solicit feedback from clients so as to improve the quality of services.

Overall, while there has been increased coverage of HIV testing and treatment services, other aspects of the services package, such as social and behaviour change communication (SBCC), social support, and addressing structural barriers are lagging. There is a sense among stakeholders that HIV has lost its position as a prioritised problem in Uganda and has been replaced by other challenges including COVID-19. Part of the reason for this could be the successes in the HIV response themselves. With more people on ART and living longer and having more decent lives, the urge to do more about HIV seems to have waned, and there is less conversation about HIV and AIDS.

### **5.2.2 Non-discrimination and Equality**

#### ***Laws and policies which provide for non-discrimination and equality***

In section two of this report, we paid close attention to the laws and policies that provide for non-discrimination, such as the Constitution of the Republic of Uganda (1995); The Equal Opportunities Commission Act (2007); The National Policy Guidelines on Ending HIV Stigma and Discrimination (2020); and The Human Rights Enforcement Act (2019). The HIV Prevention and Control Act (2014), for instance, puts the state under obligation to promote awareness of the rights of PLHIV; to promote and ensure non-discriminatory participation of PLHIV in HIV and AIDS government programmes; to provide care and support to PLHIV; and to provide adequate funding for HIV and AIDS programmes.<sup>367</sup> In addition to these, several HIV-related policies also emphasise that services must be provided on the basis of non-discrimination.

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<sup>367</sup> The HIV Prevention and Control Act, Section 24.

## Non-discrimination and equality in practice

### (a) Stigma and Discrimination in Healthcare Settings

In spite of the numerous laws and policies against stigma and discrimination that exist in Uganda, they still prevail in many Ugandan healthcare settings. The Stigma Index Report (2019) showed that some form of stigma was experienced by up to 34% of the PLHIV and 24% experienced internal stigma<sup>368</sup>. Prevalence of stigma and discrimination at mainstream health service points remains an issue of significant concern. Stigma and discrimination towards PLHIV, KPs, people with disabilities, and other vulnerable populations in healthcare settings may be a result of different factors. Health workers who are not sensitised to the nature of these groups and their needs and who are not trained to handle them, may exhibit some negative attitudes or some level of stigma when they encounter these groups seeking services. This may be because they do not know how to deal with the unique needs of these individuals. They may not know how much damage their attitude is likely to cause. Other clients at the healthcare centres may also exhibit negative attitudes towards these groups of people. Yet again, some such stigma may be unintended or born of ignorance or lack of awareness about the damage that such attitudes can cause.

*“There is a health provider in Bugiri hospital who has a daughter whom she tells about people who have tested HIV positive and when the daughter comes out and goes to the public, she also tells other people that ‘You see that lady, she has HIV,’ so that discourages us from getting the drugs from here so we just have to go to Tororo because there you will see new faces that you don’t know.” (FGD, FSW, Bugiri District).*

*“Challenge number one is stigma and discrimination; sometimes we feel shy every time going to a doctor with STIs and when you tell the doctor that you are from Kijungu and Ruti, most girls stay there and that’s where they do sex work from, and when you say you are from there, they start telling you ‘obwamaraaya bwaanyu’ meaning (it’s because of your prostitution), and ‘we can’t spend all government drugs on one person.’ These statements demoralise us. So, you end up going to Rwabyooma [a private facility] where you have to pay for medical care.” (Interview, Sex Worker, Mbarara).*

From the above, it is evident that stigma in healthcare settings is still prevalent and comes in different forms. The potential outcome is that the affected person may feel uncomfortable returning to the same facility for services and may internalise the stigma.

PLHIV who at the same time live with disability also reported specific strands of stigma directed at them in healthcare settings. In an FGD with PLHIV living with disability in Mbale district, participants narrated how, for instance, a health worker is quick to ask: “now you who is blind where did you get AIDS from?” Another FGD participant narrated the ordeal of women who are living with HIV, have a disability, and are pregnant:

*“... those who are pregnant and at the same time you are living positively and have a disability, the reception you get at the health facility is rough. ‘You are disabled, pregnant and yet you have HIV!’ So, you ask yourself where should I run to? And if you are not strong hearted you lose hope of successfully giving birth. This makes you to avoid going back to such a health facility next time” (FGD, PLHIV living with Disability, Mbale District).*

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<sup>368</sup> NAFOPHANU. The People Living with HIV Stigma Index: Uganda Country Assessment Report. Kampala, 2019.



Such questions and remarks from some health workers are judgemental and no doubt stigmatise the client and may affect their decision to return to the same facility in future. Others report that health workers shout at them when asking them to do anything, e.g., to climb on the bed, and wondered why health workers do not talk to them normally as they talk to other patients.

Evidence also shows that some of the stigma is internalised, to the extent that some PLHIV, KPs or other vulnerable individuals will decide not to seek HIV services because they think they will look out of place or other people will judge or mistreat them. Internal stigma may be based on previous experiences or simply out of what people hear or expect.

While internal stigma prevails, there are quite a large number of PLHIV who have adopted a positive attitude, adhered to treatment, and testify to the positive outcomes of this attitude and behaviour.

*P1: "As a person with HIV in Uganda, I find the drugs available as for me ... you can go to JCRC and they give you drugs, Uganda Cares also has all those drugs there. So, I find it working and good and we kept being told on how to take our drugs to see that our viral load is suppressed."*

*P4: "So long as you keep yourself well and adhere to all the medical precautions as provided by medical workers, that is how you can manage life. ... it is a personal responsibility to take heed to what you are told to do. I got infected when I was only 30 years but now, I am 52 years old. Why? because I have adhered to treatment." (FGD, PLHIV living with Disability, Mbale District).*

The extent of PLHIV who have adhered to treatment is reflected in the numbers—over 90% of people enrolled in treatment having suppressed their viral load. There is no doubt that great strides have been made in overcoming a substantial amount of stigma that would otherwise constrain adherence and retention on treatment.

While there have been extensive efforts to establish specialised services for PLHIV and KPs, for example with DICs and moonlight HIV testing, or other differentiated service delivery models, these services themselves have been found to be a potential source of stigma. Because they serve a particular group, e.g., PLHIV or sex workers, it is easy to tell that whoever is going to this place is a person living with HIV or a sex worker. This classification and labelling may be the beginning of stigmatisation.

Stigma and discrimination in healthcare settings also affect PLHIV generally, and not just KPs, as one informant explained.

*"In the general population, people who are living with HIV who are not Key populations do face stigma and discrimination just because they are living with HIV and also if you look at issues like for example you are going to an ART clinic where you are going to get your refills and it's in a general ward for out-patients. So, basically everyone is seeing who is going in that room and who is not going there. So, such things also hinder people [from seeking services.]" (Interview, Leader of a KP Consortium).*

External stigma was also reported by refugees when they try to access services from health facilities within refugee settlements. They report the existence of poor-quality services in terms of quality of customer care, availability of drugs, and waiting time, and believed that they were getting poor quality services because they are refugees. Refugees living with HIV reported experiences of stigma and discrimination in various spheres of life including in accessing healthcare services, in employment, and in social life.

*“When you go to the health centre, that is when you can access some ARV services but not everyone wishes to go there because of limited privacy. It really hurts when you go among many people, they will discriminate and talk about your HIV status.” (FGD, Refugee Women Living with HIV, Kyangwali Refugee Settlement).*

*P1: “You see life in the camp is not easy, there is no money, so at times I try to move outside the camp to look for work but when you go there, and you speak Kinyabwishi [a language from Congo], they start saying ‘these are refugees, you go back to the camp, you are not supposed to be in Uganda.’ So, it is not good because you are out of the camp to look for what to eat but again you are discriminated by the language.”*

*P2: “Yes, such statements of ‘you are refugees, go back to the camp, do not disturb us’ are normally used a lot even at health centres, the health workers normally use English while clerking us but some of us do not know how to speak English so that is why we speak our local languages. Like for me, I come from Burundi, nobody can hear what I am saying, so each time health workers are challenged by language barrier, they instead blame it on us for being refugees...”*

*R4: “Here in the camp, we are very many tribes living together. However, each time I have an issue and I go to OPM (Office of the Prime Minister), I am not assisted at all, I have tried on several occasions, but no help was coming in. I had a conflict with a neighbour who ended up cutting and injuring my head, when I reported this case, no action was taken.” (FGD, Refugee Women Living with HIV, Kyangwali Refugee Settlement).*

These reports indicate that PLHIV among the refugees are facing stigma and discrimination not only in accessing HIV-related services but also in broader aspects of life such as employment and access to justice, which ultimately affects their quality of life.

a) *Stigma and discrimination in community settings*

Stigma and discrimination directed towards PLHIV, and other vulnerable groups are also still prevalent in community settings. Stories are told of PLHIV who remove ARVs from their original containers and keep them in other disguised packages and envelopes because they do not want to be seen with ARVs. There have been reports and stories of KPs who have been thrown out of their houses, while others have been denied access to buy basic necessities from shops because of their HIV status. Some study participants reported that such persons as lesbians, gays, bisexual, transgender, and intersex (LGBTI) or sex workers are treated as outcasts in their communities. Some Organisations such as HRAPF, UGANET, CEHURD, UBUNTU, and Tranznet Uganda have documented stories of PLHIV and KPs who have suffered this kind of stigma and discrimination.

*“There is still some stigma. If you are positive, people in the community presume that your children are sick, and they keep saying ‘who will ever marry children from such a family’ you see, you keep hearing this being talked behind you, actually there was a lady whose child was teased by boys at school, the girl almost stopped her studies.” (FGD, PLHIV living with Disability, Yumbe District).*

While much of such stigma and discrimination is not backed by any by-laws, it is rooted in social and cultural norms and societal expectations. It is also fuelled by prejudices that come from entrenched attitudes. PLHIV used to be stigmatised and discriminated against in the early days of HIV when people were not aware of how HIV is spread and feared contact with a person who is HIV positive believing they too could be infected. Today, most people know that one cannot get infected with HIV by touching

or sharing a seat with an HIV positive person, but nevertheless, continue to stigmatise PLHIV. Similarly, many people know that being HIV positive is no longer a death sentence as PLHIV who are on treatment can lead healthy and normal lives like any other person, nevertheless, people continue to gossip and point fingers at people suspected or known to be HIV positive.

Stigma remains a complicated challenge partly because some of it is unintended, and the perpetrators may not even know that they are stigmatising anybody. Relatedly, some people may stigmatise others in an attempt to protect them. Having known that they are living with HIV or have another vulnerability, they may therefore excuse them or exclude them from certain activities as a way of favouring or protecting them, but in the process end up generating stigma.

These incidents of stigma and discrimination call for further engagements with communities to promote the acceptance of PLHIV and to denounce stigmatising and discriminatory practices.

*b) Stigma and discrimination in other institutional settings: Schools, Prisons and Police*

Other institutional settings such as schools, prisons and police barracks are not an exception. There have been newspaper reports about mandatory HIV testing of school children by some schools, as well as stories of PLHIV committing suicide due to what appears to be escalated levels of internal stigma, probably driven by external stigma and discrimination.

*“It has not been easy, because in Uganda people lack awareness. ... they think if one has HIV then they think of how you got it, then you will be discriminated. So, it’s hard for me especially in school, when you disclose to your friends about your status, some friends will go away from you, they don’t appear anywhere, they will say you are about to die. If you are skinny like me they will say that one is already dead. ... you cannot move freely. When you go to school you have to explain why you take the drugs let’s say you are in boarding, so if someone finds out, they may expose you and you feel like you are out of place. It is not easy at all.” (FGD, Adolescent Girls Living with HIV, Mengo, Kampala).*

In police and prisons barracks, key informants report that stigma is prevalent and drives some of their uniformed personnel who are living with HIV to avoid the health centres located within the barracks and travel to collect ARVs from distant outlets where they are not known.

*c) Stigma and discrimination in employment*

Stigma is also driving discrimination in employment, with some employers, such as those in the road construction industry or labour exporters, conducting mandatory HIV testing and denying employment opportunities to those that are found to be HIV positive. People intending to enter the uniformed forces are also subjected to mandatory medical tests including HIV testing, and those who turn out positive are not recruited. According to key informants from the uniformed forces, this policy exists because the training for recruits is strenuous and can easily put a person living with HIV at risk of worsened health condition or even death. They also argue that it is a strategy to protect others from infection. Yet according to ILO, there is no evidence that such mandatory testing contributes to HIV prevention<sup>369</sup>. The bottom line is that these practices discriminate against PLHIV and violate their right to equal opportunity to employment.

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<sup>369</sup> ILO (2016). From mandatory HIV testing for access to work to voluntary testing and counselling at work. Briefing Note, August 2016.

### 5.2.3 Privacy and Confidentiality

The privacy and confidentiality principle of the Human Rights-Based Approach (HRBA) states that service users are entitled to privacy and service providers have a duty to uphold the confidentiality of service users. Limits on privacy and forced disclosure or disclosure without consent must be restricted to specific compelling circumstances as appropriately provided for in law. As the review in the previous sections shows, the right to privacy and confidentiality is well-established in several laws and policies, including the HIV Prevention and Control Act (2014); the National HIV and AIDS Strategic Plan 2020/21–2021/25; the National Policy Guidelines on Ending HIV Stigma and Discrimination (2020); and the National HIV Testing Services Policy and Implementation Guidelines in Uganda (2016).

The HIV Prevention and Control Act (2014), makes it a criminal offence for the identity of a person tested for HIV to be disclosed contrary to the law and to medical standards for disclosing or releasing personal medical information. While the Act provides for the confidentiality of HIV test results, it also provides that HIV test results may be released to “any other person with whom an HIV infected person is in close and continuous contact including a sexual partner, if the nature of contact, in the opinion of the medical practitioner or other qualified officer, poses a clear and present danger of HIV transmission to that person.”<sup>370</sup>

Participants in this study largely felt that these provisions on disclosure of one’s HIV status without their consent violate the right to privacy and dignity and discourage people from testing for HIV. They argued that HIV status disclosure is a difficult and complex decision process, and the affected person should be supported but also allowed time to process the outcome of the HIV status, absorb it, and disclose when they are ready. They described it as a journey.

*“People should be given an opportunity to really process the outcome, because it’s not an easy thing. You know the fact that knowing that you are HIV positive, the first thing that comes to your mind is like ‘Your life is over.’ You need to process and really appreciate that situation. Let’s allow people, like we should focus in really helping this person, provide counselling, prepare someone, you know! Let them tell you their fears. Like, let’s have a social worker help this person through to prepare them mentally. So that when they are ready, then they can share with whoever, but they shouldn’t be forced.”* (Interview, Leader, KP Network Organisation-1).

*“Good practice requires practitioners to facilitate the client to be able to disclose and I think forced disclosure should only be in certain exceptional circumstances. I think the counselling procedures require that you facilitate or support the patient to get into that space to be able to disclose. I can tell you, we run the biggest HIV adolescent clinic, a good number of our children have not disclosed. The caregivers have not disclosed to those children but it is a journey. It takes us years to convince, to get the caregiver to actually say: ‘Now, I think I am ready to disclose to this child that you actually have HIV.’ But also it takes years for the adolescent to actually feel comfortable that now this is the right person I should disclose to my status. So, our role is there, we are just mediators of the process to empower you on how to approach it and when do you say, now I am ready to say but we will continue to support you with or without disclosure in terms of you accessing services.”* (Interview, Manager, HIV Programme Implementing Agency-1).

Study participants believed that the affected person is best placed to disclose to those close to him/her, because they know them better, compared to a health worker. Study participants therefore call for

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<sup>370</sup> The HIV Prevention and Control Act, Section 18(2).

supported disclosure, a process by which the support providers (health workers, counsellors, social workers) can walk along with the affected person so that the disclosure is done at an appropriate time. This process may take days, weeks, or months, and varies from person to person. There is fear that disclosure to one's sexual partner or family member by a third party, even if it is a health worker, may result into violence, breaks in relationships, and stigma towards the affected person.

In practice, ensuring privacy is still one of the challenges facing many Ugandan health facilities as they endeavour to provide HIV services. Most concerns are with the spaces where HIV counselling and testing services are provided in facilities with limited physical space. They often lack adequate counselling rooms, and therefore hold counselling sessions in places that may compromise the privacy and confidentiality of the client. Challenges in upholding privacy and confidentiality also exist in school settings, affecting school children living with HIV, especially in boarding schools.

#### **5.2.4 Respect for Personal Dignity and Autonomy**

The HRBA principle on respect for personal dignity and autonomy requires the free and full cooperation of service users; avoidance of coercive treatment; respect for informed consent; and promotion of client autonomy in decision-making. A number of laws and policies seek to guarantee this right. These include for instance:

- the National HIV and AIDS Strategic Plan 2020/21–2024/25.
- the National HIV Testing Services Policy and Implementation Guidelines in Uganda (2016).
- the Consolidated Guidelines for Prevention and Treatment of HIV and AIDS in Uganda (2020).

The main point is that persons above the age of 12 years should consent before an HIV test is given to them. The Comprehensive HIV Testing and Treatment Guidelines (2020) state that: “HTS delivery shall be ... offered using a Public Health approach that observes the 5Cs (Confidentiality, Consent, Counselling, Correct test result, and Connection to appropriate services) irrespective of HTS approach.”

With regard to consent, the guidelines state that: “All persons 12 years and above should consent to HTS on their own. In situations where consent cannot be obtained, the parent or guardian (of a child), next of kin, or legally authorised person should consent.”

On the other hand, the 2016 HCT Guidelines lists categories of persons from which informed consent may not be required in order to prevent transmission, namely pregnant and breastfeeding women and their spouses; persons who have committed sexual offences; individuals to be initiated on PEP; and donors of blood, body tissue, and organs.

Similarly, the HIV Prevention and Control Act (2014), states that the following persons shall be subjected to routine HIV testing, and lists victims of sexual offences, and pregnant women and their sexual partners. The Act does not mention the need for the consent of these persons listed for routine testing.

There have been concerns that, in line with the above provisions, pregnant mothers are in some settings subjected to mandatory HIV testing as part of the EMTCT services. Moreover, such coerced testing is undertaken with limited or no counselling of the mothers, and although they are started on treatment when found positive, they are otherwise largely left on their own to deal with the psycho-social and other ramifications, including issues of disclosure and how to deal with an HIV positive result.

Service implementers interviewed during this study, however, say they interpret the existing laws and policies as not necessarily prescribing mandatory HIV testing for pregnant women, but rather offering an opt-out option for pregnant mothers who may not want to be tested for HIV at that particular time.

There is a good level of consensus amongst implementers and other stakeholders that nobody should be forced to take an HIV test, except for purposes of investigation of sexual offences. Stakeholders believe that everyone, including pregnant mothers, should be given adequate information about the need and benefits of HIV testing both for the mother and the baby, and then mothers should be given the freedom and time to make the decision as to whether and when they would like to take the test.

*“For pregnant mothers, I think the thing is, there should be consent. People should be given the awareness, for example tell them that for a mother to bring forth a healthy bouncing baby, she needs to be tested so that if she is found to be positive, then they are put on medication to protect the baby. Create awareness, let the mothers know and consent so that they are guided in the process, so that it is not a shock if someone turns out to be HIV positive.”* (Interview, Leader, KP Network Organisation-1).

The challenge in practice is that most facilities and outlets where HTS is offered to pregnant mothers may lack adequate counsellors to provide adequate information to pregnant mothers and prepare them for the outcome of the test. Mothers who are not well prepared for the test are, if their test turns out positive, likely to face challenges in disclosure, adherence, and retention in care.

Others contend that even if HIV testing for pregnant mothers were mandatory, the benefits outweigh the harm, since it is aimed at protecting the unborn baby and ensuring that the HIV positive mother is supported to deliver an HIV-free baby, and that can only happen if the mother knows her HIV status.

There have been other violations of people’s autonomy and dignity in healthcare settings. Some participants in this study, for instance, cited experiences where women living with HIV have been advised and even coerced to use permanent methods of family planning, including sterilisation, based on the thinking that since they are HIV positive, it is best for them not have children (who may be born with HIV). In many cases, such practices have not been informed by science, are not backed by any policies, and are out of the assumption by health workers that it is in the best interest of women living with HIV not to get pregnant or have children.

*“What we hear more beyond the laws it’s the practice... one of the key issues is that we don’t have anything in law or in policy that for example says that if you are HIV positive, you shouldn’t get pregnant ... or these are the family planning methods that you should be using, yeah, we don’t have any, but in terms of practice we are seeing women who are HIV positive being told like ‘because you are HIV positive, it is in your interest and interest of your family not to continue having children and we think that the method of family planning that is good for you is sterilisation.’ ... and many women have been sterilised in that process.”* (Interview, Leader of a PLHIV Network -1).

The ICWEA conducted a study which documented the incidence and prevalence of coerced sterilisation among women living with HIV. Incidents of this nature require not just laws and policies, but improving and strengthening training, mentorship, and engagement with HIV and SRH service providers.

### **5.2.5 Meaningful Participation and Accountability**

The HRBA principle on meaningful participation and accountability requires that people living with and affected by HIV and AIDS should be at the centre of the HIV response and should actively contribute either individually or collectively to the design, implementation, and utilisation of HIV-related services. It further requires that governments and other implementers should be accountable for the resources, decisions, and actions they take in relation to all people's human rights.

Several legal and policy frameworks speak to this principle. They include: CEDAW Recommendation No. 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS) (1990); the UN General Assembly Declaration of Commitment on HIV and AIDS: 'Global Crisis – Global Action' (2001); the National HIV Testing Services Policy and Implementation Guidelines in Uganda (2016); the National HIV and AIDS Strategic Plan 2020/21–2021/25; the Consolidated Guidelines for Prevention and Treatment of HIV and AIDS in Uganda (2020); The Uganda Gender Policy (2007); and the National Adolescent Health Policy for Uganda (2004), among others. Overall, it is evident that almost every policy calls for the participation of clients in making decisions affecting their health and in designing and providing services.

Many HIV programmes and implementers have adopted mechanisms for the involvement of intended beneficiaries in planning, designing, implementing, and monitoring services. Many involve PLHIV as expert clients, peer workers, or other forms of volunteers to provide support to other PLHIV. Others hold stakeholder engagements, dialogues, and what they call 'safe space' meetings in which service users access services and provide feedback to the implementers. Others reported that they have disseminated the Patients' Charter to clients to enable them to claim their rights and demand accountability. Others are also using suggestion boxes and hotlines as channels to receive client feedback.

Many CSOs in Uganda are PLHIV-led and some are KP-led. In such cases, the PLHIV or KP members themselves are in the driving seats of these Organisations, occupying positions on the boards, or playing executive roles. There has been a tremendous increase in the number of such organisations in Uganda in recent years, including umbrella organisations that coordinate them, all of which are a demonstration that the environment for PLHIV and KPs to participate in the HIV response is not closed, despite the laws that criminalise some KPs and their sexual behaviours.

As referenced above, a community-led monitoring initiative has been piloted and is now being rolled out, which seeks to monitor, among other things, the quality of HIV and other health services, through a score card approach to collect client satisfaction. The CLM provides an opportunity for service users to participate in monitoring service quality and providing recommendations for their improvement. This contrasts with the experience of study participants from refugee settlements who report that planning for HIV and other services in the settlements is still largely top-down with limited involvement of the refugee persons.

#### ***Beyond stigma and discrimination: The exclusion of PLHIV***

In several FGDs and individual interviews conducted as part of this study, study participants explained how other community members have "written them off" as good as dead. Based on the knowledge that they are living with HIV, some community members take them as useless and as having no future. Some refer to them as "moving corpses," while others remark that "that one is dying anytime." Because

of these perceptions, PLHIV are often excluded from community activities and responsibilities. This exclusion is worse for PLHIV who may also be having other chronic conditions such as cancer.

*“They think that since I am positive, I cannot bear children, get married or have responsibilities. They really see us as being very vulnerable and we cannot participate in anything in the community.”* (In-depth Interview, Female PLHIV, Mbale District).

*“A person who has HIV is a person with no respect, she is a person looked at as one who has done all the bad things in the world, a person who has committed a blasphemous sin. Most of the time those people see us as people who are already dead, people who died a long time ago and we are walking corpses. They don’t expect much from us like running a business if given an opportunity. So, they perceive us in a negative way which is not correct.”* (In-depth Interview, Female PLHIV, Mbarara District).

In situations such as those described above, PLHIV may be denied opportunities to actively participate in service planning or implementation or in any other development activities. This treatment may have the effect of generating self-stigma and further damaging the affected PLHIV’s self-esteem.

### **5.3 Availability, Accessibility, and Affordability of Interventions that Promote Rights of PLHIV and Other People Affected By, or at Risk of HIV and How These Are Affected by the Legal and Policy Frameworks**

Leading international organisations on human rights issues recommend a set of interventions to promote the human rights of PLHIV, key populations, and vulnerable groups in the context of HIV and AIDS. These interventions include those focused on stigma and discrimination reduction; training of health workers in providing group-specific friendly services (e.g., PLHIV-friendly, KP-friendly, youth-friendly, PWD-friendly services/practices); engagement with duty-holders or duty bearers; providing legal literacy; providing legal aid services; reducing discrimination of women in the context of HIV; and advocacy for legal reform, strategic litigation, and legal reform monitoring. In this sub-section, we elaborate to what extent these interventions are available and accessible in Uganda.

#### **5.3.1 Stigma and Discrimination Reduction Interventions**

Stigma reduction has been a key focus of Uganda’s HIV responses and is highlighted in the NSP for HIV and AIDS as a key strategic intervention. The government of Uganda through the Uganda AIDS Commission has formulated specific policies to address stigma and discrimination. The Policy Guidelines on Ending HIV Stigma and Discrimination (2020) are still recent, highlighting the importance that is being attached to this challenge. A number of interventions have been undertaken by various actors including government, CSOs, and cultural and religious institutions.

During the commemoration of the International Candle Light Memorial Day in May 2021, the theme of the day was “HIV stigma-free workplaces: A journey towards ending AIDS.” The event was used to engage corporate organisations and the public through various media, including social media. These engagements reached over 12 million people. Uganda AIDS Commission (UAC) facilitated dialogues on stigma and discrimination reduction for PLHIV/TB and KPs in all regions of the country, involving religious leaders, cultural leaders, local government technical and political leaders, and PLHIV leaders. Further, UAC facilitated a national media campaign focusing on stigma and discrimination which was



assisted by trained religious, cultural, and PLHIV leaders across all the regions of the country, involving the media (radio and TV).

The Cultural Institutions Self-Coordinating Entity (SCE) which brings together all the cultural leaders of major traditional cultural institutions in Uganda has been undertaking mobilisation and dissemination of messages on HIV and AIDS. This has included: mobilisation of cultural leaders and communities for change of social norms towards reducing HIV, GBV, child marriages, and other harmful cultural practices that perpetuate the spread of HIV; training of champions to lead the fight against GBV and child marriage; and dialogues on ending teenage pregnancy and child marriage.

Buganda Kingdom, with the Kabaka (traditional King of Buganda) as the UNAIDS Goodwill Ambassador for HIV Prevention (2017-2022) uses key events such as the Kabaka's birthday to implement various HIV-related activities including media campaigns, provision of HIV services, training of traditional leaders, health workers and women leaders in HIV prevention, distribution of Information, Education and Communication (IEC) materials with Kabaka's HIV messages, and sports events such as 'the Kabaka Birthday Run.' Several other cultural institutions similarly disseminate information aimed at change of norms and community HIV/AIDS education mainly through radio/TV talk shows.

Religious institutions under the leadership of the Inter-Religious Council of Uganda (IRCU) have also been actively involved in stigma reduction interventions. They have implemented an integrated package of services (SRH, integrated with HIV prevention, and GBV), held radio talk shows, and conducted interactive dialogues.

The Ministry of Health (MoH) has developed training manuals for healthcare providers to provide friendly, stigma and discrimination-free services, and supported the training of health workers.

Many government agencies, ministries, and departments have also embraced the campaign against stigma and discrimination and are promoting the "*No tolerance towards stigma and discrimination in the workplace*" campaign.

CSOs also implement several HIV stigma and discrimination reduction interventions, including litigation, training, and dialogues. These have included sensitisation and dialogue meetings targeting Women Living with HIV (WLHIV) and duty bearers (duty-holders), including law enforcement officers, legislators, judicial officers, and local government staff. However, most of the above activities are dependent on donor support and only cover those parts of the country prioritised by donors and project implementers.

### **5.3.2 Training of Health Workers in Providing PLHIV, KP, and Youth-Friendly Services**

The MoH has developed training manuals for healthcare providers to provide friendly, stigma and discrimination-free services, and supported trainings of health workers. The aim is to equip health workers with the knowledge, attitudes, and skills to provide services that are welcoming and responsive to the needs of key target groups such as PLHIV, AGYW, KPs, and youths in general.

The STI/KP/PP unit at the MoH has been key in organising the training of health workers in different regions of the country. Several other training courses have been conducted by implementing partners (IPs) such as Baylor Uganda, Infectious Diseases Institute (IDI), Regional Health Integration to Enhance Services (RHITES), and Mildmay Uganda, as well as the Most-at-Risk Initiative (MARPI) of the Ministry of Health.

Following the opening of the MAT Centre in Butabika to provide services to PWUIDs, training for 54 key staff (health workers, program staff, and CSOs) was conducted on MAT services delivery. Under the USAID Local Service Delivery for HIV/AIDS Activity (LSDA), supported by implementing partners (IDI, Baylor, and MARPI), and working through 168 private not-for-profit (PNFP) health facilities and CSOs in East Central, Eastern, Acholi, Lango, and South-West Uganda, they have trained health facility staff, KP peer leaders, and security personnel on KP-friendly services.

Health workers and district officials have also been regularly trained on new procedures and guidelines since these change quite frequently. Some organisations make it a policy to train their workers and the health workers they work with on gender inclusion, or child safeguarding.

Once again, a key challenge is that such training is donor dependent and is limited to districts and health facilities where donor funded activities are operational. While the capacity of health workers has been regularly updated, there is a lack of competent community-based workers (such as VHTs, paralegals, para-social workers, and other types of volunteers) partly because of the sheer numbers, given that these are found in most communities.

### **5.3.3 Engagement with Policy Makers, Judicial Officers, Law Enforcement Officers, Cultural and Political Leaders**

Interventions to improve the legal and policy environment have also included engagements with and training of various policy makers, duty bearers, and implementers - including members of parliament, political leaders at different levels, magistrates, police officers, and others - on issues of human rights.

This kind of training and engagement, mostly conducted by CSOs, has focused on the human rights-based approach; on the harm reduction approach to the treatment of PWUIDs; on the intersection between HIV, the law, and human rights; on stigma reduction; on the referral processes; and on social norm transformation. Stakeholders report that these engagements have usually produced noticeable changes in the attitudes of the participants.

### **5.3.4 Legal Literacy**

Legal literacy and creating awareness about human rights, and rights of PLHIV in particular, is essential to enable vulnerable people including PLHIV to claim and realise their rights. In Uganda, programmes to create human rights awareness among PLHIV and other stakeholders have mainly been conducted by CSOs, with only limited implementation from government agencies. Such CSOs include those in the legal and gender realm such as FIDA, UGANET, and HRAPF. In some cases, they have also worked in collaboration with the PLHIV and KP-led or KP-focused CSOs, as well as the Ministry of Gender, Labour, and Social Development.

Human rights awareness campaigns have not only targeted PLHIV and other affected persons, but also stakeholders such as local leaders, law enforcement officials, and other community members. These engagements cover a wide range of rights including health rights, women's rights, land rights, and rights related to sexual and reproductive health. Some have been doing this under the "Know your Rights" flag.

These programmes, however, have been limited in scope and have only reached a small fraction of those that need them. Data from this study has helped show that in several interviews and FGDs, PLHIV reported that they did not know their rights because nobody has ever told them about these rights. They also did not know where to lodge a complaint or get help if their rights are violated.

### 5.3.5 Legal Aid Services

Some CSOs including FIDA, UGANET, HRAPF and the Women's Pro Bono Initiative have been running legal aid clinics where they provide free legal services for the vulnerable. Some have adopted innovative models, such as legal camps and mobile legal aid clinics, in a bid to take services to the communities. Some CSOs such as UGANET have conducted medical-legal clinics where both medical and legal aid services (legal literacy, consultation, filing cases, counselling) are provided to clients on the same visit at an HIV clinic. These services are focussed on the vulnerable, in particular, women living with HIV, widows, and orphans.

UGANET provides legal aid and support services related to property inheritance, land issues, and GBV. HRAPF works mainly with key populations and has handled many cases of KPs arrested by law enforcement officials to help them secure police bond, bail, or get a fair trial. The UN agencies have supported a lot of work in the area of rights and equality. KP-led Organisations such as the Uganda Key Populations Consortium and TranzNetwork Uganda provide the link between the members of KPs who need legal aid and the CSOs providing such support.

*“Each case is handled as it is. So, it’s a case-by-case analysis and response. So, you find that if people are arrested, then we have to go and bail them out and arrange legal representation. If someone has been denied a service, we ensure that they actually have access to the service. Sometimes, it’s provision of a shelter for example for those who experience sexual and gender-based violence.”* (Interview Leader, KP Network Organisation).

In an effort to make these services more accessible, these organisations have trained community-based volunteers as paralegals who then work with and assist the vulnerable to navigate the complicated legal system.

Legal aid services by CSOs are provided free of charge to help poor and vulnerable people access legal support they could otherwise not afford, given the high cost. For instance, they enable the vulnerable to obtain the services of a lawyer. The box below shows the extensive work undertaken by one of the CSOs, UGANET, over the past one year.

#### **Box 2: Creating Awareness and Building an Enabling Legal Environment—UGANET<sup>371</sup> Activities 2020-2021**

- 677 duty bearers in 6 regions engaged through workshops and radio talk shows on the human rights-based approach, and on the rights of KPS and PLHIV/TB on their roles as Duty Bearers. District action plans developed.
- Referral directories of service delivery points including legal, GBV, and human rights services developed, based on mapping exercises conducted in 20 districts in SW, Central, Eastern, Karamoja, Lango, and Busoga regions.
- Paralegals equipped with tools such as referral forms and simplified guides to facilitate GBV and legal referral and response.
- 38 judicial officers of the justice sector (High Court Judges, Registrars, Chief Magistrates, and Magistrates) across regions engaged and trained on HIV/TB and the law.
- A Judicial Handbook on HIV, TB, and the law was launched in late 2021.

<sup>371</sup> Uganda Network on Law Ethics and HIV/AIDS.

- 121 paralegals from 41 districts in 6 regions trained to build their capacity in reporting/documentation, mediation skills, and mechanisms to improve linkages & referral with partners.
- 119 community-based paralegals trained and equipped to provide legal aid outreaches.
- 1188 (799 females, 389 males) clients supported to access GBV/Legal Aid Services.
- 7805 (4637 females, 3258 males) provided legal literacy.
- 1480 (1039 females, 441 males) reached in legal aid services. 2658 (1820 females, 838 males reached with legal literacy). District leaders engaged for their support in the activity.
- 1800 calls received through the toll-free call Centre line, and 1128 clients supported (725 females, 403 males).
- **Shelter home:** 50% of the women sheltered are living with HIV; one TB case was registered and supported to receive care and treatment. Of the 25 AGYW, 13 were pregnant.
- 135 MPs in core Committees (health, human rights, education, among others) engaged in three symposia, and sensitized on HIV and the law.

Equally substantial is the work being undertaken by HRAPF in promoting and protecting the rights of PLHIV and KPs in their diversity as shown in **Table 2** below.

Whereas CSOs are providing access to justice support services through various means such as free legal aid services, many gaps and barriers remain. Services are limited and many of the people who need them do not know where to find them or cannot easily access them due to location and distance barriers. There are also gendered barriers. It was found for instance that girls facing violence fear to report it due to the shame and stigma that may result.

Provision of legal aid and justice support services comes against a background of a complicated, bureaucratic, and slow justice and law enforcement system in Uganda, often inaccessible to poor and vulnerable people. Below is further analysis of the justice system.

**Table 2: Legal and Justice Support Services and Engagements by HRAPF,<sup>372</sup> January–September 2021**

<b>Activity</b>	<b>Number of events / sessions / cases</b>	<b>Number of beneficiaries / participants reached</b>
Legal aid to members of key populations	1,045	1,600
Legal aid to women and girls living with HIV	91	524
Awareness sessions for KPs on human rights	39	1169
Awareness sessions for WGLHIV on human rights	3	202
Mobile legal aid camps	6	218
Dialogue with Local Council leaders	3	86
Meetings/trainings with police on harm reduction	11	249
Dialogues with Ministry of Health/health workers	8	244
Training of health workers on KP issues	8	256
Training Local Council leaders on KP issues	1	30
Training paralegals amongst KPs	1	53

<sup>372</sup> Human Rights Awareness and Promotion Forum.

Number of human rights violations documented	210	
Cases handled through communal justice systems		14

State-supplied legal aid options are scarce. The government has made some effort to address the lack of access to justice through the State Briefs scheme for persons charged with capital offences (but this does not extend to HIV-related cases), the Pro Bono scheme run by the Uganda Law Society, allowing students to offer legal aid, and the establishment of the Justice Centres. The efforts of various non-governmental Legal Aid Service Providers (LASPs) help fill the gap.

### **Access to justice for PLHIV, KPs, and other vulnerable groups**

Access to justice remains limited for various reasons. Established JLOS government structures such as the Judiciary, and other organs such as the Human Rights Commission and the Equal Opportunities Commission, are mainly in the urban areas and central region, presenting distance challenges that dissuade people from claiming their rights.

The legal process can be daunting. Transactions are complicated and confusing for laypersons facing an adversarial system with a strong emphasis on procedure and rules. There have been instances where people were charged ‘user fees’ for case registration and processing through the various stages. It was found, for instance, that whereas survivors of sexual offences should be provided Standard Forms free of charge, clients were asked to pay for the form in some health facilities. Survivors have to bear the transport costs of witnesses, including health workers, when their case is heard in court. Clients may also be asked to make an informal payment to the police for their cases to be processed. National Service Delivery Surveys<sup>373</sup> have indicated that more than half of those seeking redress through the JLOS (53%) had to make payments of some kind, official or unofficial. Some 60% of respondents had made unofficial payments (bribes, ‘tokens of thanks’, or ‘facilitation’) to local or central police; in one year about 52% had made unofficial payments to Magistrates Court. These kinds of costs are a barrier to reporting and processing rights violations.

There is a lack of confidence in the justice delivery system. KPs who have faced abuse, bias or discrimination are fearful of power structures and government agencies. Corruption within the law enforcement and justice systems is a major constraint to access and pursuit of justice for those whose rights have been violated. Study participants cited examples of cases where suspected perpetrators of sexual offences are reported to police, arrested, but then released without being produced in court, allegedly after bribing the police officers.

In several cases, survivors failed to see justice because the families of the violated person and the perpetrator agreed to settle the matter out of court and the case was ‘killed’ there and then. There are many examples of miscarriage of justice.

There are particular barriers to justice for orphans and other vulnerable children (OVC) reporting crimes such as dispossession of their parents’ property or sexual abuse. In many cases, the violators are family members or close relatives. One orphaned girl in Mbale who participated in this study said she was dispossessed of the property left behind by her dead parents and denied the opportunity to attend school. The property grabbers were family members and relatives that would have been expected to guarantee her rights to this property. When the girl tried to insist and to recover her property, her relatives accused her of threatening violence and got her arrested. Similar stories are

<sup>373</sup> National Service Delivery Survey 2004: 94 (Table 9.6); National Service Delivery Survey 2008: 124 (Tables 9.8,9.9).

common in many Ugandan communities and reveal the desperate situation of the vulnerable. Only a few manage to obtain support to seek redress for injustice. Most of the PLHIV negatively impacted by bad laws are already highly vulnerable. They face multiple disadvantages because they may be KPs, are in dire poverty and living with HIV. They also lack awareness of their rights. Even those who learn their rights may lack the confidence to claim them or fear to take action. A key informant from a PLHIV-led Organisation which has been working with WLHIV and raising their awareness about their rights, described how they offered support to WLHIV who had suffered coerced sterilisation, to lodge cases in court and pursue justice. The women in question would not take up the offer, arguing that the same health workers who sterilised them are the ones who provide other health services to them, and therefore they did not want to antagonise them by taking them to court.

Criminalised groups such as sex workers report that they find it hard to access justice, or even be heard and to be listened to by police and other authorities responsible for handling rights violations. The authorities often turn their attention to the criminal status of the sex workers as defined by the Penal Code Act instead of attending to the complaint.

*“The problem is that police do not help us, even if you go and report [e.g., violence done against you], he tells you to go and bring a licence that authorises you to do sex work. ... if when we face challenges and go for redress from the authorities; rather than helping us, they chase us away asking us who told us to go into prostitution.” (FGD, Sex Workers, Bugiri District).*

It also emerges that PLHIV are easy targets for false accusation. Even when they are the victims, the case can easily be turned on its head to accuse them. They find their rights are likely to be violated by police, court, or prison authorities. One PLHIV described how she was arrested after relatives made false accusations, was held in police cells for four days before being produced in court (beyond the maximum of 72 hours allowed by law), and during her stay in police cells she could not access her ARVs, as detailed in Box 3.

Many similar stories emerged, leading us to conclude that the very people expected to ensure justice are the same people who deny it. It is hard to avoid the conclusion that justice in Uganda is for sale. The situation has only improved for PLHIV and other KVPs who have been fortunate to access agencies providing legal aid such as HRAPE, UGANET, and FIDA.

Besides denial of access to medicines, those arrested and charged with sexual offences are automatically subjected to a mandatory HIV testing and anal examination, in case one is gay, MSM or transgender.

Some informants also warned us that indications that the police are not arresting sex workers, PWUIDs, and MSM as frequently as before, should not be taken to mean that

### **Box 3: Justice Failure**

*“When they took me to prison, no one understood me! I tried to explain myself when I was in prison for four days and I did not take my medication. Though I was struggling with an officer that please make sure I take my drugs. They did not give me that chance and to me my life was abused because I missed my drugs, and it is my daily treatment, and I am on cancer treatment until the time when I reached the court when I presented my papers and the lawyer saw that and said you have kept this person in police cells for all this time without her getting her treatment!”*

*“I was also there starving without anybody minding about my health. So, you know with police, they only mind about who has paid them money. You know my aunt paid them money to come and arrest me. So, for them once they are paid, they don't even take efforts to find out who is this person ... So, all 4 days I was there without my medication, and I was there trying to tell them that please can I take my drugs! No one was moved so they don't see us as people who have rights.” (IDI, Female PLHIV, Mbale District)*

the environment has improved. As long as there are punitive laws on the books, they can be used at any time to violate peoples' rights.

*“The laws exist in this country and will not work unless someone wants to make you a victim of that law, but they are there, and someone can use them to challenge you in court, and also to imprison you. ... they are not effectively implemented, and thus an advantage to that population because if they were effectively implemented many of the key populations will not be calling for meetings in the country, but they are calling for meetings because we are a country that enacts laws, and the laws go to sleep.”* (Interview, ADP Official-1).

Just because a bad law is not implemented should not be taken to mean that the environment has changed for the better. For that to happen the laws must be amended.

### **Implementation of the law and access to justice**

Participants in this study talked about the uneven implementation and weak enforcement of existing laws, even when those laws are sufficient and enabling. They cited the existence of laws against defilement as an example, despite which, cases of teenage pregnancy and under-age marriage are rampant and rarely prosecuted. Existing data show only about 36% of the suspected perpetrators of defilement are even arrested.<sup>374</sup> In many cases, after the perpetrators are identified and arrested, they are allowed to negotiate with the family of the girl and settle the matter out of court. This often ends with the offender marrying the under-age girl whom he violated. One study participant from Mbale district recounted how he was involved in the case of a girl with a disability who was hospitalised after a rape. A few days later it was revealed that the girl's parents had negotiated a small payment from the offender (to drop the charges) and this satisfied them, as they argued that at least they got something, since the girl had a disability, they did not expect her to get married and bring them bride wealth. In this case, poor enforcement of the law had been complicated by retrograde cultural beliefs and expectations.

Poor implementation and weak enforcement are exacerbated by misuse of the law for personal gain, or to victimise vulnerable people such as PLHIV.

*“We have seen people who are living with HIV when they are arrested ehhl!, a case rises quickly. You know? And they are even judged before they are listened to. That is why you see we have been fighting criminalisation of people living with HIV because it takes away even the right to a fair trial because the law says you must be treated as innocent until proven guilty, but nobody listens to this when the case involves a person living with HIV. ... you see how the public court and other people handle people living with HIV cases, they take it to another level.”* (Interview, Leader, KP Network Organisation-1).

JLOS bureaucracy, coupled with corruption and prejudice due to stigma, were found to be significant barriers to access to justice by PLHIV and other vulnerable people, as one key informant observed.

*“It is really about the implementation of the law. You find someone who has been a victim of violence has to go through a whole procedure that is very, very stressful and eventually they even fall off and decide not to pursue it. So, justice is not served for those who have been violated especially children*

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<sup>374</sup> MoGLSD (2021), Child Helpline Database.

*and women that suffer gender-based violence.” (Interview, Manager, HIV Programme Implementing Agency-1).*

*“... already accessing justice in this country is really a tough issue for anyone, so what about accessing justice for people living with HIV? With that whole stigma around HIV.” (Interview, Head of a Law/Gender and HIV focused CSO).*

The behaviour of some law enforcement officers further undermines faith in the JLOS. Many rights violations are perpetrated by the police themselves. They carry out arbitrary arrests, they detain people for longer than the prescribed hours without producing them in court, they deny them access to their medication, and sometimes they torture them, unleashing physical and/or sexual violence against them. Study participants reported numerous instances of police officers having raped sex workers after their arrest, occasionally ‘in exchange for’ their release. Victims in these circumstances find it almost impossible to attain justice, given the criminal status imposed on them as sex workers and the stigma they face as PLHIV.

*“We also get ashamed going to the authorities to seek for justice. For example, how do you go to them and start explaining to them that you are a prostitute and you have been raped? You just get ashamed.” (FGD, FSW, Bugiri District).*

What is being referred to as “shame” here is actually internalised stigma, accumulated as a result of long-term external stigma and criminalisation.

The undue length of time taken to enact human rights-based and sensitised laws in Uganda is also concerning. Examples include the HIV and AIDS Prevention and Control Act (2014), the Sexual Offences Bill, and the Domestic Relations Bill (Marriage and Divorce Bill). Some of these laws have spent over 10 years in draft form. Similarly, the petition to the Constitutional Court to remove three punitive clauses from the HIV Prevention and Control Act has taken six years to be heard. Delayed justice is indeed justice denied for some people.

### **5.3.6 Reducing Discrimination Against Women in the Context of HIV**

Most of the interventions described herein focus on women and girls as prioritised groups because of their higher levels of vulnerability and the additional human rights violations to which they are subjected. Many of the support services, such as those addressing GBV which provide shelters, toll-free helplines, and legal aid services, mainly serve women and girls. Some streams of funding from donor agencies are earmarked to support programmes either specifically targeting women and girls (e.g., under AGYW programmes), or programmes that disproportionately benefit women.

HIV programmes have also adopted various measures to uphold the rights of women clients on matters of access, consent, property rights, and so on.

### **5.3.7 Advocacy for Legal and Policy Reform, and Strategic Litigation**

PLHIV-led CSOs have been at the forefront of engagement with policy and law makers to formulate policies and enact laws that are more responsive to the realities of different categories of PLHIV. They do this by bringing the voice and the lived experience of PLHIV to be reflected in policies.



About 40 Ugandan CSOs united under the CSO Coalition on HIV and the Law have been undertaking advocacy for law reform. They have targeted parliamentarians, the Uganda Law Reform Commission, the Ministry of Justice and Constitutional Affairs, and other relevant stakeholders to advocate for reforms.

The Coalition has in particular advocated for amendments to the HIV Prevention and Control Act (2014) to make it a better law. The group prides itself on having succeeded in making improvement to the language of that law as it was being drafted to include mentions of the role of government in planning and programming for key populations, financing for HIV and AIDS activities, and inclusion of issues to address stigma. However, at that time the group was unsuccessful in its attempts to remove the three punitive clauses which later became the subject of litigation (discussed below).

The Coalition also played a key role in petitioning the President to refrain from signing the Sexual Offences Bill because, although it was directed at the protection of women and girls, it also contains clauses that re-introduce the criminalisation of consensual relations between persons of the same sex.

The organisations working under the CSO Coalition on HIV and the Law, along with those implementing the Community-Led Monitoring (CLM), have undertaken strategic litigation to challenge the contested clauses in the HIV Prevention and Control Act. Other CSOs also individually petitioned the Constitutional Court to challenge aspects of the law. The advocates in these CSOs believe that laws which criminalise the transmission of HIV do more harm than good and need to be framed with the 'human being' in mind.

*“We can be better if we look at people as human beings, as people who can make informed decisions and not being judgmental because of their status, or because of their sexual orientation. ... Look at an individual as an individual, that if I am wrong, I am wrong as a human being, and it's not because of my HIV status, the status is not what makes me who am. And it's not the status that makes me do the things that I do, so we continue to advocate to look at individuals as human beings.”* (Interview, Leader of a PLHIV Network -1).

Already two restrictive or punitive laws, the Anti-Homosexuality Act (2014) and the Anti-Pornography Act (2014), have been successfully challenged in the courts of law by coalitions of academics, advocates, and CSOs, though not without impediment. Cases filed in court can sometimes take several years to be heard. For instance, CSOs went to court in 2016 to challenge aspects of the HIV Prevention and Control Act 2014, and to date there has been no hearing. For some, this is suggestive of political interference in the work of the judiciary, undermining its independence.

CSOs have also been pressing for better and more responsive services. Advocacy has centred around such issues as the availability of ARV supplies and family planning commodities; the availability of health workers; health worker attitudes; and stigma reduction. To this end, different the organisations employ diverse strategies (see Box 4).

As a strategy in advocacy, local CSOs and PLHIV-led Organisations also seek the partnership and support of partners from other countries to advance their advocacy agenda. ICWEA for instance reported that they sometimes build alliances with international partners to advocate jointly about certain issues.

#### **Box 4: Strategies for Successful Policy Influence**

*As an organisation, we create spaces for dialogue with policy makers and decision makers and in these dialogues we bring women and people living with HIV on the table so that whatever we are presenting to policy makers, it is backed by the voices of the people themselves. I remember when we were engaging with the Ministry of Health and looking at access to DGT (a type of ARV), then we realised that we were probably not being heard.*

*We arranged a dialogue with the Ministry and then we brought young HIV positive women of reproductive age in the room; women who were HIV positive and in the reproductive age and wanted to have children.*

*This changed the whole narrative because young women were speaking for themselves and raising their issues and by the end of the meeting the situation was different and when we went into the policy room, the persons who were in the meeting were able to speak on behalf of the women that they heard and we were able to change that narrative (Interview, Leader of a PLHIV Network-1).*

#### **5.3.8 Other Services and Interventions**

Other services and interventions aimed at promoting the rights of PLHIV and KVPs have included shelters for victims of SGBV, toll-free helplines for reporting cases of rights violations, psycho-social support services, post-violence clinical care including access to HIV testing and post-exposure prophylaxis (PEP), and referral to other services.

### **5.4 Awareness of Legal and Policy Provisions and Human Rights Among PLHIV and Other Vulnerable Groups/People at Risk of HIV**

Levels of awareness regarding legal and policy provisions and human rights vary widely among PLHIV, other vulnerable groups, and people at risk of HIV, depending on where they live, their level of access to information, and whether they have interacted with HIV-focused CSOs or not. During this study, discussions with certain categories of PLHIV such as expert clients and those who had been trained or supported by leading HIV-focused CSOs indicated that these PLHIV were knowledgeable about key human rights such as the right to confidentiality and privacy, and the right to access services without discrimination.

*“The constitution and human rights laws protect me, that I have the right to seek medical attention and be treated like any other patient. I am entitled to study if I so wish. I have actually gone for a diploma. I have a right to participate in any activity, and to aspire as a political leader. I have a right to apply for any job as long as I have the qualification. I have rights to marry and bear children, right*

*to equal treatment at workplace. I now know that if my rights are abused, I will not sit down, I will report to police. I enjoy equal rights even with men.” (IDI, Expert Client, Yumbe District).*

However, when we met groups of PLHIV from remote rural locations who had not interacted with CSOs, their awareness of their rights was quite low. Sometimes, even within the same FGD, different participants would display different levels of awareness, and this always had to do with their level of exposure to and interaction with CSOs working in the HIV sector.

What these disparities reveal is that educating PLHIV about human rights is of paramount importance to empower them and raise awareness of their own rights and is really having an impact.

*“I think when we are talking of access to treatment, people just go. They don’t even know their issues around laws and policies. But people just go to access treatment and that is why sometimes when they get challenges, they just keep quiet and they don’t tell us so that we can come in and see how we can support.” (Interview, Leader of a PLHIV Network-2).*

Even among law enforcement officials we find there is limited knowledge of human rights and the law. A study conducted by UGANET, for instance, found that most law enforcement officials were not aware of the HIV Prevention and Control Act (2014) but instead relied on their knowledge of provisions of the Penal Code. These findings suggest that the HIV Prevention and Control Act has not been widely enforced as it cannot be relied on if they are unaware of it. The concern, however, is that for as long as it exists, the HIVPCA will be used at one point or another, to victimise a PLHIV.

## 6 CONCLUSIONS AND IMPLICATIONS/RECOMMENDATIONS

### 6.1 Conclusions

The objective of this LEA was to assess the extent to which the existing Ugandan laws, regulations, and policies enable or constrain key protections for people affected by HIV in Uganda.

#### *National laws, policies, and strategies that positively or adversely affect the delivery of HIV services to PLHIV and HIV affected persons*

Uganda has an extensive law and policy regime and also subscribes to, and is a signatory to, numerous international human rights instruments which guarantee the various rights of all persons and assure protection of the specific rights of marginalised and vulnerable groups, including PLHIV.

Ugandan laws, including the Constitution and the HIV Prevention and Control Act (2014) (HIVPCA) are, in the main, enabling, providing for non-discrimination, equality, and provision of and access to services for all. Moreover, Ugandan laws do not prohibit anyone from accessing HIV services. Uganda's policies on HIV and AIDS are similarly wide-ranging, covering almost every aspect of the epidemic.

At the same time the Ugandan legal landscape contains elements which constrain an effective response to the HIV/AIDS epidemic.

- Clauses in the HIVPCA which criminalise HIV transmission as “attempted” and/or “intentional.”
- Rules which permit health workers to share HIV test results without the consent of the affected person and make it appear mandatory to test pregnant women and their partners for HIV without their consent.
- Sections in the PCA which criminalise sex work and other activities associated with what they term “prostitution”.
- Sections in the PCA which criminalise the act of “having carnal knowledge against the order of nature,” which is generally understood to refer to same-sex conduct and has thus been broadly used to accuse LGBTI persons.
- Clauses in the Narcotic Drugs and Psychotropic Substances Control Act (2016) which criminalise drug possession and use.
- Lack of legal recognition of transgender persons who are rendered invisible by the Registration of Persons Act.
- Sections in the PCA which criminalise presence in a public space as “idle and disorderly,” or being a “rogue and vagabond.”

These flaws in law and policy fuel stigma against the affected PLHIV and KVPs. The effect is that they:

- Discourage HIV testing and disclosure of test results.
- Disproportionately disadvantage women and girls.
- Provide a basis for arbitrary arrest and/or harassment by law enforcement.
- Legitimise inequitable treatment of PLHIV and KVPs to deny them a fair hearing or trial.
- Violate the right to privacy, confidentiality, and personal dignity.

While Uganda's body of law does not explicitly discriminate on the basis of gender identity or sexual orientation, individual laws criminalise behaviours, thus reinforcing social stigma and fuelling cruel treatment and harassment of some PLHIV, in particular KVPs such as sex workers, LGBTI and Transgender persons, depriving them of their rights to liberty, physical integrity, freedom of association, and good health. Social stigma in turn fuels physical and verbal assault towards these groups and discourages them from seeking and utilising HIV services.

Broad or vague terminology in defining offences allows for subjective and uneven interpretation by law enforcement officials which frequently results in discriminatory and unfair treatment of PLHIV and KVPs.

Overall, the Ugandan legal landscape presents as contradictory: on the one hand the supreme law that is the Constitution stipulates all rights and freedoms for all without distinction; on the other hand, subsidiary laws, often applied on subjective or discriminatory grounds, abrogate the rights of certain people in certain circumstances.

Regarding national policies, it is clear from the results of this LEA those existing policies are largely progressive and enabling, providing service delivery and access to all, even outlawed population sub-groups such as sex workers and MSM. The few exceptions include those policies that relate to access to SRH services for adolescents 12 years and below, requiring parental consent for access to services, and those policies which fail to specify or recognise some KPs, such as transgender persons, thus rendering them invisible.

Stakeholders acknowledge that there has been considerable progress in terms of gaining better recognition and acceptance, both from communities and from government institutions, of key and vulnerable groups at high risk of HIV infection and transmission as well as increasing acceptance of the human rights and public health arguments in favour of targeting them for HIV support services, the better to attain the 90-90-90 (now 95-95-95) goals.

This is evident in the fact that many KPs have associated with peers and mobilised to form groups and organisations. The level of police harassment they used to face a decade ago seems to have reduced. KPs are receiving services, and indeed, services specifically designed for them have expanded coverage. Despite laws that continue to criminalise drug use, the opening of the MAT centre to treat persons with drug addiction and the formulation of Harm Reduction Guidelines by the MoH are key milestones. Implementation of harm reduction, however, remains in the balance, as the continued existence of punitive laws means they can be invoked at any time to violate the rights of PLHIV.

The results of this LEA show that, in line with the HRBA framework, the availability, accessibility, acceptability, and quality of services for HIV in Uganda has improved over the last five to ten years. Service coverage has expanded in general, and in particular for services targeting key populations.

However, services tailored to some high-risk sub-groups, such as AGYW and KPs are not universally provided as they remain donor dependent and only exist in some parts of the country. The adoption of DSDs, (differentiated service delivery models) has improved accessibility to services for different PLHIV categories, a development that was particularly important during the COVID-19 lockdowns when travel restrictions were in place. Men living with HIV remain underserved as HIV support services for them are limited, and they lack the same entry points into care as women. There are also gaps with regard to policies for provision of HIV services in prisons settings, and for people aging with HIV, who

are on the increase as PLHIV life expectancy increases as a result of ART. The absence of specific mention of people aging with HIV and some key population groups such as transgender and intersex persons in policies makes it more difficult to engage them in HIV/AIDS testing, care and treatment services and facilitate adherence.

As for barriers to access to HIV services, stigma, both external and internal, remains one of the major deterrents. The quality of available services is generally good, with the exception of some gaps, e.g., the lack of provision of comprehensive services in all areas, challenges with referral systems and health centre infrastructure, where there is a need for the physical structures to be adapted to improve physical access for PWDs and improve privacy and waiting times for all PLHIV.

A number of interventions have been implemented and others are ongoing to promote the rights of PLHIV in all their diversity. These include:

- Specific stigma reduction activities championed by government ministries and agencies, as well as CSOs, religious, and cultural institutions.
- Training of health workers to equip them to provide services friendly to all categories of PLHIV, including KVPs, and other target groups such as adolescents and young people.
- Sensitisation training and engagement with law makers and law enforcement officials, as well as political, cultural, and religious leaders.
- Legal interventions including legal literacy counselling, human rights awareness training, legal aid services, and strategic litigation.

PLHIV who have been sensitised, trained or exposed in other ways to system SOPs, such as those working as expert clients or community health workers, have higher awareness of available support services, of their rights, and recourse to redress if rights are violated. However, there are still many PLHIV, in particular KVPs, who have limited awareness of their rights and the availability of existing support mechanisms, which is a constraint on their agency and ability to seek redress when their rights are violated.

Finally, it has to be reiterated that notwithstanding the many laws and policies that provide for non-discrimination and equality in access to services in Uganda, the punitive and restrictive clauses in some laws have the effect of discriminating against categories of PLHIV, making it difficult for them to access services and thus undermining the effectiveness of the HIV/AIDS response.

## 6.2 Best Practices

Some best practices in fostering an enabling legal and policy environment for HIV responses can be identified from this assessment. These include the following:

*Meaningful involvement of PLHIV, key populations and vulnerable populations:* It has emerged that where PLHIV and other vulnerable groups have been actively involved in analysing their situation, and in planning and determining responses, they have taken this responsibility on board and thus been enabled to stand up and demand the services and rights to which they are entitled. They have also developed the confidence to fight stigma and discrimination and support others to continue in care. This meaningful involvement has been on a small scale to date but clear evidence of the advantages of this approach is a signal that more needs to be done to make this a standard practice.

*Engagement of duty bearers, service providers and other key stakeholders:* Many various actors in diverse roles engage in and contribute to the legal and policy environment. Engagement with the various categories of duty bearers such as policy makers, service providers, law enforcement officials, legislators, judicial officers, religious, cultural, and political leaders, has led to significant improvements in the legal environment in the past few years. Engagement with cultural institutions in campaigns to reduce stigma and end child marriage have helped to rally large sections of the general population around these causes.

*Supporting access to legal and justice support services:* Legal and justice services are expensive while most PLHIV and KVPs fall into low-income groups unable to afford private legal services. The introduction of innovative and accessible information-delivery models such as legal camps and mobile legal aid clinics helps to break down those barriers to accessing justice. However, legal aid services are still limited and reach only a small proportion of these who need them. Provision of free or low-cost legal aid services along with support for legal literacy are important steps to improving access to justice for these groups.

*Working with and through community-based volunteer workers:* Given the cost of hiring and maintaining professional staff, an effective means of broadening the scope of HIV services with limited resources is to work through community-based volunteers. Recruitment of cadres such as paralegal and para-social workers, along with expert HIV clients, has proven very effective to deliver services to PLHIV, make follow-up visits and coordinate referrals.

*Equipping health workers to integrate rights-based approaches:* Interventions that train and sensitise health workers to recognise the unique needs of PLHIV and KVPs, and to respect and uphold their rights, can make a real, meaningful change to the HIV service environment - a key route to reducing stigma in health care settings and facilitating access to HIV support services.

*Integration of medical, legal and psychosocial services:* A health service model capable of combining the input and expertise of multiple sectors and professionals to concentrate essential support services in one place and improve accessibility to users can constitute a major response. For instance, when CSOs brought medical, legal and psychosocial support services to one outreach site, it was a considerable help to PLHIV and other vulnerable clients to be able to access these complementary services in one place.

### 6.3 Recommendations

	<i>Issue</i>	<i>Recommendation</i>	<i>Responsible (Lead Agency in bold)</i>
<b>I</b>	<b><i>The Penal Code Act</i></b>		
I.1	Sections 136–139 of the Penal Code Act criminalise sex work, thereby fuelling stigma towards sex workers, providing a basis for police harassment, and discouraging	Review and amend these sections of the law in order to decriminalise sex work.	<b>Uganda Law Reform Commission, Parliament, Ministry of Justice &amp;</b>

	service utilisation by sex workers.		Constitutional Affairs
		In the short term expand interventions to provide legal support services, reduce stigma, and sensitise law enforcement officials.	<b>CSOs, UAC, MGLSD</b>
1.2	Section 145 of the Penal Code Act criminalises same sex relationships, thereby fuelling stigma towards MSM, transgender and other LGBTI people, providing a basis for police harassment, and discouraging service utilisation by these groups.	Review and reform this section of the law in order to decriminalise same sex relationships.	<b>Uganda Law Reform Commission,</b> Parliament, Ministry of Justice & Constitutional Affairs
		In the short term expand interventions to provide legal support services, reduce stigma, and sensitise law enforcement officials.	<b>CSOs, UAC, MGLSD</b>
1.3	Provisions in Sections 142 and 143 of the Penal Code Act and Article 22 of the Constitution of Uganda present contradictions on the issue of abortion. MoH guidelines on abortion were suspended.	Harmonise the legal provisions on abortion and decriminalise abortion in order to give women access to safe abortion services, guarantee autonomy and decision-making agency over their reproductive lives.	<b>Uganda Law Review Commission,</b> MoH, Parliament
1.3	Provisions criminalising Idle and disorderly found in sections 167 to 169 are overly broad, vague and unfairly affect the poor, the marginalised and those castigated as social outcasts and misfits. These unnecessarily crowd prisons and affects PLHIV uptake of HIV services.	Repeal these sections because they are archaic, out-dated and no longer serves the purpose for which they were created.  Uganda Police Force and the DPP should desist from charging and prosecuting individuals with these provisions.	<b>Uganda Law Reform Commission,</b> Parliament, Uganda Police Force, The Director of Public Prosecution
<b>2</b>	<b><i>The HIV Prevention and Control Act</i></b>		
2.1	Section 41 of the HIV Prevention and Control Act, 2014 criminalises attempted and intentional transmission of HIV. This is being	Repeal/expunge this section out of the law.	<b>Uganda Law Review Commission,</b> Parliament, Ministry of Justice &



	challenged in the constitutional court.		Constitutional Affairs
	This HIV-specific law portrays PLHIV as worse criminals than those who are HIV negative, ignoring their vulnerability and having the potential to fuel a biased trial. The HIV status of the accused is likely to arouse stigma and overshadow other facts that should be considered in determining a case.	HIV related cases such as those relating to intentional transmission of HIV should be prosecuted under the general criminal law, not HIV-specific laws.	<b>Judiciary, DPP, Police</b>
2.2	Section 13 (B & C) of the HIV Prevention and Control Act provide for routine HIV testing for pregnant women, which is interpreted as mandatory in some cases, depriving them of their autonomy in decision making, and their right to consent.	Reform the law to make it explicit that pregnant mothers should only be tested upon giving consent; health providers should provide full information about the benefits of HIV testing during pregnancy, and they should give mothers an opportunity decide whether to take the HIV test or to opt out if they so wish.	<b>Uganda Law Review Commission, Parliament, MoH</b>
2.3	Section 18(2) of the HIV Prevention and Control Act allows a health worker to disclose HIV test results to another person without the consent of the client, eroding their right to consent.	Reform the law to remove the provision for a health worker to disclose results to a third party without the consent of the client; instead support the process of disclosure by the client himself/herself.	<b>Uganda Law Reform Commission, Parliament</b>
<b>3</b>	<b><i>The Narcotics Drugs and Psychotropic Substances Control Act</i></b>		
3.1	The Narcotic Drugs and Psychotropic Substances Control Act (Sections 4–6) criminalise drug possession, trafficking, and use, thereby fuelling stigma against people who use drugs, discouraging service utilisation, and relegating them to risky injecting practices.	A harm reduction approach to dealing with drug use should be fully embraced, with the provision of a minimum service package for harm reduction as recommended by the WHO. Information on HIV and drug use should be provided to all stakeholders. Public health and human rights approaches should be integrated into national public health interventions, including the national HIV programme to ensure that people who use or injected drugs are fairly and humanely treated while seeking HIV services. Accessible public health treatment facilities for PWUIDs should be expanded	<b>UAC, MOH, UN-Human Rights, UNODC, UNDP, ULRC, Judiciary.</b>

		<p>Use Narcotics law to provide preventive and harm reduction services to PWUDs and PWIDs.</p> <p>Ensure the principle of proportionality is applied for drug-related crimes and put in place public health-based alternatives to incarceration.</p>	
<b>4</b>	<b>Other Justice Issues</b>		
4.1	Several pieces of legislation criminalise and punish behaviours of PLHIV and KVPs in a manner likely to fuel stigma and curtail service utilisation.	<p>Parliament should desist from passing laws that do not conform to the standards of human rights in the International Human Rights principles.</p> <p>Parliament should repeal all provisions that promote stigma against persons living with HIV.</p>	<b>Parliament</b>
		Strengthen advocacy for effective policy and legal reform, and political environment.	<b>CSOs, ADPs</b>
4.2	The enactment of laws takes a very long time.	Fast-track the enactment of laws including the National Health Insurance Scheme Bill 2019; and the Public Health (Amendment) Bill, 2021 which seeks to amend the Public Health Act Chapter 281. It is critical that the Bill includes a framework/component around HIV/AIDS, and health risk and management.	<b>Parliament</b>
4.3	JLOS actors are well positioned to improve the legal environment and support an equitable and effective HIV response.	Continue to strengthen the capacity of the judiciary and other JLOS actors to support the HIV response.	<b>UAC, MoH, MGLSD, Ministry of Justice &amp; Constitutional Affairs, CSOs, ADPs</b>
<b>5</b>	<b>Law Enforcement</b>		
5.1	Violence and harassment from law enforcement officials towards KVPs violates the latter's personal dignity.	Police services should ensure that PLHIV, KPs and other vulnerable persons are not a subject of harassment, violence, and rights violation at the hands of law enforcers; and should ensure that the rights of suspects are respected and protected.	<b>Uganda Police, courts of law</b>
		Law enforcement officials that violate the rights of PLHIVs should bear personal	<b>Courts of law, Police, DPP</b>

		liability in addition to vicarious liability by the government for violence and violations of the rights of PLHIVs in accordance with the law.	
		PLHIV and other vulnerable groups who suffer rights violations should have access to judicial and administrative remedies which must be adequate, effective, and prompt. These include reparations in the forms of restitution, rehabilitation, compensation for physical or mental harm suffered, lost earnings and other material damages, and costs incurred in instituting and pursuing the case to conclusion. Other remedies include satisfaction ranging from measures to cease continuing violations, public disclosure, to guarantees of non-repetition of violation among others.	<b>Courts of law</b>
5.2	PLHIV arrested on various grounds are often denied access to treatment and medication, leading to poor adherence.	Pre-trial detention centres such as police cells should provide an environment for PLWHIVs to continue with their medication in order to avoid non-adherence to drugs and relapsing.	<b>Uganda Police, Ministry of Internal Affairs</b>
<b>6</b>	<b>Community Norms &amp; Practices</b>		
6.1	The legal and policy environment goes beyond laws and policies. Indeed, laws and policies alone are not enough to change the environment for HIV responses. Some of the stigma and discrimination as well as violence against PLHIV, KPs, and vulnerable groups are rooted in community norms and practices.	Scale up engagements in communities with cultural, religious, political, and other community leaders at different levels to create awareness about PLHIV rights through “Know your Rights” campaigns, change attitudes, and influence norm transformation.	<b>MGLSD, UAC, CSOs</b>
<b>7</b>	<b>HIV related Policies</b>		
7.1	Some policies, while providing enabling conditions, do not mention all categories of key populations, rendering them invisible.	Undertake policy reform to ensure inclusivity of KPs using more explicit language that specifies all the high-risk vulnerable and key population groups as target groups for HIV and AIDS services.	<b>MoH, UAC</b>
<b>8</b>	<b>Service Issues</b>		

8.1	PLHIV-friendly services are still limited and not accessible to all in need.	Scale up/expand the coverage of friendly and accessible services/practices including differentiated services for adolescents and young people, persons with disability, men living with HIV, and other vulnerable groups.	<b>MoH</b> , ADPs, Ips
8.2	Much of the on-going work to promote and protect the rights of PLHIV is not to scale, dictated by available donor funding.	Invest more resources in building an enabling environment to bring interventions to scale.	<b>UAC</b> , MoH, MGLSD, MoFPED, ADPs
8.3	HIV services in prisons settings are not tailored to existing inmate prison profiles and health burden.	Reform prisons HIV services to include (or link to) services for mental health, trauma management, skin infections. Infrastructure and human resources should also be accordingly aligned. Develop guidelines for HIV services provision in prison settings.	<b>MoH</b> , Uganda Prisons Services, ADPs
8.4	HIV has brought new demands and additional workload on health workers. There are no counsellors in health facilities and other HIV service outlets.	Upgrade the staffing norms in health facilities to provide for more health workers; include a position of a counsellor for all health facilities that provide HIV services, especially those providing ART.	<b>MOH</b>
8.5	HIV stigma is still prevalent in all settings. Stigma in health settings discourages service utilisation by PLHIV and KPs.	Scale up interventions for stigma reduction in communities, health facilities, workplaces, schools, and all settings.	<b>MGLSD</b> , MOH, UAC, all actors
		Scale up interventions that identify and work with Champions to address stigma and discrimination, SGBV, and other rights violations.	<b>MGLSD</b> , UAC, CSOs
		Give skills and empower vulnerable communities to demand better services, and to hold service providers and duty bearers accountable.	<b>MoH</b> , UAC, IPs, ADPs, KP-led CSOs, UKPC, PLHIV-led CSOs
		Ongoing efforts to train health workers to provide HIV services to KVPs are commendable. These should continue county-wide to create a critical mass of health workers who are aware of the needs of the different and intersecting issues that affect PLHIV and KVPs seeking services.	<b>MoH</b> , UAC, IPs, ADPs, KP-led CSOs, UKPC, PLHIV-led CSOs
		Develop a harmonised and standardised curriculum for training health workers in	<b>MoH</b> , IPs, ADPs, KP-led CSOs,

		providing PLHIV, KVP, PP, and PWD-friendly and accessible services. Integrate human rights, gender equality, and stigma reduction into pre-service and in-service curricula of institutions that train health workers, judicial officers, police officers, and other relevant professionals.	UKPC, PLHIV-led CSOs
8.6	The pre-existing needs and vulnerabilities for PLHIV and vulnerable groups have been worsened by the COVID-19 pandemic and the associated lockdowns.	Scale up provision of comprehensive care packages targeting different PLHIV groups and vulnerable populations, including young mothers who became pregnant or were married at early age during the lockdowns.	<b>MoH</b> , IPs, ADPs, MGLSD
		As schools reopen and guidelines on re-entry of teenage mothers are rolled out, engage strongly with all school stakeholders to improve the environment for the young mothers to be accepted and to learn.	<b>MOES</b> , MGLSD, IPs, CSOs
		Undertake stakeholder engagements to resolve issues around the Sexuality Education Framework, the School Health Policy, and the Guidelines for the Prevention and Management of Teenage Pregnancy in School Settings to enable ownership and rollout of these policies.	<b>MOES</b> , MGLSD, UNICEF, UNFPA, UNESCO, FBOs
<b>9</b>	<b><i>Stigma and Discrimination in Employment</i></b>		
9.1	PLHIV face discrimination in access to employment as a result of employer policies and practices such as those in uniformed services and other agencies that have mandatory HIV screening during recruitment.	Reform policies and practices in recruitment. Mandatory HIV screening should not be required of job applicants or persons in employment. Instead, voluntary HIV testing should be encouraged and supported with appropriate counselling.	<b>MGLSD, UAC</b> , Uganda Police, Uganda Prisons, Uganda People's Defence Forces
<b>10</b>	<b><i>HIV Commodities and Supplies</i></b>		
10.1	Procurement and availability of condoms, lubricants, and drugs for treatment of STIs are not stable and dependent on donor funding.	Government should ensure procurement and availability of commodities that reduce the risk of transmission of HIV and other sexually transmitted infections such as condoms and lubricants, as well as harm reduction supplies such as drugs and syringes for PWUIDs.	<b>MoH</b>
<b>11</b>	<b><i>Monitoring and Tracking Progress in the Legal Environment</i></b>		

11.1	A system is needed to track implementation of these recommendations and other actions aimed at improving the legal and policy environment. Existing M&E systems are not adequate.	Strengthen the monitoring of progress in improving the legal and policy environment; include indicators in the NSP, NPAP, and M&E Framework, and strengthen mechanisms for data collection on these indicators.	<b>UAC, MoH, ADPs</b>
<b>12 Financing Interventions to Improve the Legal and Policy Environment</b>			
12.1	Current HIV financing is inadequate and unsustainable.	<p>Increase donor and in-country funding sources for sustainable HIV financing. There is also a need to strengthen gender-responsive budgeting.</p> <p>The Parish Development Model (PDM) should be leveraged as a channel of disseminating HIV prevention messages, collecting data on HIV as part of the PDM information System, and for mainstreaming HIV responses into the PDM pillars. An HIV Focal Person should be co-opted onto the Parish Development Committee to ensure HIV issues are incorporated. HIV status and impact should be used as part of the vulnerability criteria to access support under PDM, and PLHIV groups should be prioritised for such support.</p>	<b>UAC, MoH, MoLG, MoFPED, ADPs, Districts</b>

# ANNEXES

## Annex I: References

### International human rights instruments

- Joint United Nations Programme on HIV/AIDS (UNAIDS). *Unite with women - Unite against violence and HIV*. March 2014. [https://www.unaids.org/en/resources/documents/2014/20140312\\_JC2602\\_UniteWithWomen](https://www.unaids.org/en/resources/documents/2014/20140312_JC2602_UniteWithWomen)
- Joint United Nations Programme on HIV/AIDS (UNAIDS). *Global AIDS Strategy 2021–2026—End Inequalities*. *End AIDS*. March 2021. <https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy>.
- United Nations Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW). *CDAW Recommendation No. 15: Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*. A/45/38. 1990. <https://www.refworld.org/docid/453882a311.html>.
- United Nations Committee on Economic, Social and Cultural Rights (CESCAR). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*. E/C. 12/2000/4. August 11, 2000. <https://www.refworld.org/docid/4538838d0.html>.
- United Nations Committee on Economic, Social and Cultural Rights (CESCAR). *General Comment No. 20 (2009): Non-discrimination in Economic, Social and Cultural Rights*. E/C. 12/GC/20. July 2, 2009. <https://www.refworld.org/docid/4a60961f2.html>.
- United Nations Committee on the Rights of the Child (CRC). *General Comment No. 3 (2003): HIV and the Rights of the Child*. CRC/GC/2003/3. March 17, 2003. <https://www.refworld.org/docid/4538834e15.html>.
- United Nations Economic and Social Council (ECOSOC). *Resolution on the UNAIDS Joint Programme*. E/RES/2019/33. August 2, 2019. <https://digitallibrary.un.org/record/3814619?ln=en>.
- United Nations Committee on the Rights of the Child (CRC). *General Comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child*. CRC/GC/2003/4. July 1, 2003. <https://www.refworld.org/docid/4538834f0.html>.
- United Nations General Assembly. *International Covenant on Civil and Political Rights*. December 16, 1966. <https://www.ohchr.org/Documents/ProfessionalInterest/ccpr.pdf>.
- United Nations General Assembly. *International Covenant on Economic, Social and Cultural Rights*. December 16, 1966. <https://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf>.
- United Nations General Assembly. *Convention on the Elimination of All Forms of Discrimination against Women*. December 18, 1979. <https://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf>.
- United Nations General Assembly. *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities: Resolution adopted by the General Assembly [on the report of the Third Committee]*. A/48/627. December 20, 1993. <https://www.refworld.org/docid/3b00f2e80.html>.
- United Nations General Assembly. *General Assembly Declaration of Commitment on HIV/AIDS*. A/RES/S-26/2. June 25–17, 2001. [https://www.unaids.org/sites/default/files/sub\\_landing/files/aidsdeclaration\\_en\\_0.pdf](https://www.unaids.org/sites/default/files/sub_landing/files/aidsdeclaration_en_0.pdf).
- United Nations General Assembly. *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*. *Resolution adopted by the General Assembly*. A/RES/60/263. June 2, 2006. [https://data.unaids.org/pub/report/2006/20060615\\_hlm\\_politicaldeclaration\\_ares60262\\_en.pdf](https://data.unaids.org/pub/report/2006/20060615_hlm_politicaldeclaration_ares60262_en.pdf).
- United Nations General Assembly. *Convention on the Rights of Persons with Disabilities*. A/RES/61/106. December 13, 2006. <https://www.refworld.org/docid/4680cd212.html>.

United Nations. *Convention on the Rights of Persons with Disability, General Comment No.2, Accessibility*. UN Doc. CRPD/C/GC/2, 11 April, 2014. <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/033/13/PDF/G1403313.pdf?OpenElement>

United Nations General Assembly. *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*. Resolution adopted by the General Assembly. A/RES/65/277. June 10, 2011. [https://www.unodc.org/documents/southeastasiaandpacific/2012/02/hlm-hiv/20110610\\_UN\\_A-RES-65-277\\_en.pdf](https://www.unodc.org/documents/southeastasiaandpacific/2012/02/hlm-hiv/20110610_UN_A-RES-65-277_en.pdf).

United Nations General Assembly. *Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030*. Resolution adopted by the General Assembly. A/RES/70/266. June 8, 2016. <https://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS>.

United Nations General Assembly. *Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030*: Resolution adopted by the General Assembly. June 8, 2021. [https://www.unaids.org/en/resources/documents/2021/2021\\_political-declaration-on-hiv-and-aids](https://www.unaids.org/en/resources/documents/2021/2021_political-declaration-on-hiv-and-aids).

### Soft law instruments

Joint United Nations Programme on HIV/AIDS (UNAIDS). *HIV Prevention 2020 Road Map: Accelerating HIV prevention to reduce new infections by 75%*. October 10, 2017. <https://www.unaids.org/en/resources/documents/2017/hiv-prevention-2020-road-map>.

United Nations General Assembly. *Transforming our world: The 2030 Agenda for Sustainable Development*. A/RES/70/1. September 25, 2015. <https://sustainabledevelopment.un.org/post2015/transformingourworld/publication>.

World Health Organisation (WHO). *Consolidated guidelines on HIV prevention, diagnosis, and treatment & care for key populations*. July 1, 2014. <https://www.who.int/publications/i/item/9789241507431>.

World Health Organisation (WHO). *Global Health Sector Strategy on HIV 2016-2021: Towards ending AIDS*. WHO/HIV/2016.5. May 3, 2016. <https://www.who.int/publications/i/item/WHO-HIV-2016.05>.

World Health Organisation (WHO). *Consolidated Guidelines on Sexual and Reproductive Health of Women Living with HIV*. WHO/RHR/17.03. 2017. [https://www.who.int/reproductivehealth/publications/gender\\_rights/srhr-women-hiv/en/](https://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/).

### Regional instruments

African Union. *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*. Adopted by the 2<sup>nd</sup> Ordinary Session of the Assembly of the Union. Maputo, November 25, 2005. [https://au.int/sites/default/files/treaties/37077-treaty-charter\\_on\\_rights\\_of\\_women\\_in\\_africa.pdf](https://au.int/sites/default/files/treaties/37077-treaty-charter_on_rights_of_women_in_africa.pdf).

African Union. *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa*. Adopted by the 30<sup>th</sup> Ordinary Session of the Assembly of the Union. Addis Ababa, January 29, 2018. [https://eaccess.s3.amazonaws.com/media/attachments/resources\\_mainresource/556/AU\\_Protocol%20on%20the%20Rights%20of%20Persons%20with%20Disabilities\\_E.PDF](https://eaccess.s3.amazonaws.com/media/attachments/resources_mainresource/556/AU_Protocol%20on%20the%20Rights%20of%20Persons%20with%20Disabilities_E.PDF)

African Union. *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa*. Adopted by the 19<sup>th</sup> Summit of the African Union. July 16, 2012. [https://www.unaids.org/sites/default/files/media\\_asset/20120715\\_TheRoadmap\\_AU\\_en\\_0.pdf](https://www.unaids.org/sites/default/files/media_asset/20120715_TheRoadmap_AU_en_0.pdf).

East African Community. *Treaty for the Establishment of the East African Community*. 1999



[https://www.eacj.org/?page\\_id=33#toc-article-118-health](https://www.eacj.org/?page_id=33#toc-article-118-health)

East African Community. *The East African Community HIV and AIDS Prevention and Management Act*. 2012.

<https://www.kelinkeny.org/wp-content/uploads/2017/04/EAC-HIV-ACT-2012.pdf>

East African Community. *East African Community Gender Policy*. Arusha, 2018.

<http://fawe.org/girlsadvocacy/wp-content/uploads/2018/12/EAC-Gender-Policy.pdf>

East African Community. *Treaty for the Establishment of the East African Community (as Amended on 14<sup>th</sup> Dec, 2006 and 20<sup>th</sup> Aug 2007)*. Arusha. [https://www.eacj.org/?page\\_id=33](https://www.eacj.org/?page_id=33)

Organisation of African Unity (OAU). *African (Banjul) Charter on Human and People's Rights*. CAB/LEG/67/3. June 27, 1981. <https://www.achpr.org/legalinstruments/detail?id=49>.

Organisation of African Unity (OAU). *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*. OAU/SPS/ABUJA/3. April 27, 2001. <https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf>.

## **Laws, Government of Uganda**

*Anti-Pornography Act: Act 1 of 2014*. May 9, 2014. <https://media.ulii.org/files/legislation/akn-ug-act-2014-1-eng-2014-02-17.pdf>.

*Children (Amendment) Act: Act 9 of 2016*. June 2, 2016.

<https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/104395/127307/F-171961747/UGA104395.pdf>.

*Constitution of the Republic of Uganda*. 1995.

<https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/44038/90491/F206329993/UGA44038.pdf>.

*Domestic Violence Act: Act 2 of 2010*. April 29, 2010. <https://media.ulii.org/files/legislation/akn-ug-act-2010-3-eng-2010-04-09.pdf>.

*Employment Act: Act 6 of 2006*. August 7, 2006. <https://media.ulii.org/files/legislation/akn-ug-act-2006-6-eng-2006-06-08.pdf>.

*Equal Opportunities Commission Act*. May 18, 2007. <https://old.ulii.org/node/24768>.

*Health Services Commission Act: Act 15 of 2001*. July 6, 2001. <https://media.ulii.org/files/legislation/akn-ug-act-2001-15-eng-2001-07-06.pdf>.

*HIV and AIDS Prevention and Control Act*. July 17, 2014.

<https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/110805/137931/F-1081306421/UGA110805.pdf>.

*Human Rights Enforcement Act*. March 31, 2019.

<https://chapterfouruganda.org/sites/default/files/downloads/Human-Rights-%28Enforcement%29-Act-2019.pdf>.

*Judicature (Fundamental and Other Human Rights and Freedoms) (Enforcement Procedure) Rules: Statutory Instrument 31 of 2019*. May 31, 2019. <https://media.ulii.org/files/legislation/akn-ug-act-si-2019-31-eng-2019-05-31.pdf>.

*Narcotic Drugs and Psychotropic Substances (Control) Act: Act 3 of 2016*. February 15, 2016.

<https://media.ulii.org/files/legislation/akn-ug-act-2016-3-eng-2016-02-05.pdf>.

*Non-Governmental Organisations Act: Act 5 of 2016*. March 14, 2016. <https://media.ulii.org/files/legislation/akn-ug-act-2016-5-eng-2016-03-03.pdf>.

*Penal Code Act*. Chapter 120. June 15, 1950. <https://media.ulii.org/files/legislation/akn-ug-act-ord-1950-12-eng-2014-05-09.pdf>.

*Public Order and Management Act: Act 9 of 2013*. November 20, 2013.

<https://media.ulii.org/files/legislation/akn-ug-act-2013-9-eng-2013-10-11.pdf>.

*Sexual Offences Act (Draft)*. Adopted by Parliament May 5, 2021.

## **Policies and Planning Frameworks, Government of Uganda**

- Ministry of Gender, Labour and Social Development (MGLSD). *National Policy on HIV/AIDS and the World of Work*. July 2007. <http://library.health.go.ug/publications/hivaids/national-policy-hivaids-and-world-work-2007>.
- Ministry of Gender, Labour and Social Development (MGLSD). *The Uganda Gender Policy*. 2007. <http://extwprlegs1.fao.org/docs/pdf/uga163564.pdf>.
- Ministry of Gender, Labour and Social Development (MGLSD). *National Action Plan on Women, Girls, Gender Equality and HIV & AIDS 2016/17–2020/21* (NaWoGGE). 2017. <https://library.ursb.go.ug/cgi-bin/koha/opac-detail.pl?biblionumber=679>
- Ministry of Health (MoH). *National Adolescent Health Policy for Uganda*. October 2004. [https://healtheducationresources.unesco.org/sites/default/files/resources/national\\_adolescent\\_health\\_policy\\_for\\_uganda.pdf](https://healtheducationresources.unesco.org/sites/default/files/resources/national_adolescent_health_policy_for_uganda.pdf).
- Ministry of Health (MoH). *Patients' Charter*. October 2009. <http://library.health.go.ug/sites/default/files/resources/Patient%20charter.pdf>.
- Ministry of Health (MoH). *The National Adolescent Health Strategy 2011–2015*. 2011. <https://scorecard.prb.org/wp-content/uploads/2018/05/National-Adolescent-Health-Strategy-2011-2015.Uganda.pdf>.
- Ministry of Health (MoH). *Second National Health Policy*. July 26, 2010. <http://library.health.go.ug/publications/policy-documents/second-national-health-policy-2010>.
- Ministry of Health (MoH). *Adolescent Health Policy Guidelines and Service Standards*. May 2012. <http://library.health.go.ug/publications/adolescent-health/adolescent-health-policy-guidelines-and-service-standards>.
- Ministry of Health (MoH). *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights* (2012).
- Ministry of Health (MoH). *Uganda Family Planning Costed Implementation Plan, 2015-2020*. November 2014. [https://www.healthpolicyproject.com/ns/docs/CIP\\_Uganda.pdf](https://www.healthpolicyproject.com/ns/docs/CIP_Uganda.pdf).
- Ministry of Health (MoH). *Investment Case: Reproductive, Maternal, New-born, Child and Adolescent Health Sharpened Plan for Uganda 2016/17–2019/20*. April 2016. <https://www.health.go.ug/download-attachment/8ZSPWjPp2U3IUzaZCvnlDhRcBG7dQ9OCGjmIPj4G00>.
- Ministry of Health (MoH). *National HIV Testing Services Policy and Implementation Guidelines in Uganda*, 4<sup>th</sup> edition. October 2016. <http://library.health.go.ug/publications/hivaids/national-hiv-testing-services-policy-and-implementation-guidelines-uganda>.
- Ministry of Health (MoH). *National Policy Guidelines on Post Exposure Prophylaxis for HIV, Hepatitis B and Hepatitis C*. November 2017. Available at: <http://library.health.go.ug/publications/policy-documents/national-policy-guidelines-post-exposure-prophylaxis-hivhepatitis-b>.
- Ministry of Health (MoH). *Consolidated Guidelines for Prevention and Treatment of HIV and AIDS in Uganda 2020*. <http://library.health.go.ug/publications/hivaids/consolidated-guidelines-prevention-and-treatment-hiv-uganda-1>.
- Ministry of Health (MoH). *Addendum to the HIV Testing Services Policy & Implementation Guidelines: HIV Self-Testing and Assisted Partner Notification*. November 2018. [https://www.health.go.ug/download-attachment/Sv3MJWLFryzTR69NvhNTzDuglek9ELnr5vfctI\\_pwYE](https://www.health.go.ug/download-attachment/Sv3MJWLFryzTR69NvhNTzDuglek9ELnr5vfctI_pwYE).
- Ministry of Health (MoH). *Leave No-one Behind: A National Plan for Achieving Equity in Access to HIV, TB and Malaria Services in Uganda 2020–2024*. 2019. [https://www.theglobalfund.org/media/9768/crg\\_humanrightsluganda2020-2024\\_plan\\_en.pdf](https://www.theglobalfund.org/media/9768/crg_humanrightsluganda2020-2024_plan_en.pdf)

Ministry of Health (MoH). *Technical Guidelines for Universal Access to HIV Prevention, Treatment and Care for People who Use Alcohol, Drugs and Other Substances*. 2019.

Ministry of Health (MoH). *National Comprehensive Condom Programming Strategy & Implementation Plan 2020–2025*. September 2020. <http://library.health.go.ug/publications/family-planning/national-comprehensive-condom-programming-strategy-implementation-plan>.

National Planning Authority (NPA). *Third National Development Plan (NDP III) 2020/21 – 2024/25*. Kampala. [http://www.npa.go.ug/wp-content/uploads/2020/08/NDPIII-Finale\\_Companded.pdf](http://www.npa.go.ug/wp-content/uploads/2020/08/NDPIII-Finale_Companded.pdf)

Uganda AIDS Commission (UAC). *Presidential Fast Track Initiative on Ending AIDS in Uganda: A Presidential Handbook–Revised Edition*. December 2020. [https://drive.google.com/u/0/uc?id=IRGrLExMIOZiyZIn0sg4q266EjyN\\_JeDR&export=download](https://drive.google.com/u/0/uc?id=IRGrLExMIOZiyZIn0sg4q266EjyN_JeDR&export=download).

Uganda AIDS Commission (UAC). *The National HIV and AIDS Strategic Plan 2020/2–2024/25*. February 23, 2021. [https://uac.go.ug/index.php?option=com\\_content&view=article&id=24&catid=8&Itemid=101](https://uac.go.ug/index.php?option=com_content&view=article&id=24&catid=8&Itemid=101).

Uganda AIDS Commission (UAC). *The National HIV and AIDS Priority Action Plan 2020/21–2022/23*. July 16, 2021. [https://uac.go.ug/index.php?option=com\\_content&view=article&id=34:hiv-prevention-11&catid=8&Itemid=101](https://uac.go.ug/index.php?option=com_content&view=article&id=34:hiv-prevention-11&catid=8&Itemid=101).

## Reports

Equal Opportunities Commission (EOC). *Annual Report on the State of Equal Opportunities in Uganda FY 2019/2020*. (Kampala, Uganda: 2020). <https://eoc.go.ug/eoc/wp-content/uploads/2020/09/7th-Annual-Report-on-the-State-of-Equal-Opportunities.pdf>.

Forum for African Women Educationalists Uganda Chapter (FAWE Uganda). Newsletter. 1<sup>st</sup> Edition, 2021.

Human Rights Awareness and Promotion Forum (HRAPF). *The Human Rights Advocate*. 2nd Issue, March 2015. <https://hrapf.org/images/humanrightsadvocate/SECOND-ISSUE-OF-THE-HUMAN-RIGHTS-ADVOCATE.pdf>.

Human Rights Awareness and Promotion Forum (HRAPF). *Position Paper on the Non-governmental Organisations Act, 2016*. (Kampala, Uganda: March 2016). <https://hrapf.org/images/legalanalyses/160320hrapfpositionpaperonthengoact2016.pdf>.

Human Rights Awareness and Promotion Forum (HRAPF). *Legal Regulation of Sex Work in Uganda: Exploring the Current Trends and Their Impact on Human Rights of Sex Workers*. (Kampala, Uganda: October 2016). [https://hrapf.org/images/researchpapers/161228legalregulationofsexworkersinugandastudy\\_updated-1.pdf](https://hrapf.org/images/researchpapers/161228legalregulationofsexworkersinugandastudy_updated-1.pdf).

Human Rights Awareness and Promotion Forum (HRAPF). *The Narcotic Drugs and Psychotropic Substances (Control) Act, 2015 and the Legal Regulation of Drug Use in Uganda: Analysing the Tension Between Criminal Law, Public Health and Human Rights*. (Kampala, Uganda: October 2016). <https://www.mhinnovation.net/sites/default/files/downloads/organisation/THE%20NARCOTIC%20DRUGS%20AND%20PSYCHOTROPIC%20SUBSTANCES%28CONTROL%29%20ACT%2C%202015%20AND%20THE%20LEGAL%20REGULATION%20OF%20DRUG%20USE%20IN%20UGANDA.pdf>.

Human Rights Awareness and Promotion Forum (HRAPF). *A Quick Scan of the Laws and Policies Affecting the HIV Response Among Men who Have Sex with Men in Uganda*. (Kampala, Uganda: February 2017). <https://hrapf.org/images/legalanalyses/Quick%20scan%20booklet%20on%20laws%20affecting%20MSM%20in%20Uganda.pdf>.

Human Rights Awareness and Promotion Forum (HRAPF). *A Guide to the Normative Legal Framework on the Human Rights of LGBTI Persons in Uganda*. (Kampala, Uganda: October 2019). [https://hrapf.org/images/legalanalyses/15\\_10\\_21\\_hrapf\\_compilation\\_on\\_lgbti\\_rights\\_final\\_design\\_.pdf](https://hrapf.org/images/legalanalyses/15_10_21_hrapf_compilation_on_lgbti_rights_final_design_.pdf).

- Human Rights Awareness and Promotion Forum (HRAPF). *The Impact of the Legal and Policy Framework on Access to Justice for Transgender Persons in Uganda*. (Kampala, Uganda: December 2019). <https://hrapf.org/index.php/resources/research-reports/156-the-impact-of-the-legal-and-policy-framework-on-access-to-justice-for-transgender-persons-in-uganda/file>.
- Human Rights Awareness and Promotion Forum (HRAPF). *Consolidated Human Rights Violations Against Key Populations in Uganda 2019*. (Kampala, Uganda: May 2020). <https://www.hrapf.org/index.php/resources/violation-reports/170-a-consolidated-report-on-human-rights-violations-against-key-populations-in-uganda-2019/file>.
- Human Rights Awareness and Promotion Forum (HRAPF). *How Laws that Promote Human Rights Impact on Access to HIV and TB Services for Key Populations in Uganda*. (Kampala, Uganda: December 2020). <https://www.hrapf.org/index.php/resources/legal-policy-analyses/175-how-laws-that-promote-human-rights-impact-on-access-to-hiv-tb-services-for-key-populations-in-uganda/file>.
- Human Rights Awareness and Promotion Forum (HRAPF). *Analysis of the Sexual Offences Act, 2021 and its implications on the human rights of criminalised minorities*. (Kampala, Uganda: May 2021). <https://www.hrapf.org/index.php/resources/legal-policy-analyses/190-hrapf-legal-analysis-of-the-sexual-offences-act-2021/file>.
- Joint United Nations Programme on HIV/AIDS (UNAIDS). *The Sustainable Development Goals and the HIV Response: Stories of putting people at the Centre*. (Geneva, Switzerland: 2017). [https://www.unaids.org/sites/default/files/media\\_asset/SDGsandHIV\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/SDGsandHIV_en.pdf).
- Ministry of Gender, Labour and Social Development (MGLSD). *Uganda Violence against Children Survey*. Kampala, 2018. <https://www.unicef.org/uganda/media/2156/file/Violence%20Against%20Children%20Survey%202018.pdf>
- Ministry of Health (MoH) and ORC Macro. *Uganda HIV/AIDS Sero-behavioural Survey: 2004–05*. (Calverton, Maryland: Ministry of Health and ORC Macro, 2006). <https://stacks.cdc.gov/view/cdc/6783>.
- Ministry of Health (MoH). *Release of Preliminary Results of the Uganda Population Based HIV Impact Assessment (UPHIA)*. Kampala, 2022. <https://www.mediacentre.go.ug/media/release-preliminary-results-2020-uganda-population-based-hiv-impact-assessment>
- Ministry of Health (MoH), PEPFAR, CDC, UVRI, UBOS, UNAIDS Uganda, WHO Uganda, WESTAT and ICAP at Columbia University. *Uganda Population-based HIV Impact Assessment (UPHIA) 2016–2017: Final Report*. (Kampala, Uganda: 2017). <http://library.health.go.ug/publications/hivaids/uganda-population-based-hiv-impact-assessment-uphia-2016%E2%80%932017>.
- Ministry of Health (MoH). *Uganda National Adolescent Health Landscape and Recommendations for Improved Service Delivery Report*. (Kampala, Uganda: 2019). <https://www.health.go.ug/cause/the-uganda-national-adolescent-health-landscape-and-recommendations-for-improved-service-delivery-report/>.
- National Forum of People living with HIV (NAFOPHANU). *The People Living with HIV Stigma Index: Uganda Country Assessment Report*. Kampala, 2019. <https://www.stigmaindex.org/wp-content/uploads/2019/11/PLHIV-Stigma-Index-Report-Uganda-2019.pdf>
- Nyirankindi (n.d). *Review of the Legal and Regulatory Framework on HIV and SGBV in Capital Projects in Uganda*.
- Uganda AIDS Commission (UAC). *Joint Annual Review Report 2020/2021 (Draft)*. (Kampala, Uganda: 2021).
- Uganda Bureau of Statistics (UBOS). *Uganda National Household Survey*. (Kampala, Uganda: 2020). [https://www.ubos.org/wp-content/uploads/publications/09\\_2021Uganda-National-Survey-Report-2019-2020.pdf](https://www.ubos.org/wp-content/uploads/publications/09_2021Uganda-National-Survey-Report-2019-2020.pdf).

- Uganda Human Rights Commission (UHRC). *The 20<sup>th</sup> Annual Report–2017*. (Kampala, Uganda: 2018). <https://www.uhrc.ug/download/uhrc-20th-annual-report-2017/>.
- Uganda Human Rights Commission (UHRC). *The 21<sup>st</sup> Annual Report–2018*. (Kampala, Uganda: 2019). <https://www.uhrc.ug/download/uhrc-21st-annual-report/>.
- Uganda Network on Law, Ethics and HIV (UGANET). *The state of Human Rights Violations of Persons Living with HIV/AIDS and TB in Uganda in 2020*. (Kampala, Uganda: 2021). <https://uganet.org/wp-content/uploads/2021/01/UGANET-Report.pdf>.
- Uganda Police Force. *Annual Crime Report 2018*. (Naguru, Uganda: 2019). <https://www.upf.go.ug/wp-content/uploads/2019/05/annual-crime-report-2018..pdf>.
- Uganda Police Force. *Annual Crime Report 2019*. (Naguru, Uganda: 2020). <https://www.upf.go.ug/wp-content/uploads/2020/04/Annual-Crime-Report-2019-Public.pdf?x45801>.
- Uganda Police Force. *Annual Crime Report 2020*. (Naguru, Uganda: 2021). <https://www.upf.go.ug/wp-content/uploads/2021/04/ANNUAL-CRIME-REPORT-2020-1.pdf?x74136>.
- Uganda AIDS Commission (UAC) and Ministry of Health (MoH). *Analysis of HIV Prevention Response and Modes of Transmission in Uganda: Final Synthesis Report*. (Kampala, Uganda: 2014).

### **Power Point Presentations**

- Byamukama, D. (2020): 'Synthesis, Consolidation and Building Consensus on Key Population Size Estimation Numbers in Uganda'. Power point presentation, PEPFAR Uganda Science Summit, January 13-14, Kampala, Uganda.

### **Journal Articles**

- Doshi, R.H. et al, (2019): 'Estimating the size of key populations in Kampala, Uganda: 3 Source Capture – Recapture Study'. *JMIR Public Health Surveillance*, 5 (3). <https://publichealth.jmir.org/2019/3/e12118/PDF>

### **Books**

- Bronfenbrenner, Urie. *The Ecology of Human Development*. (Cambridge, MA: Harvard University Press, 1981).

### **Databases**

- MoGLSD (2021), Child Helpline Database. Ministry of Gender, Labour and Social Development, Kampala. <http://uchl.mglstd.go.ug/login.html>

### **Fact Sheets**

- Uganda AIDS Commission (2021): 2021 Fact Sheet. <https://uac.go.ug/media/attachments/2021/09/13/final-2021-hiv-aids-factsheet.pdf>

### **Websites**

- Human Rights Watch, "Uganda: Deeply flawed HIV Bill approved 13<sup>th</sup> May 2014," <https://www.hrw.org/news/2014/05/13/uganda-deeply-flawed-hiv-bill-approved>. Accessed on 16<sup>th</sup> May 2021.
- Strategic Initiative for Women in the Horn of Africa (SIHA), "Anti-Pornography Act – Human Rights Activists and Civil Society Organisations Challenge the Legality of the Act in the Constitutional Court

- Uganda' 7<sup>th</sup> May 2021," <https://sihanet.org/anti-pornography-act-human-rights-activists-and-civil-society-organisations-challenge-the-legality-of-the-act-in-constitutional-court-uganda/>. Accessed 30<sup>th</sup> May 2021.

### **Briefing Notes**

International Labour Organisation (ILO). *From mandatory HIV testing for access to work to voluntary testing and counselling at work*. Briefing Note, August 2016. Geneva.

## Annex 2: The USAID/Uganda Civil Society Strengthening Activity

The Uganda Civil Society Strengthening Activity is a five-year Activity (September 2020–August 2025) funded by the United States Agency for International Development (USAID) and implemented by East-West Management Institute inc. (EWMI) in partnership with the International Center for Non-for-profit Law (ICNL), Uganda’s Network of Indigenous Voluntary Associations (DENIVA), and Common Ground Consulting (CGC). CSSA supports the capacity strengthening of Ugandan civil society organisations to influence and contribute to improved development outcomes in four thematic areas: (1) health, with particular attention to achieving Uganda’s HIV/AIDS goals; (2) education, youth, and child development; (3) agriculture and food security; and (4) democracy, rights, and governance.

To achieve its aim, CSSA implements activities under three components:

**Component 1:** Strengthen the advocacy capacity of CSOs to influence national and local development.

**Component 2:** Improve the organisational capacity of advocacy and service delivery oriented CSOs to sustainably fulfil their missions; and

**Component 3:** Promote a more supportive environment to sustain a vibrant civil society.

EWMI’s approach to implementing CSSA emphasises local ownership of CSSA’s interventions and initiatives, building the capacity of CSOs, and investing in their sustainability, as well as utilising Uganda’s local expertise and resources. CSSA is committed to gender equality and social inclusion and aims to improve the welfare of women, youth, children, underserved communities, and other vulnerable populations.

## Annex 3: Sampling of Districts

Region	District	Supporting US Agency and IP	Other Inclusion Criteria
Kampala	Kampala	CDC (IDI)	CSSA district, urban centre, presence of all PLHIV categories, presence of national level key informants
Central 1	Kalangala	CDC (RHSP)	High HIV prevalence, fisherfolk
Central 2	Buikwe	DOD (MUWRP)	High HIV prevalence, rural and urban characteristics
East Central	Bugiri	USAID (URC/RHITES-EC)	Rural and urban characteristics
Mid-East	Mbale	USAID (Intra Health/RHITES-E)	Urban characteristics, various key population groups
North-East	Kotido	USAID (Intra Health/RHITES-E)	CSSA district, typical Karamoja district – hard to reach, limited services, unique social cultural setting

Mid-North	Gulu	USAID (URC/RHITES-N-ACHOLI)	CSSA district, high HIV prevalence, urban setting with various PLHIV categories
West Nile	Yumbe	CDC (IDI)	Refugee population
Mid-West	Kikuube	CDC (IDI)	Presence of refugees, fisherfolk, and oil exploration activities with high migrant population
South-West	Mbarara	USAID (EGPAF/RHITES-SW)	CSSA district, high HIV prevalence, big urban setting

#### **Annex 4: List of Organisations from whom key informants were drawn**

<b>Constituency</b>	
Policy and Law makers	Uganda AIDS Commission, HIV/AIDS Committee of Parliament, Legal Affairs Committee of Parliament, MOH AIDS Control Division, MGLSD, Uganda Law Reform Commission
Human Rights Agencies	Uganda Human Rights Commission, Equal Opportunities Commission
Law Enforcement Agencies	Uganda Prisons Service, Police, Judiciary, DPP, UPDF
Development Partners	USAID/PEPFAR, CDC, DOD, UNAIDS, UNDP, UN-Women, UNFPA, UNICEF, Embassy of Ireland UKAid, HOPG/ADPG
HIV/AIDS and Human Rights Focused Civil Society Organisations and Implementing Partners	TASO Uganda, Uganda Network of Young People Living with HIV and AIDS (UNYPA), Maama Club, National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU), Children's AIDS Fund Uganda (CAFU), AMICAALL Uganda, International Community of Women living with HIV Eastern Africa (ICWEA), Uganda Network on Law Ethics and Human Rights (UGANET), Human Rights Awareness and Promotion Forum (HRAPF), Uganda Network of AIDS Service Organisations (UNASO), Uganda Law Society (Legal Aid Project), Akina Maama wa Africa, HEPS Uganda, National HIV Law Coalition, Human Rights Defenders, District Networks of PLHIV, District/Regional based IPs.
Key Population led /support Organisations	Most at Risk Populations Initiative (MARPI), Sexual Minorities Uganda (SMUG), Uganda Network for Sex Work -Led Organisations (UNESO), Women's Organisation Network for Human Rights Advocacy (WONETHA) Uganda, Uganda Harm Reduction Network (UHRN), etc
Policy Implementers and Service Providers	AIDS Information Centre, Makerere University Joint AIDS Program (MJAP), AIDS Healthcare Foundation (AHF), Reach Out Mbuya Parish HIV/AIDS Initiative, Baylor Uganda
Religious, Cultural and local leaders / institutions	Christian Faiths, Muslim Faiths, Buganda Kingdom, Elders in Karamoja, cultural leaders in other regions
District officials	District Health Office, District Community Development Office





UGANDA AIDS COMMISSION




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