

**BASELINE ANALYSIS ON THE POLICY ENVIRONMENT FOR
ACCESS TO SEXUAL AND REPRODUCTIVE
HEALTH AND RIGHTS AND HIV & AIDS
SERVICES FOR LGBT PERSONS IN UGANDA**



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ABOUT HUMAN RIGHTS AWARENESS AND PROMOTION FORUM

Human Rights Awareness and Promotion Forum (HRAPF) is an independent, non-partisan, non-governmental human rights advocacy organisation. HRAPF seeks to create awareness of human rights and provide legal support to the most marginalised groups as a means of stemming abuse of their fundamental rights. HRAPF envisions a society where the human rights of all persons, including marginalised groups, are valued and respected. This is achieved through promoting respect and observance of human rights of marginalised groups through legal aid service provision; legislative advocacy; research and documentation; legal and human rights awareness; and capacity building and partnership.

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ACRONYMS

AGHA Uganda	Action Group for Health, Human Rights and HIV/AIDS Uganda
AGYW	Adolescent Girls and Young Women
ART	Anti-retro viral therapy
ARVs	Anti-retro viral medicines
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CEHURD	Centre for Health, Human Rights and Development
CSO	Civil Society Organization
DG	Director General
EMTCT	Elimination of Mother to Child Transmission (of HIV)
FARUG	Freedom and Roam Uganda
FGD	Focus Group Discussion
GOU	Government of Uganda
HC	Health Centre
HCT	HIV Counselling and Testing
HEPS Uganda	Coalition for Health Promotion and Social Development
HMIS	Health Management Information System
HRAPF	Human Rights Awareness and Promotion Forum
HTS	HIV testing services
IBU	Ice Breakers Uganda
IPPF	International Planned Parenthood Federation
JLOS	Justice, Law and Order Sector
KCCA	Kampala Capital City Authority
KII	Key Informant Interview
KPs	Key Populations (affected by HIV and AIDS)
LGBT	Lesbian, Gay, Bi-sexual, Transgender
MARPI	Most at Risk Populations Initiative
MARPS	Most at Risk Populations

MOH	Ministry of Health
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
OHCHR	Office of the United Nations High Commissioner for Human Rights
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PWDs	People with Disabilities
PWID	People Who Inject Drugs
RHU	Reproductive Health Uganda
RMNCAH	Reproductive, Maternal, New-born, Child, Adolescent Health
SANAC	South African National AIDS Council
SDGs	Sustainable Development Goals
SMC	Safe Male Circumcision
SMUG	Sexual Minorities Uganda
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TEU	Trans Equality Uganda
TFR	Total Fertility Rate
TOR	Terms of Reference
UAC	Uganda AIDS Commission
UHRN	Uganda Harm Reduction Network
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UTT	Universal Test and Treat
WHO	World Health Organization
WSW	Women who have Sex with Women

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EXECUTIVE SUMMARY

This policy analysis assesses the policy and policy implementation gaps regarding access to sexual and reproductive health services and rights (SRHR) generally and HIV and AIDS services in particular, for lesbian, gay, bisexual, transgender (LGBT) persons in Uganda. The study is qualitative and data collection included a desk review of international and national policy frameworks and literature; 17 in-depth interviews with key informants from government agencies, LGBT-focused civil society organisations (CSOs), and development partners; four focus group discussions (FGDs) with LGBT persons; and validation meetings with stakeholders.

The results of the study indicate that Uganda has a number of policies and guidelines regarding the provision of SRHR and HIV and AIDS services to the population. These include: The National Policy Guidelines and Service Standards for Reproductive Health Services (2001); The Investment Case / Revised Sharpened Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health (2016); The Uganda Family Planning Costed Implementation Plan (2015 – 2020); The National Comprehensive Condom Programming Strategy and Implementation Plan (2017 – 2021); The National HIV and AIDS Strategic Plan (NSP) (2015/16 – 2019/20); The Roadmap for HIV Prevention (2018); The National Adolescent Health Policy (2004) and The National Adolescent Health Strategy (2011). Most of these policies such as the NSP, the HIV Testing Policy and Guidelines, and the Roadmap for HIV Prevention have provisions to address key populations, while some others do not. In addition, even those that have provisions for key populations do not have any specific provision that address the specific SRHR / HIV and AIDS services for LGBT persons as a separate sub-population category. Instead, most of these policies and guidelines contain universalist provisions that address the provision of SRHR / HIV and AIDS services for the general population and in some cases for key populations in general. In many cases where key populations are addressed, only the MSM (men who have sex with men) sub-group is mentioned leaving out other LGBT sub-groups. The silence about LGBT persons in most of the policies leads to no specific service package being prescribed for these persons. Silence about LGBT sub-groups also leads to them being ignored or left out of planning and implementation of services.

At the same time, however, these policies do not prohibit provision of SRHR/HIV and AIDS services to LGBT persons, and indeed are based on the principles of equity and non-discrimination in service delivery.

Within this policy terrain, some service providers such as the Most at Risk Populations Initiative (MARPI), a public-private partnership initiative have been able to operate within these policy frameworks and reach LGBT persons and other key populations on an extensive scale, reaching all 12 Regional Referral Hospitals and 23 district hospitals as well as collaborating with dozens of key population drop-in centres run by NGOs and donor-funded projects. These services that are tailored to key populations however remain concentrated in major urban centres and are out of reach for LGBT persons that may be living in rural areas. The impetus to provide SRHR / HIV and AIDS services to KPs on a wider scale over the recent years was attributed to a number of factors, which, among others include advocacy by human rights and LGBT-focused civil society organisations (CSOs), and the support leveraged by the letter written by the Director General of Health Services in the Ugandan Ministry of Health in April 2014 and the Ministerial Directive issued in June 2014, all urging for non-discrimination of patients during

health care service delivery.

It was found that most of the difficulties in reaching LGBT persons with services lie both in the implementation sphere, as well as in the restrictive legal environment that criminalises same-sex relationships; and require mandatory disclosure of one's HIV status. These legal provisions have had the effect of instilling fear among LGBT persons as well as health service providers. They have also created an environment in which the public perceives LGBT persons as criminals.

Comparison with the policy frameworks from other countries indicates that some countries in the East and South African region are more explicit about LGBT as a priority population of interest in matters of SRHR / HIV and AIDS. South Africa was found to have the most progressive policy regime that is inclusive of LGBT persons. The South African National Strategic Plan on HIV and AIDS, TB and STIs 2017-2022 lists LGBT persons among the target groups and specifies the core and additional service packages to serve transgender and other LGBT persons. In addition, South Africa has an LGBT HIV Plan 2017-2022 which outlines service packages for LGBT persons. These policy frameworks provide important lessons for countries like Uganda.

Implementation of SRHR / HIV and AIDS services for LGBT persons is in addition hampered by challenges such as lack of awareness about LGBT issues, unfavourable attitudes and stigma, poor financing and coordination, inadequate infrastructure and limited information about LGBT issues. These are compounded by structural barriers that include the restrictive legal environment, an unfavourable political environment, and cultural and religious values and beliefs.

The limited access of LGBT persons to SRHR / HIV and AIDS services obstructs the realisation of their human rights. The key rights affected are the right to a standard of living adequate for health and wellbeing; the right to health and reproductive health; the right to equal treatment and non-discrimination; the right to a family; the right to life and to dignity and personal integrity; the right to privacy; and the right to freedom of expression, association, participation and assembly. The LGBT community is also excluded and 'left out' of policies, contrary to the principle underlying the Sustainable Development Goals, of 'leaving no one behind'.

The inadequate access to SRHR / HIV and AIDS services also leaves LGBT persons at risk of acquiring HIV, and not accessing appropriate care in case they are infected.

Recommendations

To the Government of Uganda (GOU) / Ministry of Health (MOH)

- GOU/MOH should make SRHR / HIV and AIDS policies more inclusive of sexual and gender minorities, and use more explicit language that specifies LGBT sub-populations as target groups for SRHR / HIV and AIDS interventions. Learning from countries such as South Africa, Uganda should formulate specific policies to address the needs of sexual and gender minorities.
- The on-going efforts to train health workers to provide KP-friendly services are commendable and should be scaled up. MOH and partners should train health workers about different kinds of sexes, gender and how to handle persons with different gender and sexual identities and orientations. The MOH and partners should provide more funding to support these activities.

- MOH should scale up the availability of all services included in the minimum package of services for key populations and the additional services tailored to the specific needs of different LGBT sub-groups including PrEP, SMC and UTT to ensure they are readily accessible.
- MOH in collaboration with CSOs should create greater awareness about the availability of PEP and PrEP services.
- GOU/MOH should ensure procurement and availability of commodities that reduce the risk of transmission of HIV and other sexually transmitted infections, as well as commodities such as hormones for gender affirmation. Lubricants and drugs for the management of drug addictions should be included on the essential medicines list.
- GOU/MOH should also recognise LGBT organisations as partners in the campaign to improve SRHR and to fight HIV and other infections.

To human rights and LGBT Civil Society Organisations

- Effective policy reform and implementation cannot be achieved in a restrictive legal and political environment. Human rights organisations should continue the advocacy and legal efforts to improve the legal and political environment surrounding LGBT issues in Uganda.
- LGBT organisations and partners should conduct more research and generate evidence to facilitate planning, advocacy and policy making that is inclusive of LGBT issues. Evidence is needed to understand the HIV risks associated with the sexual practices of LGBT persons and to demonstrate the HIV burden posed by sexual behaviour amongst LGBT persons in order to justify investment in and prioritisation of LGBT issues by government and donors. Research is also needed on awareness of, use and demand for lubricants in HIV prevention.
- LGBT-focused CSOs should train LGBT persons about their sexual and reproductive health status, needs, risks and services available in order to promote demand and utilisation of services.
- Human rights organisations and LGBT-focused CSOs should engage more with communities, local leaders, law enforcement officials, and other stakeholders to change attitudes towards LGBT persons and reduce stigma and discrimination.

To health service providers (CSOs, health facilities)

- Even as advocacy efforts for more inclusive policies continue, LGBT organisations and service providers should utilise the positive aspects in the existing policy frameworks to scale up services for LGBT persons and reach the unreached.
- SRHR / HIV and AIDS service providers should scale up the use of tested approaches that work well with LGBT persons such as peer-led and community outreach approaches in order to reach LGBT persons.

To Parliament of Uganda

- The Parliament of Uganda should reform laws that negatively impact the environment for LGBT persons to seek and access services including those that criminalise sex work, same-sex marriage, and same-sex sexual acts.
- The Parliament of Uganda should allocate more financial resources towards scaling up HIV and SRHR services across the country, including those for training health workers in working with key populations, procurement of necessary commodities and supplies, and expansion of services geographically.

To other sectors

- Other relevant sectors, namely, JLOS, the Social Development Sector, Education and others should, as part of their roles provided for under the Multi-Sectoral HIV and AIDS framework developed by the Uganda AIDS Commission, work to remove barriers to access to services for LGBT persons.

1 INTRODUCTION AND BACKGROUND

1.1 Introduction

This report presents the results of a baseline policy analysis study on access to Sexual and Reproductive Health and Rights (SRHR) and HIV and AIDS services for lesbian, gay, bisexual, transgender people (LGBT) in Uganda conducted by Human Rights Awareness and Promotion Forum (HRAPF). This report is organised as follows: section one provides the introduction and background and the methodology used; section two sets out the SRHR policy framework; section three presents and discusses the findings; while section four provides the conclusions and recommendations.

1.2 Background

Whereas there are a number of policies in Uganda that provide for the access to SRHR/HIV and AIDS services to the general population,¹ it is not clear to what extent they provide for access to LGBT persons specifically. There are numerous gaps in the existing policy framework with regard to access to SRHR/HIV and AIDS services for LGBT people. The gaps in policies in turn affect the provision of services to LGBT persons. In addition, there are implementation challenges of the existing policies, both in the public sector or the private sector.

In response to the above, HRAPF conducted this in-depth analysis of the existing policies from the Government of Uganda that are related to the provision of SRHR/HIV and AIDS services. The analysis focused on 1) the provisions in the policies for the provision of SRHR / HIV and AIDS services for LGBT persons in Uganda; 2) the gaps in these policies and the way they are implemented that limit provision of as well as access to these services; and 3) the policies that simply exclude LGBT persons entirely. The object of the exercise was to analyse existing gaps and suggest how the gaps may be bridged to ensure that LGBT persons can access SRHR / HIV and AIDS services without discrimination.

1.2.1 The right to health and SRHR/HIV and AIDS situation of LGBT Persons

The right to health is a universal right. This right, together with the right to sexual and reproductive health is arguably protected within Uganda's Constitution² as well as in international human rights treaties and instruments such as the Universal Declaration of Human Rights, Article 25,³ and the International Covenant on Economic, Social and Cultural Rights (1967) Article 12.⁴

¹ These include: The Roadmap for HIV Prevention (UAC, 2018); The National Comprehensive Condom Programming Strategy and Implementation Plan (2017 – 2021); the Investment Case/Revised Sharpened Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health (2016); the National HIV and AIDS Strategic Plan (NSP) 2015/16 – 2019/20; the Uganda Family Planning Costed Implementation Plan (2015 – 2020); The National Adolescent Health Strategy (2011), the National HIV and AIDS Priority Action Plan (2015/16 – 2017/18); the National Adolescent Health Policy (2004); and the National Policy Guidelines and Service Standards for Reproductive Health Services (2001).

² The Constitution of the Republic of Uganda (1995) does not explicitly provide for the right to health, but recognises the state's obligation to access to health and basic medical care in Objectives XIV and XX of the National Objectives and Directive Principles of State Policy. These in light of Article 8A of the Constitution are now arguably justiciable. But beyond these, the Constitution protects the rights to life, and the right to health may be implied from this right, among other rights. See generally, B Twinmugisha 'Protection of the right to healthcare of women living with HIV/AIDS (WLA) in Uganda: The case of Mbarara hospital' HURIPEC Working Paper No. 5, April 2007, 19-21.

³ United Nations General Assembly, Universal Declaration of Human Rights (1948) Article 25.

⁴ United Nations, The International Covenant on Economic, Social and Cultural Rights (1967) Article 12.

Box 1: Sexual and reproductive health

‘Good sexual and reproductive health can be defined as a state of complete physical, mental and social wellbeing in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when and how often to do so.’⁵

The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa in particular, which is a supplement to the African Charter on Human and Peoples’ Rights, clearly spells out the health and reproductive rights of women, and these include:⁶ the right to a standard of living adequate for the health and well-being; the right to the enjoyment of the highest standard of physical and mental health; the right to control their fertility; the right to decide whether to have children, the number of children and the spacing of children; the right to choose any method of contraception; the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; the right to be informed of one’s health status and on the health status of one’s partner; and the right to have family planning education.⁷

However, realisation of the right to health – specifically with regard to access to sexual and reproductive health and HIV and AIDS services – remains an unfulfilled ideal in many parts of the world, especially for minority social groups such as lesbian, gay, bisexual, transgender (LGBT) people.⁸ These sexual and gender minority groups have particular SRHR and HIV-related needs.⁹ Globally, there is evidence that HIV prevalence is much higher among key population groups than in the general population.

HIV prevalence among men who have sex with men (MSM) is as high as 25% in Ghana, 30% in Jamaica, 43% in Coastal Kenya, and 25% in Thailand.¹⁰ It is even higher among transgender women, reported at more than 25% in some Latin American Countries, and between 10-42% in some Asian countries.¹¹ A meta-analysis published in 2013 reported an HIV prevalence of 19.1% among transgender women.¹² UNAIDS also shows that the risk of acquiring HIV is 27 times higher among MSM and 13 times higher among transgender women.¹³ UNAIDS data further shows that gay men and other MSM accounted for 12% while sex workers accounted for 5% of all new HIV infections globally in 2015.¹⁴

⁵ United Nations Populations Fund website <https://www.unfpa.org/sexual-reproductive-health> (accessed 17 December 2018).

⁶ See Box 2 below.

⁷ United Nations General Assembly, Universal Declaration of Human Rights (1948) Article 25; United Nations, The International Covenant on Economic, Social and Cultural Rights (1967) Article 12; African Union, The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa. (2003) Article 14.

⁸ GA Albuquerque et al ‘Access to health services by LGBT persons: systematic literature review’ 16:2 BMC International Health and Human Rights (2016).

⁹ World Health Organization ‘Sexual Health, Human Rights and the Law’ (2015) 24-25.

¹⁰ The Global Fund ‘Addressing sex work, MSM and transgender people in the context of the HIV epidemic’ (2011) 2.

¹¹ As above.

¹² S Baral et al ‘Worldwide burden of HIV in transgender women: a systematic review and meta-analysis’ (2013) 13:2 *Lancet* 214-222.

¹³ UNAIDS ‘World AIDS Day Fact Sheet’ (2018)3. Accessed December 5, 2018 at http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf.

¹⁴ UNAIDS ‘Data 2017’ (2017) 9.

Given the uneven distribution of HIV risk and SRHR needs among different population groups, appropriate targeting of investments in SRHR and HIV is crucial to the success of these services. Yet targeting of marginalised populations such as LGBT who at the same time contribute significantly to new HIV infections has been inadequate in many countries. SRHR and HIV services remain largely inaccessible to sexual and gender minorities such as MSM and transgender people. According to UNAIDS, in 2008 more than 70% of countries did not report on levels of access to HIV services for MSM and transgender people,¹⁵ indicating either lack of services targeting these groups or lack of service data or both. Even where services exist, fear of stigma, discrimination and violence are often a major barrier to the utilisation of services by the members of sexual and gender minority groups.

1.2.2 The context of SRHR/HIV and AIDS in Uganda

Uganda has made significant efforts in recent years to improve sexual and reproductive health and rights services in the country. This is evidenced by improvements in key SRHR indicators such as maternal mortality rates which have improved from 505 deaths per 100,000 live births in 1995 to 438 deaths per 100,000 live births in 2011, and increased life expectancy at birth, from 47 and 45 years for females and males in 2000/01 to 57 and 54 years respectively in 2011.¹⁶ Total Fertility Rate (TFR) has also declined from 7.1 children per woman in 1991 to 5.8 children per woman in 2014.¹⁷ The unmet need for family planning among married women has reduced from 38% in 2006 to 28% in 2014; and modern contraceptive use among married women has increased from 18% in 2006 to 35% in 2014.¹⁸ Uganda has also made tremendous achievements since the 1990s in countering the further spread of HIV and mitigating its consequences. Recent statistics show that new HIV infections have reduced from 135,000 in 2010 to 46,000 in 2017.¹⁹ Despite this progress, HIV prevalence in Uganda is recorded to be generally higher among key populations than in the general population. HIV Prevalence rates have for instance been estimated at 13.7% among men who have sex with men (MSM), compared to a prevalence of 6-7% in the general adult population.²⁰ Key population groups have also been identified among the main source of new HIV infections in the country, contributing about 46% of all new infections in 2008²¹ and 21% in 2014, though they constitute only an estimated 5% of the population.²²

Over the last three years, Uganda's response to HIV has been based on the National Strategic Plan for HIV & AIDS (NSP) 2015/2016 – 2019/2020, with the overall goal: 'towards Zero new infections, Zero HIV and AIDS related mortality and morbidity, and Zero discrimination'. The NSP is anchored on four thematic areas, namely, Prevention, Care and Treatment, Social Support and Protection, and Systems Strengthening. Uganda is committed to the global 90-90-90 targets to be achieved by 2020 and ending AIDS by 2030. It is however estimated that Uganda as a country may not meet the above targets if the environment for HIV response

¹⁵ The Global Fund (n 10 above) 2.

¹⁶ Ministry of Health 'Investment Case: Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda (2018) 1.

¹⁷ Uganda Bureau of Statistics 'The National Population and Housing Census 2014 – Main Report' (2016) 16.

¹⁸ Uganda Bureau of Statistics 'Uganda Demographic and Health Survey 2016. Key Indicators' (2017) 20.

¹⁹ Uganda AIDS Commission 'The Presidential Fast Track Initiative on Ending AIDS as a Public Health Threat in Uganda by 2030. Year 1 Report' (2018) 12.

²⁰ Crane Survey 'HIV Infection among Men Who Sex with Men in Kampala' (2010) 3.

²¹ Uganda AIDS Commission 'Modes of Transmission Study' (2008).

²² Uganda AIDS Commission 'Modes of Transmission Study' (2014) 10. PEPFAR 'Uganda: Country Operational Plan 2018 Summary Direction Summary' (2018) 56.

among key population groups – who contribute significantly to new infections – is not improved.

1.2.3 The SRHR/HIV and AIDS service needs and recommended package of services for LGBT persons

LGBT persons have additional SRHR/HIV and AIDS needs beyond the needs of the general population. This is a result of their peculiar sexual behaviour, such as anal sex, which are often practiced in environments that do not support HIV prevention. Two of the LGBT sub-groups that are known to have the greatest risk of HIV infection are transgender persons and MSM. Transgender persons' immediate HIV risk is associated with sexual behaviour especially unprotected anal sex, but also other high-risk behaviour such as commercial sex and sex under the influence of drugs. The risk for HIV infection is known to be greater among transgender women compared to transgender men. MSM are at a higher risk of HIV and STIs compared to the general population due to the level of friction during anal intercourse that may lead to tearing of the lining of the rectum.²³ The presence of untreated STIs among MSM is also a frequent co-factor in HIV transmission. STDs located in the anus and rectum are often asymptomatic and may therefore remain untreated.²⁴ MSM are also at a risk of viral hepatitis. In terms of SRH, transgender persons have needs that differ greatly from those of the general population in that they would often require gender-affirming surgeries and hormone therapy.²⁵ LGBT persons or same-sex couples are also likely to be in need of medical services which would assist in reproduction such as in-vitro fertilisation. LGBT persons' vulnerability to sexual violence in a context which is highly homophobic also creates a greater need for abortion and post-abortion services as well as PEP.

A combination of interventions is required to respond effectively to the HIV and SRHR needs of key populations generally and LGBT persons in particular. Leading HIV and SRHR international agencies including WHO, UNAIDS, IPPF and UNFPA recommend the minimum package of services for LGBT persons to include the following:

- HIV prevention services:
 - Condom and condom-compatible lubricants
 - Post exposure prophylaxis (PEP)
 - Pre-exposure prophylaxis (PrEP)
- Behavioural interventions (IEC, risk reduction counselling, etc.)
- Voluntary HIV testing and counselling in community and clinical settings with linkages to prevention, care and treatment services.
- HIV treatment and care including antiretroviral treatment and management
- Prevention and management of co-infections and other co-morbidities including prevention, screening and treatment for viral hepatitis, tuberculosis, and mental health conditions
- Sexual and reproductive health interventions
- Contraception
- Safe abortion services
- Post-abortion care services
- Diagnosis and treatment of STIs

²³ UNAIDS 'AIDS and men who have sex with men. UNAIDS Technical Update' (2000) 3.

²⁴ As above.

²⁵ World Health Organization (n 9 above) 4, 24-25.

- Screening for cervical cancer and HIV-related cancers
- Gender affirming services.²⁶

1.2.4 The legal framework setting the scene for LGBT access to SRHR / HIV and AIDS services in Uganda

Uganda's supreme law, the Constitution of the Republic of Uganda (1995), provides among its social and economic objectives that the State shall ensure that all Ugandans enjoy rights and opportunities and access services, including health services. The Constitution also includes provisions for fundamental rights of all individuals under Article 20 and provisions against discrimination under Article 21.

On the other hand, Uganda is one of the 38 African countries that criminalise consensual same-sex activities. Article 31(2a) of the Constitution prohibits marriage between people of the same sex. In addition, sections 145, 146 and 148 of the Penal Code Act criminalise consensual same-sex relations as 'carnal knowledge against the order of nature', 'attempts to have carnal knowledge against the order of nature', and 'indecent practices' respectively. Section 145 prohibits consensual sex between individuals of the same sex and sets punishment by life imprisonment for such acts. Section 146 says that any person who attempts to commit the 'unnatural offences' enumerated in Section 145 commits a felony and is liable for seven years' imprisonment. Provisions such as those in the Penal Code Act instil a sense of fear not only among LGBT persons to seek services, but also among the providers of health services who are supposed to serve them.

In addition, the government of Uganda sought to further criminalise same-sex conduct and activity through the Anti-Homosexuality Act 2014. The Act sought to criminalise same-sex acts and set a punishment of imprisonment for life upon conviction (Section 1). The same law also sought to punish anybody believed to be aiding or abetting homosexuality. It read: 'A person who aids, abets, counsels or procures another to engage in acts of homosexuality commits an offence and is liable, on conviction, to imprisonment for seven years' (Section 7). The law also went ahead to prohibit same-sex marriage (Section 12), and the promotion of homosexuality, including financing, offering premises, broadcasting or undertaking any other activity that promotes homosexuality (Section 13). The law was overturned in the same year by the Constitutional Court following a petition by concerned citizens and civil society organisations including HRAPF.²⁷

While the government of Uganda has since shelved the legislation on anti-homosexuality, there have not been efforts directed towards establishing legal protection for LGBT people, and there is active harassment of LGBT persons and organisations by both state and non-state actors.²⁸ Homosexuality is also believed to be misunderstood as being illegal by many Ugandans

²⁶ World Health Organization 'Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations' (2016) 22; World Health Organization 'HIV and Young Transgender People. Technical Brief (2015) 18-19; World Health Organization 'HIV and Young Men who have Sex with Men. Technical Brief' (2015) 18 and International Planned Parenthood Federation, Brussels and United Nations Population Fund Eastern Europe and Central Asia 'Health, rights and well-being: A practical tool for HIV and sexual and reproductive health programmes with young Key Populations in Eastern Europe and Central Asia' (2017) 75.

²⁷ Prof J Oloka Onyango and 9 Others v Attorney General Constitutional Petition No. 008 of 2014.

²⁸ Consortium on Monitoring and Documenting Violations based on Sexual Orientation and Gender Identity The Uganda Report of Human Rights Violations based on Sexual Orientation and Gender Identity, 2018: Increasing protections and reducing state violations (2018) 9-22.

which contributes to stigmatisation, discrimination and other violations of the rights of LGBT people in all spheres of the Ugandan society. This reinforces negative perceptions of LGBT persons as criminals unworthy of protection or service provision, and lends credence to the perpetrators of human rights violations based on sexual orientation and gender identity. This feeds into the rampant homo- and transphobia in Uganda and is shared by both the general public and the duty bearers in government, the health service providers and law enforcers who, as a result, neglect to discharge their constitutional obligation to protect the right to health of LGBT persons in Uganda.

Uganda has also enacted laws with provisions that limit or undermine SRHR/HIV and AIDS service access for key populations such as LGBT persons. In 2014 the HIV and AIDS Prevention and Control Act became law. It provides for mandatory or routine HIV testing, disclosure of HIV test results to third parties and criminalisation of intentional and attempted transmission of HIV.²⁹ These provisions risk escalating stigma and discrimination associated with seeking SRHR / HIV and AIDS services.

There are other laws that indirectly affect LGBT persons in Uganda, for example they are arrested under section 167 of the Penal Code Act for 'being idle and disorderly', section 168 as 'rogues and vagabonds'³⁰ and section 381 as impersonators, especially transgender persons. These provisions, and the way that they are used to target LGBT persons for arrest, have the effect of driving LGBT persons away from needed SRH and HIV/AIDS prevention and treatment services. The Non-Governmental Organizations Act 2016 affects LGBT organisations as well as requiring mandatory registration of NGOs and yet it does not allow for registration of organisations whose objectives 'are prejudicial to the laws of Uganda' and LGBT organisations may be among these.³¹ This denial of the right to association weakens the LGBT movement and adds to the stigma attached to LGBT persons which makes it difficult to access SRH services. The provisions also inhibit the provision of these services by non-profit organisation as this may be viewed as an objective 'prejudicial to the laws of Uganda'.

LGBT persons who consume prohibited drugs or associate with people who use such drugs are also often arrested under the Narcotic Drugs and Psychotropic Substances Control Act, 2015. A study by HRAPF and UHRN (2016) which assessed the interface between regulation of drug use in Uganda, public health and human rights notes that this Act focuses more on the criminal aspects of drugs and does not pay much attention to the welfare of people who use drugs. The Act treats people who use drugs as criminals who need to be subjected to the criminal law rather than human beings in need of services or assistance.³²

Previous studies and reports have noted that the criminalisation of same-sex relations, sex work and drug use in Uganda makes key populations an easy target for police abuse and brutality.³³ Because of the presumed criminality of their lifestyles, police authorities often

²⁹ Section 43 of the HIV and AIDS Prevention and Control Act, 2014.

³⁰ Parts of this provision have been challenged in Francis Tumwesigye Ateenyi v Attorney General, Constitutional Petition No. 36 of 2018, which was filed with the support of HRAPF.

³¹ See for example Human Rights Awareness and Promotion Forum 'Position paper on the Non-governmental Organisations Act, 2016' (2016) 3-4 <https://hrapf.org/?mdocs-file=1669&mdocs-url=false> (accessed 20 November 2018).

³² Human Rights Awareness and Promotion Forum (HRAPF) and Uganda Harm Reduction Network 'The Narcotic Drugs and Psychotropic Substances (Control) Act 2015 and the Legal Regulation of Drug use in Uganda' (2016) 10, 75-76.

³³ Danish Refugee Council and Danish Immigration Service 'Situation of LGBT persons in Uganda' (2014) 30, 63 and WONETHA et al 'Human rights violations of sex workers in Uganda' (2016) 4.

perpetrate violence against these groups that amounts to torture and to cruel, inhuman, and degrading treatment – such as beating, rape, extortion of money, arbitrary arrest and detention. These abuses are largely perceived within law enforcement circles as legitimate. Other people also take advantage of the presumed illegality of sexual and gender minorities and key populations in general and exploit, discriminate or inflict violence against them. The victims are often not able to report these incidences to the police, because many times, the police are among the perpetrators.

1.3 Objectives of the Study

The main objective of the study was to generate information on the policy and policy implementation gaps for access to SRHR / HIV and AIDS services for LGBT persons in Uganda.

The Specific Objectives were:

- a. To review the national policy framework on access to SRHR / HIV and AIDS services for LGBT persons in Uganda.
- b. To identify the policy and policy implementation gaps that hinder access to SRHR / HIV and AIDS services for LGBT persons in Uganda.
- c. To examine the human rights implications of the gaps in the policy framework that hinder access to SHRH/HIV&AIDS services by LGBT persons in light of Uganda's human rights and constitutional framework.
- d. To undertake a comparative analysis of the policy framework of other comparable jurisdictions in the region that support access to SRHR and HIV/AIDS prevention and care services for sexual and gender minorities.
- d. To examine the relative impact of the lack of access to SRHR / HIV and AIDS services for LGBT persons to the spread of the HIV epidemic among the LGBT community.
- e. To examine other structural barriers to access to SRHR / HIV and AIDS information and services among LGBT persons in Uganda.
- f. To make recommendations on the next advocacy strategies and steps to address policy gaps on the provision of SRHR / HIV and AIDS services to LGBT persons in Uganda.

1.4 Methodology

1.4.1 Overall Study Design

This was a policy analysis study. The study was conducted through a largely qualitative approach. It consisted of a desk review of policy documents, key informant interviews with selected informants, and focus group discussions with LGBT persons. A qualitative approach was deemed suited to this kind of study because it would enable a detailed analysis of the content and implications of existing policies, as well as views of the stakeholders about these policies and their implications.

1.4.2 Geographical Scope

Data for the study was collected mainly from Kampala City and the surrounding districts of Wakiso and Mukono. Documents for review were sourced from the relevant government agencies specifically the Ministry of Health and the Uganda AIDS Commission, as well as from libraries and online sources. Study participants were identified and interviewed from their

work places or places of operation. Policies and guidelines available at the global level from leading health and human rights agencies such as WHO, UNAIDS and other UN agencies were also referred to.

In addition, policies and guidelines from South Africa were reviewed to compare and learn from the steps they have taken to address human rights for LGBT persons. Extensive reference is made to the case of South Africa, given its advanced progress in addressing LGBT issues.

1.4.3 Study participants

Study participants consisted of policy makers, policy implementers, service providers, development partners supporting SRHR / HIV and AIDS and human rights work, and the target groups i.e. the LGBT persons themselves.

1.4.4 Sample size and sample selection

The review of documents aimed to cover all relevant policies and implementation guidelines. On the other hand, sample sizes of individuals in the study were selected purposively. The guiding principle in sampling these was to select and interview study participants up to a point where sufficient information has been obtained, or where all themes and sub-themes and issues under study have been discussed, i.e. at the point of saturation.³⁴ Key informants were also sampled to ensure representation of different stakeholder groups and institutions.

The table below summarises the key informants covered by the study and the methods and criteria used to select them.

Table 1: Summary of sample sizes and composition

Target population

Sample size and selection methods / criteria

Methods of data collection

Policy makers

- 6 from government agencies (MOH and UAC)

Individual In-depth Interviews

Development Partners

- 2 informants from Netherlands Embassy and UN Family

Individual In-depth Interviews

³⁴ The research team set out to include between 25 and 40 LGBT research participants as 30 participants is generally considered as the mean in qualitative research SE Baker & R Edwards 'How many qualitative interviews is enough? Expert voices and early career reflections on sampling and cases in qualitative research' National Centre for Research Methods Review Paper 5; B Saunders et al 'Saturation in qualitative research: exploring its conceptualization and operationalization' 52:4 *Quality and Quantity* (2018) 1893-1907.

Policy Implementers and service providers

- 4 NGO staff from LGBT focused organisations, namely: Sexual Minorities Uganda (SMUG), IceBreakers Uganda (IBU), Trans Equality Uganda (TEU), Spectrum Uganda, and Freedom and Roam Uganda (FARUG).
- 1 other SRHR focused-organisations: International Planned Parenthood Federation (IPPF)
- 3 human rights advocacy CSOs: Centre for Health, Human Rights and Development (CEHURD), Action Group for Health, Human Rights and HIV/AIDS Uganda (AGHA), and Coalition for Health Promotion and Social Development (HEPS).
- 1 Justice, Law and Order Sector (JLOS) staff member

Individual In-depth Interviews

Target groups

- 1 FGD with transgender³⁵ persons
- 1 FGD with Women who have Sex with Women (WSW)
- 2 FGDs with Men who have Sex with Men (MSM)

Focus group discussions

1.4.5 Data collection methods and tools

The study utilised three main methods of data collection, namely:

Desk review: A desk review of policy documents and guidelines that are relevant to LGBT persons' access to SRHR / HIV and AIDS services, in Uganda as well as Rwanda and East African regional documents. The aim was to undertake an analysis of the policy provisions and omissions relating to the provision of SRHR / HIV and AIDS services and how they affect access to services by LGBT persons. Policy documents were sought from the Ministry of Health and the Uganda AIDS Commission, and from online sources. Below is a list of policies and guidelines that were reviewed:

- The National HIV and AIDS Strategic Plan (NSP) 2015/16 – 2019/20.
- The National HIV and AIDS Priority Action Plan 2015/16 – 2017/18.
- National Action Plan on Women, Girls, Gender Equality and HIV&AIDS 2016/17 -2020/21.
- National HIV & AIDS Monitoring & Evaluation Plan 2015/16 – 2019/20.
- The Policy on eMTCT and a report on Implementation.
- The National HIV Testing Services Policy and Implementation Guidelines (MOH, 2016).
- The Uganda Presidential Fast Track Initiative 2017.
- The HIV/AIDS Prevention Roadmap (UAC, 2018).
- The Multi-sectoral HIV Response for MARPS in Uganda: Programming Framework 2014-2016 (UAC, 2014).
- The MARPS Priority Action Plan 2015/16 - 2017/18.
- The Health Sector Action Plan for HIV/STI Prevention in Sex Work Settings (MOH 2013)

³⁵ Transgender persons have a gender identity or gender expression that differs from their biological sex assigned at birth.

- The Consolidated Guidelines for HIV Prevention & Treatment (MOH, 2016).
- National Policy Guidelines & Service Standards for Reproductive Health services (2011).
- The Investment Case / Strategy for Reproductive, Maternal, Newborn & Child Health 2018-2020 (MOH 2016).
- The Uganda Family Planning Costed Implementation Plan (2015 – 2020).
- The National Comprehensive Condom Programming Strategy and Implementation Plan (2017 – 2021).
- Implementation Guidelines for the RMNCAH Strategy.
- The Anti-stigma Policy (2018).
- The HIV Prevention and Control Act 2014.
- Uganda Gender Policy 2007 (under revision).
- Constitution of the Republic of Uganda (1995).
- The National Adolescent Health Policy (2004).
- The National Adolescent Health Strategy (2011).

Documents (policies and guidelines) reviewed at the global level include:

- The Sustainable Development Goals
- WHO (2017) Consolidated Guidelines on SRHR of Women living with HIV
- WHO (2014) Consolidated Guidelines on HIV prevention, diagnosis and treatment & care for Key Populations
- Various international human rights instruments and frameworks

In-depth / Key Informant Interviews: These were conducted with selected key informants as outlined above. Key informants helped to identify any other relevant policies, and guidelines relevant to service access by LGBT persons, as well to understand the implementation gaps. Key informants also provided information about the implications of the existing policies for the spread of HIV among LGBT persons. Key Informant interview guides were designed for this purpose.

Focus group discussions: Focus group discussions were conducted with the members of the LGBT community. FGDs helped to gather data on experiences in accessing SRHR / HIV and AIDS services, to identify implementation gaps and implications, as well as recommendations that can feed into advocacy programmes. FGD participants were mobilised through the organisations / CSOs that work with them. Each FGD was facilitated by two persons: one to moderate the discussion and another to manage the recording of the discussion. Each FGD lasted between one and two hours and took place at a venue recommended by the participants themselves in order to ensure safety and convenience. An FGD guide was designed and used for this purpose.

1.4.6 Validation meetings

Validation meetings were held with stakeholders at various stages of the study, namely at inception, and after development of first and second drafts of the report in order to share study outputs and receive feedback from the stakeholders. The stakeholders included LGBT persons, staff from LGBT-focused CSOs and human rights CSOs, and policy makers from relevant government agencies, particularly the Ministry of Health and the Uganda AIDS Commission.

1.4.7 Data processing and analysis

Data was analysed manually using document analysis and thematic procedures. Matrices and other relevant formats were used to organise the data and sort emerging responses

along themes aligned to the study objectives. Data from different sources were triangulated for validity and complementarity. During analysis, attention was paid to the content and provisions of existing policies on the one hand, the existing gaps, the recommended service package for LGBT persons, and the services available on the ground on the other.

1.5 Ethical Issues

The study team members observed all applicable ethical principles relating to the study of vulnerable and minority groups. These included informed consent, voluntary participation, privacy, confidentiality, anonymity and doing no harm. Oral consent was obtained from the study participants using pre-prepared consent scripts, and using the local language of the participants. Potential participants were informed that their participation in the study was voluntary. They were also informed that they had the right to withdraw from the study at any time during the time of data collection, if they so wished, without having to give a reason and without affecting their access to services or any of their rights. LGBT peer workers assisted the team to identify and mobilise LGBT members to take part in the study, which enhanced acceptance to participate in the study. Data from the study participants was handled with utmost confidentiality. Information obtained was not shared with other people apart from those working directly on the study. All personal information relating to the participants from the LGBT community such as their names and age, and other identifying information were coded to remove the possibility of identification by non-authorised persons. All collected data was securely kept under lockable drawers. All interviews with LGBT persons were conducted in privacy and in places suggested by them.

2 THE POLICY FRAMEWORK FOR ACCESS TO SEXUAL AND REPRODUCTIVE RIGHTS BY LGBT PERSONS IN UGANDA

2.1 Introduction

This section discusses the policy environment for access to Sexual and Reproductive Health Rights (SRHR) for LGBT persons in Uganda and identifies the various policy gaps.

2.2 The National Policy Framework on SRHR/HIV and AIDS Services in Uganda

Uganda has a number of policies and guidelines regarding the provision of sexual and reproductive health services to the population. These include: The Roadmap for HIV Prevention (UAC, 2018); The National Comprehensive Condom Programming Strategy and Implementation Plan (2017 – 2021); the Investment Case/Revised Sharpened Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health (2016); the National HIV and AIDS Strategic Plan (NSP) 2015/16 – 2019/20; the Uganda Family Planning Costed Implementation Plan (2015 – 2020); The National Adolescent Health Strategy (2011), the National HIV and AIDS Priority Action Plan (2015/16 – 2017/18); the National Adolescent Health Policy (2004); and the National Policy Guidelines and Service Standards for Reproductive Health Services (2001).

A review of these policies and guidelines reveal the absence in many policy documents of specific provisions that address the specific SRHR/HIV and AIDS services for LGBT persons as a priority population category. Instead, most of these policies and guidelines contain universalist provisions that address the provision of SRHR/HIV and AIDS services for the general population or at best for key populations in general. The policies are reviewed below starting with the broad strategic plans and then zeroing down on specific policies. Those dealing with SRHR generally are dealt with before those focusing on HIV/AIDS-specific policies.

2.2.1 The broader SRHR policies

The relevant policies in this category include:

The Investment Case/Revised Sharpened Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health (MOH 2016) targets to improve the continuum of services along the life cycle i.e. pregnancy, childbirth, childhood, and adolescence. The plan is based on five strategic shifts which among others include increasing access for high-burden populations. This strategic shift is explained to include interventions to reach under-served populations, who ideally should include key population groups such as LGBT persons. The plan, however, does not specify who the high-burden or underserved populations are. The plan also talks about rights, equality and gender balance and outlines the specific issues under this theme such as discrimination against women and girls; unequal access to services between men and women; disparities according to residence, education level, and age; and rights of people with disabilities, children and people with mental illness. There is however no mention of key population groups including LGBT persons. As a result of this silence about LGBT persons and other key populations, no relevant service package for these groups are provided for.

The Uganda Family Planning Costed Implementation Plan, 2015–2020 (CIP) seeks to provide a framework for achieving Uganda’s family planning vision, which is ‘Universal access to family planning to help Uganda attain the middle-income country status by 2040’. The operational goal of the plan is to ‘Reduce unmet need for family planning to 10 percent, and increase the modern contraceptive prevalence rate (mCPR) amongst married and women in union to 50 percent by 2020’.³⁶ The CIP details the country’s plans to achieve its vision and goals through providing high-quality, rights-based family planning information and services. The CIP includes analyses of the use and demand for male and female condoms. Besides the general population of reproductive age, the CIP puts attention on some vulnerable and marginalised groups such as the youth and people with disabilities, but not on key populations affected by HIV and AIDS. This is a grave oversight, considering the particular needs which LGBT persons have when it comes to preventing pregnancy as well as reproducing within a same-sex relationship. There is need for specific programming addressing family planning in the context of multiple sexual partners and the double lives which LGBT persons would often feel pressured to maintain.

The National Action Plan on Women, Girls, Gender Equality and HIV & AIDS (2015/16-2018/20) is also silent on LGBT persons and other key population groups. Instead, this document only identifies vulnerable populations such as young girls and boys, the girl child, PWDs, orphans and vulnerable children, and widows.

The National Adolescent Health Policy (MOH 2004) is intended to benefit all people in Uganda with a focus on young people of all ages. The Policy further emphasises a stronger focus on adolescents living in difficult circumstances such as war-torn areas, those without employment; those involved in hazardous employment such as commercial sex, those who are orphaned and adolescents living with HIV among others. No specific mention is made of key population groups such as LGBT persons.

The National Adolescent Health Strategy (MOH 2011) has its mission as ‘[t]o facilitate the attainment of a good standard of health by all adolescents in Uganda in order to promote health and productive life for development.’ Evidently, the strategy which is intended to operationalise the policy does not go a long way in recognising and paying due regard to the socio-cultural factors that might hinder the provision of quality and accessible SRHR services to some key groups including LGBT persons except with regard to the prevention and control of the spread of STI/HIV/AIDS where it identifies MSM as a specific group that will be targeted with interventions such as health education, laboratory diagnosis, counselling and provision of antiretroviral drugs (MOH 2001).

The National Policy Guidelines and Service Standards for Reproductive Health Services (MOH 2001) states that all people are eligible for health services and that the services ought to be provided in a friendly environment and a manner that meet their needs. But like the other relevant policies and guidelines analysed in this study, they focus on the traditionally known categories of vulnerable groups such as adolescents particularly girls, orphans, those with disabilities, those living in poverty or with AIDS. LGBT persons are not recognised and/or mentioned as a population category of interest.

Although the above mentioned SRHR policies and guidelines purport to be inclusive, they largely use universalist language that does not include LGBT persons. A few of them mention MSM but no other sub groups within the LGBT umbrella, thus leaving many LGBT persons

³⁶ Ministry of Health ‘Uganda Family Planning Costed Implementation Plan 2015 – 2020’ (2014) 1.

out/behind.

2.2.2 The HIV/AIDS specific policies

There are a number of policies that specifically deal with HIV/AIDS. These deal with LGBT persons as follows:

The National Strategic Plan (NSP) for HIV & AIDS 2015/16 – 2019/20 recognises KPs / MARPs as a category at a higher risk of HIV and indeed as a group that contributes to the new infections experienced in the country. The NSP 2015/16-2019/20 includes ‘non-discrimination’ as one of its guiding principles, and states that ‘no person shall be discriminated from accessing HIV and AIDS services’. Another guiding principle is ‘human rights and gender-based approach to programming’. These two principles would imply that LGBT persons are adequately covered by the plan. For much of the objectives and strategies outlined in the NSP, the document refers to key populations and most at risk populations in general terms without specifying who these are. The NSP for instance lists as one of the strategic actions under HIV prevention, the scale up of comprehensive interventions targeting MARPS.³⁷ Under the prevention thematic area, the NSP emphasises that there would be a need to focus on ‘targeted biomedical and behavior change interventions for *existing and emerging key populations as well as vulnerable groups* in addition to the general population’. The *existing* key population groups are then explained to include sex workers, truckers, MSM, fisherfolk and uniformed services personnel. The *emerging* key population groups are operationalised to include prisoners, miners, plantation workers, boda boda taxi men, brick layers and salt extractors.³⁸ No specific mention is made of LGBT persons apart from the MSM. The strategies of the NSP also include a focus on condom promotion and distribution but lubricants and other specific commodities that may be useful to the prevention of HIV among LGBT persons are not mentioned.

Similarly, **the National HIV and AIDS Priority Action Plan (2015/16 – 2017/18)** which was designed to operationalise the NSP, recognises key populations and singles out MSM among the LGBT category. There is no recognition of other LGBT subgroups. This Action Plan outlines a number of strategic outcomes and strategic actions that include a focus on key populations. These range from outcomes and actions on risk reduction, stigma and discrimination, scaling up of services, revision of laws and policies, and strengthening institutional systems and mechanisms for responding to HIV among different population groups including key populations.³⁹

The National Comprehensive Condom Programming Strategy and Implementation Plan (2017 – 2021) sets out a vision ‘where all risky sexual acts,⁴⁰ are protected by a male or female condom’ and a goal of ‘contributing to national targets for reduction in sexually transmitted infections including HIV and unintended pregnancies through ensuring that all sexually active individuals in Uganda have adequate information and access, and correctly use quality condoms whenever they need them’.⁴¹ The strategy reviews levels of condom use among the general population as well as among key populations but mostly refers to sex workers, fisherfolk, truckers and uniformed personnel.⁴² However, MSMs are mentioned among the

³⁷ Uganda AIDS Commission ‘National HIV and AIDS Strategic Plan [NSP] 2015/2016- 2019/2020’ (2015) 22.

³⁸ As above at 21.

³⁹ Uganda AIDS Commission ‘National HIV and AIDS Priority Action Plan 2015/16 – 2017/18’ (2015) 9–42.

⁴⁰ Sex acts that can result into contraction of STIs including HIV and /or unintended pregnancies.

⁴¹ Ministry of Health ‘National Comprehensive Condom Programming Strategy and Implementation Plan 2017 – 2021 (2017) 17.

⁴² As above at 5.

target groups of the strategy.⁴³ The strategy estimated the male condoms needs of MSM to constitute 1% of the total condom need in the country. The strategy sets targets to increase consistent condom use during high-risk sexual encounters and includes a target to increase condom use for MSMs to 90% (baseline was not known).⁴⁴ The strategy recognises the role and importance of lubricants in HIV prevention, when used alongside condoms. Factors for low use of lubricants are noted to include non-availability, low awareness about them, and low knowledge of their use. The strategy however acknowledges that they have been largely a private sector commodity and therefore expensive; and were only made available in the public sector in 2017 with a batch of about 900,000 units with support from the Global Fund. Lubricants are not on the MOH's essential drugs and supplies list and are therefore not prioritised for procurement. The strategy also notes that there is little information about use of lubricants in Uganda since no studies have yet been conducted.⁴⁵ One of the planned activities is to expand condom and lubricant availability beyond the traditional channels (public health facilities) to non-traditional channels.

The Anti-stigma Policy (2018) calls for provision of HIV and AIDS related services to all that need them without stigma and discrimination.

The National HIV Testing Services Policy and Implementation Guidelines (MOH, 2016) recognise that key populations may not easily access HIV testing services due to a number of constraints including stigma, limited access to testing services, lack of confidentiality and criminalisation of KP sexual behaviours. The policy and guidelines are based on a number of guiding principles that include protection of human rights, the right to dignity (including privacy and confidentiality), the right to access healthcare, and promoting equality for priority populations (including KPs). Specifically, the policy and guidelines state that 'HIV testing services should be made accessible to all persons in Uganda irrespective of race, age, religious or political affiliation, ethnicity, disability, gender, economic or social status, or sexual orientation ...'.⁴⁶ The policy and implementation guidelines put emphasis on what are termed priority populations and states that: 'populations with increased risk of HIV infection, yet have limited access to HIV testing services shall be prioritized'. The policy objective is stated as: 'To ensure that HIV testing services address the specific needs and concerns of priority populations'. It adds that 'HIV testing services shall be designed to address the unique needs of persons categorised as priority populations'. Whereas this policy and guidelines describe key populations as 'high burden / high risk populations', whose HIV prevalence is higher than the average national prevalence, they are listed to consist of sex workers and their clients, long-distance truck drivers, MSM, fisherfolk, boda boda riders and uniformed forces. Other LGBT groups than MSM are not included in the above. This indicates that there is need to demonstrate the HIV burden imposed by LGBT persons if they are to be considered a high burden / priority population category. The HIV testing policy and guidelines recommend that HIV testing services for key populations should be provided through innovative community and facility-based approaches. Community-based approaches are listed to include mobile outreaches, moonlight clinics, and special events in safe environments. They also emphasise the use of peer-led strategies to reach key population groups. The policy and guidelines further state that at facility level, HIV testing services 'should be friendly, confidential, non-judgemental, and convenient for key populations'.⁴⁷ The policy and guidelines further state

⁴³ As above at 19.

⁴⁴ As above at 18.

⁴⁵ n 22 above at 13.

⁴⁶ Ministry of Health 'National HIV Testing Services Policy and Implementation Guidelines' (2016) 30.

⁴⁷ As above at 24.

that in addition to HIV testing services, testing and screening for STIs, TB and viral hepatitis should be offered to key populations as part of the integrated HIV testing services package. They further provide that KP members who test HIV negative should be re-tested every three months. Provisions are also made regarding post-test counselling of KP members. Overall, it can be observed that whereas the HIV testing policy and guidelines are silent about LGBT persons, they provide a favourable framework for providing HIV testing services to KPs in general, and service providers targeting LGBT persons can easily use this framework to reach their target groups.

The Roadmap for HIV Prevention (UAC 2018) which is one of the most recent policy frameworks produced in November 2018 recognises key populations as one of the main sources of new infections in Uganda, and outlines interventions and targets for MSM. Other LGBT categories are not explicitly addressed. For MSM, the roadmap outlines a technical package of services that include: (i) In community settings: community empowerment, HIV testing services, condoms and lubricants; (ii) In facility settings: HIV testing services, PrEP, condoms and lubricants. The roadmap also outlines social-cultural, legal and policy, institutional and workplace, social-economic, as well as health system interventions and enablers, for different population groups including key populations. The details of these are included in Annex 1. Actions to address HIV among KPs are also included amongst the different priority actions under the various strategic areas. Some of the key priority actions outlined include:

- Focusing on key populations, improving case finding and linkage to care.
- Reducing stigma and social discrimination against PLHIV and KPs.
- Mapping of key populations geographically and targeting interventions to mapped hotspots.
- Remove laws, policies and practices hindering fair access to services.⁴⁸

Overall, the HIV Prevention Roadmap is substantially inclusive of interventions that address HIV prevention for key populations, despite the fact that other LGBT groups besides MSM are not explicitly mentioned.

Another important national document where issues for key populations are contained is the **'Training Guide for Health Service Providers to provide Key, Vulnerable and Priority Population-Friendly Health Services in Uganda'** developed by the Ministry of Health.⁴⁹ This training manual is a tool to be used in the training of health service providers to key populations including LGBT persons. The manual recognises different LGBT sub-populations and seeks to make trainees aware of these sub-groups, their sexual behaviors and the attendant risks for HIV infection. The manual also includes an outline of the package of services ideal for key populations (Annex 2). As such, policies that are specific to HIV/AIDS do generally recognise Key Populations and many include MSM in terms of service provision.

2.2.3 Conclusions on the policy framework generally

Most of the reviewed policies do not specifically address LGBT persons, although many address MSM as a part of KP and in relation to the prevention of HIV/AIDS. Nevertheless, it is important

⁴⁸ As above at 21 – 33.

⁴⁹ Ministry of Health 'Training Guide for Health Service Providers to provide Key, Vulnerable and Priority Population-Friendly Health Services in Uganda' Draft, May 2018.

that services should be provided to all on the basis of fairness, without discrimination. This is also noted by key informants who underscore that the existing policies are inclusive as they advocate for equity in access for everyone though they may not specifically mention LGBT persons. This is also the same approach adopted by the Constitution of the Republic of Uganda which provides in Article 21 the right to equality and non-discrimination including on grounds of sex, race, colour, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability.

Well, in the Constitution, there is an article which talks about not discriminating people. Otherwise, I think all the other provisions are of a generic nature. In fact, it's on the service level where we try to ensure that the needs of specific population groups are taken care of. However, at the policy level, all people are treated equally without discrimination (Key informant, SRHR CSO).

This review has not identified any provision in the policies and guidelines of Uganda that explicitly prohibits the provision of sexual and reproductive health services to LGBT persons.

It is evident that the challenge to providing accessible and quality SRHR/HIV and AIDS services to LGBT persons lies less with the policy framework and more with the legal framework including the criminalisation of same-sex relations, and the provision in the HIV Prevention and Control Act, 2014 which provides for mandatory disclosure of one's HIV status: an issue that risks escalating stigma and discrimination associated with seeking HIV/AIDS services. In addition, other provisions such as those in the Penal Code Act instil a sense of fear not only among LGBT persons to seek services, but also among the providers of these services. Key informants agree that the existence of laws that for instance criminalise same-sex behaviour affect care-seeking behaviour of the key population groups. Such laws have the effect of driving key population groups underground. They create fear among service providers who do not want to be seen or assumed to be promoting prohibited behaviour. Because of that fear, some service providers may choose not to provide services to key population groups such as MSM. Accordingly, it was noted that there is need to create an environment in which both the key populations and the service providers feel secure to seek and provide services.

Nevertheless, there is recognition among several key informants that compared to the laws, the policies relating to access to SRHR / HIV and AIDS services for LGBT persons have been progressive. Indeed, it was noted that the new guidelines for example on HIV, such as the HIV testing policy and guidelines, have some provisions on how to handle key populations. It was also noted that the MOH, through its various policies is very clear on issues of stigma and discrimination and provides that health services must be provided to all without discrimination.

All health policies I think even when you talk about SRHR guidelines, Health Sector Development Plan, they recognise that Uganda is diverse and there are different persons, different people with different sexual intentions and they recognise that everyone has access to services and government needs to provide services for such individuals. The policies are progressive compared to the laws because policies are drafted by technical people who understand the dynamics of such people and they recognise evidence based on science and recommendations of technical people but when you go back to law and practice, that's when the challenge comes in (Key Informant, Human Rights CSO).

The silence about key populations in most policy frameworks reflects the unsupportive policy environment regarding key population groups in Uganda. However, it must also be seen as an indicator of a very narrow conceptualisation of gender as consisting of only the binary categories, 'male and 'female' as well as a narrow understanding of sexuality and sexual behaviour consisting only of male to female and female to male attraction (heteronormativity). It could also reflect the moral beliefs of the authors of these documents – who believe that by explicitly stating the key populations to be targeted in policy frameworks, they will indirectly be promoting their sexual behaviours. Focus on key populations in policy frameworks can also lead to accusations of promotion of same-sex behaviours, which policy-makers may want to avoid.

Some of the Ministry of Health's efforts to resolve the apparent confusion/contradictions arising from restrictive laws and the effect of health service provision to KPs was the writing of a letter by the Director General of Health Services in the Ministry of Health in April 2014 entitled 'Non-discrimination of patients during health care service delivery'. This letter was addressed to all hospital Directors for national and regional referral hospitals, all District Health Officers, Medical Superintendents, Health Facility In-charges, ART clinic In-charges, Antenatal care clinic In-charges, and implementing partners. The letter reiterated the Ministry of Health's commitment to achieve the aims of the National HIV Prevention Strategy 2011 – 2015. The letter then reminded all health care service providers '(i) not to discriminate against any individual who seeks health care, (ii) to maintain maximum confidentiality of all patient information during service delivery, (iii) to disclose information only to authorized persons and if disclosure will improve patient care and treatment'.⁵⁰

The DG's letter was followed by a Ministerial Directive issued in June 2014, which also called for non-discrimination in the provision of health services. The Minister, through this Directive, re-affirmed the rights of all Ugandans including minority groups to access health services; and government's commitment to provide health services to all based on the principles of inclusion, non-discrimination, privacy and confidentiality, and accountability and transparency.⁵¹

The DG's letter and the Ministerial Directive were issued in the wake of the passing of the Anti-homosexuality Bill 2014 into law, and the subsequent sentiments among different sections of the community which fuelled interpretations that service providers were not supposed to provide services to homosexuals because they were criminals. Health workers hesitate/refrain from providing health services to homosexuals in fear of that being interpreted to amount to 'abetting criminality'. The Anti-homosexuality Act had the potential impact to negatively affect the right of sexual and gender minorities to access health services. Ultimately, the enactment of the Anti-homosexuality Act was feared to affect Uganda's progress in fighting HIV and AIDS, if for instance sections of the population known to have high HIV prevalence rates were denied access to services.

The DG's letter and the Ministerial Directive re-affirmed the Ministry's position about providing health services to all without discrimination, which potentially could improve provision of and access to services by marginalised groups such as LGBT.

⁵⁰ Letter written by JR Aceng, the Director General of Health Services, Ministry of Health 'Non-discrimination of patients during healthcare service delivery' (2014).

⁵¹ Ministry of Health 'Ministerial Directive on Access to Health Services without Discrimination' (2014) 4.

Overall therefore, Uganda has a mix of policies that provide for key populations, and those that are silent about key populations. It is noted that most of the recent policies address issues affecting key populations. However it is problematic that LGBT persons are mentioned only in relation to HIV and AIDS prevention and their identity as a main driver of the spread of the virus. LGBT persons' access to SRHR services are not addressed apart from HIV/AIDS and their specific needs in this regard are not recognised at all. Even where key populations are recognised, however, there is a widespread tendency to focus on MSM while other groups are not explicitly mentioned. A key respondent from an organisation focusing on Lesbian, Bisexual and Queer women commented that:

I don't think there are policies that target us as the LBQ but there are those that generally favor us as women or girls but not directly favoring us as the Women who have Sex with Women. For HIV, there are policies that favor MSM and the transgender but not us as LBQ. There are some that target girls and women as a sex but not addressing the LBQ needs (Key Informant, CSO)

Ministry of Health officials argue that policies are supposed to remain broad and do not have to mention all the details that they address:

When we are formulating policies, we address issues broadly at the strategic level. We do not have to go into all the details. Policies are supposed to be broad enough to accommodate all relevant issues (Key Informant, MOH).

MOH officials also argued that even if the term 'LGBT' is not mentioned in policies, often the services that address the needs of this group are provided for in the policies since such services offered to the general population are similar to the services needed by KPs. Other stakeholders, however, expressed concern that issues that are not explicit in policies can easily be ignored, forgotten or deliberately excluded when it comes to implementation.

2.3 Comparison of SRHR / HIV and AIDS policy frameworks from Uganda and other African jurisdictions

Besides reviewing the national policy frameworks on access to SRHR / HIV and AIDS services for LGBT persons in Uganda, this study also reviewed and compared with policy frameworks from South Africa, a country that has managed to go beyond negative societal attitudes against LGBT persons to enhance protection, as well as with Rwanda and Malawi – and the East African Community block.

It is noted from the discussion on the previous sub-section that Ugandan policies, while they make assertions against discrimination, do not explicitly mention sexual orientation and/or gender identity as grounds against which discrimination should be prohibited. South Africa is known to have one of the most progressive Constitutions in the world with regard to protection of sexual and gender minorities. As far back as 1996, South Africa was one of the first countries in the world to include in its constitution the prohibition of discrimination on the basis of sex, gender and sexual orientation. South African laws also allow emancipation of sexual and gender minorities, by for instance allowing people to apply for legal adjustment of one's sex description without having to undergo reassignment surgery.⁵² South Africa is also

⁵² Alteration of Sex Description and Sex Status Act 49 of 2003. Section 2(1).

among the few countries in the world that allow the sex category 'X' on passports in addition to the options of 'M' and 'F'.⁵³

In light of this enabling legislative environment, South Africa's NSP 2017-2022 has a specific focus on key populations. Goal No.3 of the NSP is to 'Reach all key and vulnerable populations with customised and targeted interventions'. The NSP clearly identifies sexual and gender minorities among the key populations to be targeted with tailored HIV interventions. For instance, it lists transgender people and MSM among the key populations for HIV and STI control; and lists other LGBT populations among the vulnerable populations targeted for HIV and STI control.

South Africa's NSP also lists an inclusive package of services for all key and vulnerable populations that is to be customised to the age and population served. The package consists of the following services:⁵⁴

- Service delivery in non-traditional settings, including after-hours and weekends
- Health information customised to client needs
- Sexual and reproductive health services
- HIV screening, testing and treatment
- STI screening and treatment
- TB screening, treatment (including preventive therapy) & contact tracing for DS – and Dr – TB
- Mental health screening and psycho-social support
- Access to PEP and post sexual-assault support
- Alcohol and drug use screening and referral to harm reduction services
- Violence screening and referral to psycho-social and other support services
- Condom and lubricant promotion and provision
- Targeted social and behaviour change communication
- Core rights-based programme components:
 - Human rights and constitutional protection
 - Health empowerment
 - Economic empowerment
 - Gender norms and equality
 - Justice
 - Principles of universal design and accommodation that enables reasonable access for persons with disabilities

Population-specific additions to the inclusive package of services described above

Men who have sex with men

- Peer-led outreach
- PrEP
- Lubricant, condom options
- Hepatitis B screening and immunization
- Rectal care and treatment

⁵³ United Nations Development Programme 'Intersex Research Study 2017' (2018) 22.

⁵⁴ South African National AIDS Council 'National Strategic Plan on HIV, TB and STIs 2017-2020' (2016) 66.

Transgender persons

- Peer-led outreach
- Specialized counselling support
- PrEP
- Female condoms and lubricants
- Rectal care and treatment

Other LGBT populations

- Peer-led outreach
- Empowerment programmes including skills building, ABET, and facilities of post-school training and employment.
- Enhanced programmes for legal and counselling support

Prior to the adoption of this plan, the South African government was already providing a few specialised health and social services focusing on LGBT people. Several community-based organisations (CBOs) had established programmes to fill this gap, working closely with government. These partnerships between the South African government and civil society ensure equitable services to LGBT people and the NSP was expected to further strengthen and scale up the partnerships.

As can be noted from the above, although some Ugandan policy frameworks endeavour to outline services targeting key populations, the South African NSP clearly outlines additional services for LGBT persons which the Ugandan policies lack.

South Africa developed a National LGBT HIV Plan 2017-2022 in response to the global call to reach key and vulnerable populations with targeted interventions, and in support of its National Strategic Plan for HIV, TB and STIs 2017-2022. The National LGBT HIV Plan was developed under the leadership of the Multi-sectoral LGBT Technical Working Group - made up of various stakeholders, including government, LGBT organisations, experts of LGBT programming, development partners and CSOs - coordinated by the South Africa National AIDS Council (SANAC) Secretariat. The plan provides for a standardised minimum package of services to be implemented by all sectors within and outside government.

The goal of the South African National LGBT HIV Framework is to provide consolidated guidance to reverse the burden of disease from HIV, STIs and TB and to promote a rights - and evidence-based environment for LGBT people in South Africa. The plan is based on a number of guiding principles including community-led, rights-based, evidence-based, and multi-sectoral programming. The Plan outlines five interlinked service packages, namely, health, empowerment, psychosocial support, human rights, and evaluation. It also endorses the provision of PrEP for HIV negative MSM including gay and bisexual men and Universal Test and Treat (UTT) for all LGBT persons. The plan sets five-year objectives and targets as shown in Annex 3.

The plan discusses issues affecting the access to and utilisation of HIV services by LGBT persons, including health care worker attitudes, health care worker knowledge of LGBT issues, targeting and scope of health programmes; and recommends various options for improving access to services for LGBT persons, including use of community-based outreaches and a peer-led approach.

The plan also outlines the package of services to be delivered to different LGBT sub-populations as shown in Table 2 below:

Table 2: Service Packages in South Africa's LGBT HIV Plan⁵⁵

LGBT Sub-population

Package of Services

A: All LGBT (Core health package)

- Peer-led outreach
- Clinic based services
- Condoms and condom-compatible lubricant
- HIV, STI and TB screening, prevention, care and treatment
- SRH services
- Laboratory services

B: Women who have Sex with Women (WSW) – (additional services to the above)

- Research on STI and HIV transmission
- Dental dams, finger cots, and other prevention commodities
- HIV education to debunk myths on lack of HIV transmission risk
- Family planning
- PAP smears
- PMTCT
- Mammograms

C: MSM – (additional services to A above)

- PrEP and universal test and treat (UTT)
- Rectal care and treatment
- Screening for viral hepatitis

D: Trans* - (additional services to A above)

- PrEP and UTT
- Referral for surgery
- Family planning
- PAP smears
- PMTCT
- Mammograms
- Rectal care and treatment
- Screening for viral hepatitis

⁵⁵ South African National AIDS Council 'South African National LGBT HIV Plan 2017-2022' (2016) 8.

The plan also outlines the package of services under the other service package areas (empowerment, human rights, psycho-social support and evaluation).

Besides South Africa, Malawi which also criminalises same-sex conduct also protects LGBT persons. For instance the Malawian National Sexual and Reproductive Health and Rights (SRHR) Policy states that ‘all the people of Malawi shall have access to health services without distinction of ethnicity, gender, age, disability, **sexual orientation**, mental and health status, religion, political belief, economic, socio-cultural condition or geographical location.’⁵⁶

For Rwanda, which does not expressly criminalise same-sex relations, but where attitudes are also generally not supportive, the Adolescent Sexual Reproductive Health and Rights Policy recognises that adolescents are a heterogeneous group of people and therefore aims to address the unique needs of various groups of adolescents and young people. Specifically, the policy refers to marginalised groups including Gay-Lesbian-Transgender (GLTBs) that need to be targeted.⁵⁷ As a result, Rwanda’s National HIV and AIDS Strategic Plan (2013-2018) put in place deliberate interventions intended to reduce the burden of the disease among key populations including men who have Sex with Men (MOH Rwanda, 2013).⁵⁸

The East African Community (EAC), the regional body that integrates countries in the East African region has also formulated an HIV and AIDS Act (2012)⁵⁹ and a number of policies and frameworks on HIV and AIDS. A bill on sexual and reproductive health rights has also been formulated and is under discussion.⁶⁰ The EAC HIV and AIDS Act prohibits compulsory testing for HIV (Article 21), discrimination in health institutions (Article 31), and provides for the protection of vulnerable groups and most-at-risk populations (Articles 33-39). The policies and strategic frameworks of the EAC on HIV and AIDS also recognise key populations and specifically single out MSM as a KP sub-group to be targeted by regional interventions.

2.4 Conclusion

The policy framework of Uganda on SRHR as well as on HIV/AIDS generally leaves a lot to be desired as regards LGBT inclusion. Whereas effort has been made to specifically include MSM within a number of the policies, this does not apply to all, thus sending mixed signals. The comparison to South Africa shows how policies can be done more progressively when there are more enabling laws. However, the disabling legal framework should not be forgotten because policies have to align with the laws, and thus may not go contrary to the position of the law. However, there is a line between aiding and abetting the commission of the offence of ‘carnal knowledge against the order of nature’ and providing SRHR/HIV/AIDS services for LGBT persons. South Africa perhaps has a more enabling policy environment because the laws are also enabling. Nevertheless, Malawi with an almost similar legal regime as Uganda has shown that protection can be done even with criminal laws. As such the criminal laws remain largely excuses.

⁵⁶ Ministry of Health (Malawi) ‘National Sexual and Reproductive Health and Rights (SRHR) Policy’ (2017) 20.

⁵⁷ Ministry of Health (Rwanda) ‘Adolescent Sexual Reproductive Health and Rights Policy’ (2012) 13, 19.

⁵⁸ Ministry of Health (Rwanda) ‘Rwanda HIV and AIDS National Strategic Plan 2013 – 2018’ (2013) 27.

⁵⁹ The East African Community HIV and AIDS Prevention and Management Act 2012.

⁶⁰ The East African Community Sexual and Reproductive Health Rights Bill, 2017.

3 PUTTING POLICIES INTO PRACTICE: ACCESS TO SRHR/HIV AND AIDS SERVICES BY LGBT PERSONS IN UGANDA

3.1 Introduction

This section examines the day to day realities of LGBT persons when they seek Sexual and Reproductive Health and Rights (SRHR) services in Uganda.

3.2 Availability of Sexual and Reproductive Health and Rights services for LGBT persons in Uganda

Health services in Uganda are provided in a variety of settings including facility-based as well as community-based settings; public as well as private and private-not-for-profit (PNFP) facilities. The public health services are provided through a hierarchy of facilities ranging from national referral hospitals, to regional referral hospitals, general and district hospitals, mini-hospitals referred at Health Centre IV, Health Centre IIIs, and Health Centres II. Services at community level are provided through a network of volunteer community health workers known as Village Health Teams (VHTs).⁶¹ Private and PNFP services also operate at different levels ranging from hospitals to clinics and community based services. HIV and SRH services are also widely provided through specialised clinics run by government, NGOs, donor-funded projects or various forms of partnerships involving public and private actors.

This study found that the provision of SRHR/HIV and AIDS services that are friendly or suited to the needs of LGBT persons in Uganda has improved in recent years. There are specialised clinics that target key populations including LGBT persons, and these include Most at Risk Populations (MARPI)⁶² clinic and Reach Out Mbuya. Some civil society organisations (CSOs) for example Freedom and Roam Uganda (FARUG) and Ice Breakers Uganda (IBU) also have mini clinics. Another clinic, Alive Medical Services, in Namuwongo also provides services to KPs.

MARPI, for instance, reported that they provide a comprehensive package of services that includes general HIV information and education, comprehensive HIV counselling and testing, HIV care and treatment, STI treatment and screening, provision of condoms and other contraceptives, gender-based violence services including support for rape survivors. They also provide PEP and PrEP, TB and cervical cancer screening and safe male circumcision, and referral for the services they may not have. They also provide proctology services, which are services or examinations for people that may have anal pathologies.

A key development in the SRHR/HIV and AIDS landscape for key populations in the last three years is the expansion of the MARPI to cover all the 12 regional referral hospitals, 23 district hospitals (with drop-in centres) and other outlets (mainly supported by donor-funded projects including SUSTAIN URC, RHITES, Global Fund, IDI, and Baylor Uganda). This expansion has included training health workers in providing KP-friendly SRHR/HIV and AIDS services

⁶¹ The policy on VHTs is under transition, and they will be replaced by Community Health Extension Workers (CHEWs).

⁶² Most at Risk Populations Initiative.

to key populations, sensitising local leaders, sensitising law enforcement agencies (police, prisons and district security officials), sensitising managers of hotels, brothels and other entertainment places, and peer-led community dialogues. The Ministry of Health (MOH) has developed a training manual in order to standardise training of health workers in different sites. The manual includes modules on introduction to key populations, stigma and discrimination, gender-based violence facing KPs, the legal and policy environment affecting KPs, package of services for KPs, and monitoring and evaluating services for KPs.⁶³ Implementing partners are also required to work with local CSOs and as a result, there is increasing involvement of local organisations.

Even among members of the LGBT community interviewed in this study, there is a recognition that there has been some progress not only in terms of expanding the range of service providers available, but also in terms of capacity building through in-service training to ensure that the services are friendly to the needs of LGBT persons.

They are well trained and they have enough skills Even most of the doctors have approached us and they want to attend our meetings to learn and know how to deal with complications and treat several diseases affecting MSM. Some of them have worked with public health facilities. There's a project of UHMG that helped on 21 health facilities to work out by providing these services (FGD, Men who have Sex with Men).

It has been easy because we have trained some health workers and oriented them on how to deal with stigma (FGD, Men who have Sex with Men).

MARPI in particular was pointed out for its friendly services:

... at MARPI it's very easy than elsewhere because they know about us and they know that we are in existence. ... I usually go to MARPI Mulago and they are friendly and they do not ask much about partners (FGD, Women who have Sex with Women).

On the other hand, it was argued by some key informants that the SRHR/HIV and AIDS services needed by LGBT persons are not very different from those needed by the general population, and therefore the existing SRHR/HIV and AIDS services to a large extent already cover the needs of LGBT persons.⁶⁴

3.2.1 Facilitative factors in the provision of SRHR / HIV and AIDS services to LGBT

Study participants from the LGBT community acknowledged the improvements in SRHR / HIV and AIDS services available to them. They were able to point out where services have been good and where they have been able to access the needed services. The factors that have enabled greater access to services include the following:

a) Availability of friendly services

Study participants commended the facilities where KP-friendly services have been established and health workers trained.

⁶³ Ministry of Health 'Training Guide for Health Service Providers to provide Key, Vulnerable and Priority Population-Friendly Health Services in Uganda' Draft, May 2018.

⁶⁴ Key Informant, MOH.

In XXX HC IV, there is always someone who works on the LGBT persons. Normally, there is a peer who identifies you and takes you straight to the health worker. The only challenge is that, these peers never work on a daily basis. And the health worker cannot work on you without the peer (FGD, Transgender, Kampala).

You don't have to disclose your sexual orientation because by the time you go to the health facility you know someone you are going to meet and the one to welcome you. So you go when you have a focal person to meet you (FGD, Women who have Sex with Women).

b) Linkages and referral systems

Others are pleased that they were referred to other places if the services they needed were not readily available.

According to where we were in 2010, there's a great improvement in accessibility, and we have cards that we give that our patients take along with them to be able to get treatment quickly and for easy identification (FGD, Men who have Sex with Men).

c) Partner support

Others benefit from the support of their partners to access SRHR services. Partners give information and encouragement.

When I did an HIV test for the very first time, I was motivated by my partner because before I had never tested and I used to be so confident that I am negative without a test. So if at all I didn't get her, I wouldn't have tested and I would still be there with a biased mind (FGD, Women who have Sex with Women).

d) Relative liberalism in urban centres

The anonymity offered by the urban setting was also hailed as an enabling factor to service utilisation.

There's an advantage for us here in town because culture is not so much considered but in villages culture is much respected and people lack information. Homophobia is much in the villages and we request them to be helped out, be sensitised (FGD, Women who have Sex with Women).

e) Increased self-efficacy

It was noted that over time the trainings given to members of the LGBT community have improved their self-efficacy, which has enabled them to seek services.

We teach the LGBT members how to deal with personal stigma. We train them on how to erase stigma out of them. We have conducted orientations and trained some health workers how to deal with stigma and we also have focal persons and by the time someone goes to the health facility, they know someone to meet and eagerly awaiting to work on them (FGD, Men who have Sex with Men).

f) Strong advocacy from the KP CSOs fraternity

Study participants also noted that provision of services to key populations has largely been enabled by the strong advocacy activities from the human rights and KP-focused CSOs. These organisations have been at the forefront of demanding for a non-discriminative and all inclusive environment for the provision of health services to all. They have advocated for the procurement of condoms and lubricants, training of health workers, and expansion of specialised clinics that attend to the needs of key populations. They have also challenged legislation and acts that violate the rights of key populations, such as acts of police brutality.

g) The Director General of Health Services' Letter of 2014 on Non-Discrimination in provision of healthcare services and the Ministerial Directive on Non Discrimination

The impetus to provide SRHR/HIV and AIDS services to KPs on a wider scale over the recent years has been provided by the letter written by the Director General of Health Services in the Ministry of Health in April 2014 on non-discrimination of patients during healthcare service delivery already referred to in sub-section 3.2 on national policy frameworks.⁶⁵ Study participants reported that this letter helped to clear the air about the Ministry's position with regard to providing health services to KPs. The letter, it was argued, gave reassurance to service providers that providing services to KPs was not against the law, and was sanctioned by the government. It also gave some level of confidence to KPs, including LGBT persons, to seek health services, wellknowing that the Ministry was on their side.

The DG's letter was issued shortly after followed by the Ministerial Directive in June 2014, which also called for non-discrimination in the provision of health services. The Minister through his directive re-affirmed the rights of all Ugandans including minority groups to access health services; and government's commitment to provide health services to all based on the principles of inclusion, non-discrimination, privacy and confidentiality, and accountability and transparency.⁶⁶

The DG's letter and the Ministerial Directive were issued in the wake of the passing of the Anti-homosexuality Bill 2014 into law, and the subsequent sentiments among different sections of the community which fuelled interpretations that service providers were not supposed to provide services to homosexuals because they were criminals. Health workers hesitate/refrain from providing health services to homosexuals in fear in being interpreted to be abetting criminality. The Anti-homosexuality Act had the potential impact to negatively affect the right of sexual and gender minorities to access health services. Ultimately, the enactment of the Anti-homosexuality Act was feared to affect Uganda's progress in fighting HIV and AIDS, if for instance sections of the population known to have high HIV prevalence rates were denied access to services.

3.2.2 Implementation gaps and barriers that hinder service access for LGBT persons in Uganda

The provision of and access to SRHR / HIV and AIDS services by LGBT persons is characterised by some challenges. While a review of the key policies and guidelines relating to the provision of sexual and reproductive health services in Uganda does not reveal any expressly prohibitive provisions towards LGBT persons, the framework is not necessarily favourable. Hence the review has identified gaps and limitations that constitute a barrier to access to SRHR/HIV and AIDS services for LGBT persons, as identified below:

⁶⁵ Aceng, n 30 above.

⁶⁶ Ministry of Health 'Ministerial Directive on Access to Health Services without Discrimination' (2014) 4.

a) Lack of awareness about LGBT issues

First, key informants reported that there is lack of awareness amongst both the LGBT persons themselves as well as amongst health service providers regarding the sexual and reproductive health needs of LGBT persons. For instance, it was argued that transgender persons themselves may not know what exact services suit their situation and do not know what to demand from the health care providers. Similarly, health care providers are not well informed about the health needs of transgender people. They do not know what it means to be a transgender woman; they do not know the health needs of the transwomen. Transgender people sometimes lack information about their rights, while others do not know where they can even access SRHR/HIV and AIDS services.

b) Social stigma and negative attitudes

In addition, the sociocultural environment within which these services are provided is laden with negative attitudes and perceptions towards LGBT persons, thus hindering not only access to and utilisation of SRHR/HIV and AIDS services by LGBT persons, but also service providers' preparedness to provide the needed services as underlined by one of the key informants in this study:

... they [stakeholders, LGBT persons] think that the law stops people [LGBT] from accessing services. But the law does not stop anyone from going to any facility and accessing services but that is because they do not have information. But even the providers themselves think that the law stops them from providing services which is not true. So, the other people fear to come because they fear the law, but even these ones who should have been providing services also fear the law (Key Informant, Key Populations Specialised Clinic).

Therefore, it is apparent that such an environment is fuelled by widespread but mistaken perceptions that the law prohibits the provision of services to LGBT persons.

Nevertheless, there has not been sufficient effort especially on the part of the government to dispel such beliefs and perceptions in order to give LGBT persons in the country the confidence to seek services without fear of reprehension. The bulk of work in relation to this is being undertaken by non-state actors, most of which perceive that the law prohibits them from providing services and therefore continue to operate in fear as emphasised by the key informant cited above.

In addition, study participants pointed to widespread incidents of stigma experienced within health care settings. Such stigma comes from health workers either due to lack of experience in handling LGBT persons or lack of appropriate training and skills.

When you go to the health facility and you are in our age they first ask you whether you are sexually active and whichever answer you give, they ask to first do a pregnancy test on you. That's not comfortable with me because I know I cannot be pregnant (FGD, women who have sex with women).

Even some counsellors are of poor conduct because you have a problem and you go to visit a counsellor. Instead of him/her advising you like a counsellor he starts convincing and judging you like why can't you leave this habit and character of homosexuality and go and get married. You see the person discouraging you instead of giving you counselling (FGD, women who have sex with women).

In other cases, health workers are quick to attach gender labels to clients calling them men or women, when in actual sense the client may be self-identifying differently. LGBT persons who are labelled contrary to their self-identity may find it hard to seek services from such providers.

They once did that to me and I felt so small. They were calling me a man because I had short hair and they were accusing me of cutting short hair. ... and that was stigmatising (FGD, Women who have Sex with Women).

Poor attitudes and stigma were found not to be restricted to health workers but to other service providers such as the police.

I even sometimes wonder how I can go to the police and tell them that I was raped because they are themselves going to flirt with me that they were right to rape me because I was dressed like men. So I get worried about the ethical conduct of certain civil servants (FGD, women who have sex with women).

The experiences of stigma and discrimination amongst LGBT persons were in turn found to be instilling a sense of fear or internalised stigma among the LGBT persons, which itself constrains their readiness to seek health services.

Fear is still there amongst us. Like of recent a friend of mine was asking me that "how can I go and ask the doctor health services and in explanation I tell them that I am a transgender?" She proved to be in fear of disclosing her sexuality (FGD, Women who have Sex with Women).

Other informants argued that previous experiences of LGBT persons with the negative attitudes of health workers and the stigma that is associated with being different from the 'norm', can constrain seeking appropriate care, as one informant argues below:

If you have money you can go to private clinics but you are stigmatised from there. That is why we go to MARPI because they know we are transgender and know our illness. You can go with the boil in the anus and they will not ask why you have it there. But other facilities would want to know how you got [a] wound in your anus and this makes us so uncomfortable (FGD with transgender persons, Kampala).

Transgender women fail to access SRHR services at some health facilities. Like when one transgender woman comes and she fails to introduce herself properly. In most cases they have to disguise as either male or female. You can't even express yourself here in Uganda that you are different, it's not allowed. So as a transgender woman one has to hide, you can't express yourself, you can't introduce yourself freely and at the end of the day you fail to get the rightful service because you may have anal warts and you fail to disclose it to a health provider because she will start asking how you got them, so due to that many of them do not speak out (Key Informant, LGBT Organization).

Gaps were also noted to exist in terms of the capacity to provide services to LGBT persons without stigma and without being influenced by individual prejudices.

The biggest gap to providing services to these people is in the capacity i.e. making all the duty bearers to appreciate that despite their own values, cultures, beliefs and religion, they should not in any way discriminate key populations (Key Informant, MOH).

Responses from the LGBT members thus reveal a level of internalised stigma, whereby they feel they will be stigmatised if they go out to seek services or if they provide information about themselves.

c) Inadequate number of health workers trained in providing KP-friendly services

Even in health facilities where some health workers have been trained to provide KP-friendly services, the common practice has been to train one or a few health workers. This often leaves the majority of the health workers unlikely to provide friendly services to sexual and gender minorities as one key informant observed.

We have certain friendly health providers but we only have like one contact person in the whole facility so when you enter they start rumoring that the people of so and so have come and you're given like labels which creates stigma (Key Informant, LGBT Organisation).

In some cases, health workers who have been trained to provide KP-friendly services have been transferred elsewhere, leaving a gap in the provision of friendly services. This is common in health facilities where only one or a few health workers had been oriented to provide KP-friendly services.

Some health workers are given transfer like those in public health facilities are given transfers and we fail to trace or access them sometimes which becomes a problem for us (FGD, men who have sex with men).

d) Service procedures and arrangements

Study participants also reported that some of the procedures used at service delivery points are not conducive to the LGBT persons. These include requirements to come with sexual partners, and inadequate attention to privacy and confidentiality. These are illustrated by the voices from study participants.

If it's HIV, they ask you to come with a partner and that's not possible for us to go with our lesbian partners. So what I do is just to go and look for a male friend and walk with him to the facility (FGD, women who have sex with women).

If they asked me to go with a partner, I would not go with a partner because I know they're going to create stigma to me (FGD, women who have sex with women).

The challenge on accessibility is that in government health facilities there's what we call triage where the health workers ask patients to publicly say their diseases. That's where someone gets a problem in saying a certain disease like anal warts (FGD, men who have sex with men).

e) Lack of the needed services

Other challenges were also pointed out with regard to the range of services available and the lack of certain aspects of the minimum package that is essential for LGBT persons.

Some health facilities don't have the needed necessary minimum package in that they don't even have lubricants (FGD, Men who have Sex with Men)

In Mulago they introduced those services [in-vitro fertilisation] but it's very expensive because I heard that to do fertility it's almost 14 million. So I suggest that they should reduce on the prices because I would like to have a child without doing the natural sex but I can't afford that money. (FGD, Women who have Sex with Women)

... the problem is that lubricants have been restricted so much and they're no longer easy to access. Female condoms are there but they are not user-friendly and that's why even most of the times women who have sex with men rely on men to put on male condoms because the female ones aren't user-friendly. Dental dams are also not user-friendly and not even accessible (FGD, Women who have Sex with Women).

LGBT persons have specific services that they require like the hormonal replacements and other services that help them enjoy their rights, things that identify their gender are not available locally and they are not well regulated, the prices are a bit high and many of individuals have to rely on donors to be able to receive these services. ... They just provide curative and preventive services but they don't provide other physiological and physical services that these persons may need (Key Informant, Human Rights CSO).

f) Limited service spread-out

It was also noted that the existing friendly services are still concentrated around Kampala, and have only recently spread to major towns where Regional Referral Hospitals are located. There is however still a challenge in getting similar services outside the major towns.

Certain people who have challenges to access them like someone is in Hoima and he cannot access the needed health services which are here in Kampala. You find someone in Gayaza but they can't access services because they do not have transport. Then we also use peer to peer approach (FGD, men who have sex with men).

g) Inadequate equipment and infrastructure

There is also a challenge of equipment and infrastructure such as examination and treatment rooms. Key informants reported that some of the equipment and technologies needed to address the SRHR needs of LGBT persons, such as proctology services are only found in MARPI Mulago. This limits the scope of services that can be provided to LGBT persons.

Well, to manage a problem that manifest in the anal areas, you need some special capacity and equipment which may not be available in other facilities, but for us here, we are able to provide these services because we have the needed facilities and equipment (Key Informant, Key Populations Specialised Clinic)

h) Budgeting and coordination issues

Another policy implementation gap has to do with issues of budgeting and coordination of SRH service provision.

Some of the challenges include the issue of budgeting where for instance these people

tell you that they do not have funds to specifically target or implement services for LGBT persons. You know, they always talk about progressive realisation which in a sense stifles implementation until such time when resources are available and yet they seem to never get available (Key Informant, SRHR CSO).

Inadequate budgets affect the procurement of commodities necessary to provide appropriate services to LGBT persons. One such aspect of sexual and reproductive health services specifically for LGBT persons that has been affected by budget constraints is lubricants. This study found that the first and only consignment of lubricants was purchased in 2016/2017 and many of the LGBT persons interviewed expressed concern over limited availability of lubricants.

The other challenge we have been having is the low stock of lubricants in the country. And mind you, even simply being heard talking about lubricants literally implies that we are supporting LGBT persons and yet for us we know that these lubes can even be used by other people such as sex workers or those who meet clients that use that passage. We as a country first purchased lubricants with support from Global Fund in 2016. That consignment contained 1,000,000 sachets of lubricants. I know that we were supposed to place another order, but I do not know how far we have gone with that. However as of now, we only have a few lubricants in stock (Key Informant, MOH).

In relation to the above, key informants also cited challenges related to coordination of SRHR/HIV and AIDS issues between the various stakeholders in particularly the government ministries responsible not only for policy formulation, but also coordinating the implementation, monitoring and evaluation of interventions.

The other issue is that of coordination for instance inter-ministerial coordination - who takes the core responsibility for some of these policies such as the school health policy or that sexuality framework. Normally, you find that there is conflict between the various ministries such as Education, Health and Gender on who to spearhead the development and implementation of the policy and guidelines and what the role of each will be (Key Informant, SRHR CSO).

i) Limited information and evidence

This study has also identified limited information as a key gap that limits access to sexual and reproductive health services for LGBT persons. Many LGBT persons lack information on the available services and where to access them.

I think that information is much needed. If you enter the health facility asking for information about the LBQ you cannot access or get it like the way you can access information on the women generally. Information on how someone can have children without having the natural sex with a man is not available (Key informant, LGBT Organisation).

Related to the above, this study has also identified that there is lack of evidence among stakeholders including service providers and policy makers on various LGBT issues such as number of LGBT persons, HIV prevalence among LGBT persons, their sexual practices, how these expose them to risks such as HIV infection and therefore the kind of services they need as well as the policies and guidelines to regulate the provision of these services.

It was argued by key informants from the CSOs working with LGBT persons that the gaps in data concerning LGBT persons are due to non-inclusion of specific monitoring indicators in the data collection tools of the MOH such as the Client Register Book to capture LGBT-relevant aspects. For instance, clients have to register in this book as either male or female, and there is no provision for transgender or other. As a result, transgender people are forced to register as either male or female. This means that it is not possible to tell from such records and the resulting data, how many transgender persons have sought for services, how many have been served and what type of services they have received. Consequently, there is no data on transgender people, that could have been useful even for planning and advocacy purposes.

When it comes to statistics, they [MOH and implementers] do not have the information about the LBQs and the bad thing is that we have tried to collect some data, we provide them with that information but they never acknowledge it. They just keep on challenging us with fake questions like how do the lesbians have sex and that what kind of sex do we have and then how does that kind of sex put us at a risk of being in need of the SRH services. ... This [absence of data on LGBT people] brings a gap because there is no collected data that can be used to defend the health rights of LGBT persons or the health rights of the transgender people because when you are advocating for human rights or anything else you have to base on the data captured on the ground (Key Informant, LGBT Organisation).

It was noted that there is also lack of harmonisation and standardisation in the data collection tools used by different implementers and service providers. Some of the tools have been designed to meet specific donor needs and do not align with the MOH tools.

3.3 Other structural barriers to access to SRHR / HIV and AIDS services by LGBT persons

LGBT people need various SRHR and HIV and AIDS services. Currently, they get these services from a number of places such as MARPI Mulago, Mengo Hospital (Contract for Hepatitis B screening), Alive Medical Namuwongo, KCCA health facilities, Mildmay, Life Link Hospital and other private facilities. For general services most LGBT persons feel free to access services from any service provider. Challenges come in instances where they need to seek services for highly sensitive conditions such as anal warts or where they are asked to come with their sexual partners. A number of other structural barriers were identified.

3.3.1 The restrictive legal environment

Study participants decried the restrictive legal environment which treats LGBT persons as criminals by virtue of their sexual identity and orientation. While Ugandan laws prohibit commercial sex and same sex acts; these laws are used to restrict other freedoms of the LGBT community such as freedom of association and freedom of assembly. It was reported that LGBT persons are often arrested by the police under flimsy pretexts such as being idle and disorderly. The law enforcement officials are believed to have the backing of the political leadership in the country.

The political setting in our country is a barrier and it even causes self-stigma. Our existence here is not safe because we are treated like criminals, every time you wake up you wake up in fear and you feel like you're a criminal (FGD, Men who have Sex

with Men).

3.3.2 The political environment

The legal restrictions on LGBT persons are intertwined with unfavourable political sentiments. As demonstrated by the formulation of the annulled Anti-homosexuality Act, the political leadership in Uganda (the presidency, parliament and lower levels of leadership) are openly against same-sex relationships and any other sexual orientations and identities that do not fit into gender stereotypes and the heterosexual norm. Because advocacy for the rights of sexual and gender minorities has been championed by civil society,⁶⁷ government functionaries may also be quick to label advocacy efforts for sexual and gender minorities as leaning in favour of the opposition political camps.

Whenever they attach LGBT issues with any political issue around, it takes us back to zero. For example right now this 'People Power' issue is being attached to LGBT. The more they attach political issues to LGBT, if we have taken 100 steps forward it takes us back to zero because they say that its LGBT people supporting the opposition so they should not be given their rights. The more we give them their rights the more they will support the opposition side (Key Informant, LGBT Organisation).

3.3.3 Cultural and religious barriers

Study participants also identified barriers to service access rooted in cultural and religious beliefs and values. Ugandan society is largely based on patriarchal structures and heteronormative ideas about sex, love and desire. Men and women are culturally expected to play distinct roles and to behave in particular ways. As a result, anybody who behaves contrary to established norms is likely to attract ridicule, stigma and discrimination.

...definitely, because culturally men are supposed to behave like men and women are supposed to behave like women, so if one behaves otherwise then they go beyond the cultural values and expectations. Thus you cannot fit in that culture anymore. ... The way the community and culture brings us up if you behave the opposite way then you are considered a curse and you can't fit in the same community thus these LGBT people can't be comfortable with the community that curses them (Key Informant, LGBT Organisation).

Similarly, Uganda is mainly a Christian country with over 85% of the population subscribing to the Christian faiths.⁶⁸ Accordingly, the teachings of the Bible which recognise marriage between a man and a woman are held in high regard by the majority of the people. Acts such as homosexuality are seen as unacceptable in the eyes of God.

About the religious beliefs, basing on the Bible they always tell us that Sodom and Gomorrah were destroyed because of homosexuality, God created a man and a woman so sex should be between a man and a woman not fellow men or fellow women, that sex is supposed to be for procreation not commercial or any other reason. So we are always seen as bad omen (Key Informant, LGBT Organisation).

These structural factors are deep-rooted and are not easy to change. Even with progressive

⁶⁷ Civil society organisations that are involved in governance and rights issues in Uganda are also under tight scrutiny and restriction by government under the pretext that they are fronts for local and international political interests opposed to the ruling regime.

⁶⁸ Uganda Bureau of Statistics 'The National Population and Housing Census 2014 – Main Report' (2016) 19.

policies, their implementation can be rendered difficult if the structural barriers persist.

3.4 Conclusion

Despite policies that are more or less silent about LGBT persons, there has been a marked improvement in the past decade in accessibility to services by LGBT persons. The Ministry of Health has taken the lead in this regard. This has been fuelled by a number of factors, least of which is recognition that LGBT persons, or at least MSM contribute to the continued high HIV prevalence levels and that there providing services for them is likely to reduce the general HIV prevalence rate. Also donors have been supportive of such initiatives, and now initiatives such as MARPI, a public-private partnership initiative do exist. These services have been noted and commended by LGBT persons themselves. However, there are still a number of challenges mainly arising from the prohibitive legal framework and social-cultural attitudes that are not favourable to LGBT persons. LGBT persons still face stigma and discrimination while accessing SRH services.

4 THE IMPLICATIONS OF THE POLICY AND IMPLEMENTATION GAPS ON THE HUMAN RIGHTS OF LGBT PERSONS AND THE HIV SITUATION IN UGANDA

4.1 Introduction

The policy gaps as well as the challenges in implementation of these policies have a number of implications for the rights of LGBT persons. The rights relevant to LGBT peoples' access to health care including Sexual and Reproductive Health services as well as other related rights are enshrined in various international, regional and national human rights frameworks including the Universal Declaration of Human Rights (1948), the International Covenant on Economic, Social and Cultural Rights (1967), Convention on the Elimination of all Forms of Discrimination Against Women (1979), the African Charter on Human and Peoples' Rights (1981) among others. Another important international human rights instrument that is specific to matters of sexual orientation and gender identity is the Yogyakarta Principles (2006). In full, the Yogyakarta Principles are entitled 'The Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity'. The Yogyakarta Principles identify specific rights and related duties and obligations required of States in order to ensure that LGBT people are able to exercise and enjoy those rights. The following are some of the specific rights relevant to the subject under discussion:

4.1.1 The right to a standard of living adequate for health and wellbeing

Article 25 of the Universal Declaration of Human Rights provides for everyone's right to a standard of living that enables enjoyment of good health through among others, access to medical care and other social services. It states:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, ... (UN General Assembly 1948).

4.1.2 The right to health/Health and reproductive rights

The International Covenant on Economic, Social and Cultural Rights (1967), in its Article 12 provides for the right to health, stated as 'the right of everyone to the enjoyment of the highest standard of physical and mental health.' The steps to be taken by States Parties to realise this right include the 'creation of conditions which would assure to all medical services and medical attention in the event of sickness'. Clearly then, the right to health of LGBT persons cannot be realised if they do not access SRHR and HIV & AIDS services.

In addition, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa is a supplement to the African Charter on Human and Peoples' Rights. The Protocol elaborates health and reproductive rights for women. It states in Article 14 that: 'States Parties shall ensure that the right to health of women including sexual and reproductive health is respected and promoted. This includes:

- a) the right to control their fertility;
- b) the right to decide whether to have children, the number of children and the spacing of children;
- c) the right to choose any method of contraception;
- d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
- e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected by sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
- f) the right to have family planning education.

The Protocol further states that States Parties shall among other things, (a) provide adequate, affordable and accessible health services, including information, education and communication programmes ... (c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. Other international human rights instruments such as the International Covenant on Social, Economic and Cultural Rights also provide for the right to health for all individuals.

It is therefore clear that if LGBT persons do not access SRHR / HIV and AIDS services, they cannot realise the above health and reproductive rights. For instance, if they do not access family planning services, then they cannot regulate their fertility. They cannot decide whether and when to have children, or indeed how to have children. A key issue raised by LGBT study participants was indeed lack of information and advice on how they can have children if they cannot get them through the conventional male-female sexual intercourse.

Other international frameworks that provide for the right to SRHR include the Sustainable Development Goals (SDGs), the Abuja Declaration on HIV and AIDS, Tuberculosis (TB) and other related infectious diseases (2001); Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) (2009) among others. The right to SRHR is also enshrined in Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa or the 'Maputo Protocol' (2003).

As previously noted, the Constitution of the Republic of Uganda (1995) also provides that all Ugandans shall enjoy rights and opportunities and access services, including health services.

4.1.3 The right to equal treatment and non-discrimination

A key principle in most of these international, regional as well as national human rights treaties and commitments is 'non-discrimination' which implies that service provision should refrain from creating any distinction, exclusion or restriction made on the basis of various grounds which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms (OHCHR and WHO 2008). Therefore, anything be it policy, programme or practice related that does not provide equal opportunities for all people to access sexual and reproductive health services constitutes an infringement on their fundamental human rights, particularly the right to health.

In addition, international human rights frameworks are all unanimous that all individuals must be protected against discrimination and outline the obligations of States to respect,

protect and fulfil the rights of everyone, irrespective of their backgrounds or status.

In addition the right to non-discrimination implies that LGBT persons, like any other person have a right to enjoy all other human rights. It is also important to highlight that human rights are universal:⁶⁹ every human being is entitled to the same rights no matter who they are or where they live. The claim for LGBT rights is not a claim for special rights; it is a claim for the rights that every human being is entitled to. All states, regardless of their political, economic and cultural systems have a legal duty to promote and protect the rights of all people. In this respect, it is important to emphasise that state obligations under international human rights treaties focus on the states' duty and obligation to respect, protect, and fulfil people's human rights. These three duties mean that: (i) Respect – States must refrain from interfering with or curtailing the enjoyment of human rights, (ii) Protect – States must protect individuals and groups against human rights abuses, (iii) Fulfil – States must take positive action to facilitate the enjoyment of human rights.⁷⁰ Any government's failure to respect, recognise, protect and fulfil the rights of LGBT people constitutes a violation of international human rights law.

As observed in previous sub-sections, the policy provisions in the Ugandan context do not outrightly exclude LGBT persons from accessing sexual and reproductive health services. Indeed, the Constitution of the Republic of Uganda includes provisions against discrimination under Article 21. Nevertheless, most of the policies and/or their implementation do not go far enough in addressing the specific needs of LGBT persons particularly in terms of creating a friendly and favourable sociocultural environment that would support universal access to sexual and reproductive health services and rights. For instance, LGBT people interviewed during this study reported that many have been victims of corrective rape, and usually experience challenges in accessing support services such as post exposure prophylaxis.

PEP services are only available in certain health facilities. We have members that get raped, but they cannot access PEP services and it makes them get infections. Others say they do not even know about the availability of PEP services. Many lesbians are raped, and they get unwanted pregnancies but remember there's an abortion bill which restricts them from aborting yet they don't want to give birth (Key Informant, LGBT Organisation).

However, further information from MOH revealed that PEP services are available in all ART accredited facilities across the country. It is however also true that ART accredited facilities are not readily accessible within a radius of 5 kilometres and mainly consist of Health Centre IV level facilities and upwards.

Many other LGBT people who participated in this study revealed that the social stigma surrounding the 'gay' status often prevents them from accessing other sexual and reproductive health services such as lubricants. It should also be noted that the gaps in budgeting for commodities such as lubricants which are particularly needed by LGBT persons also negatively impact on the enjoyment of their right to health.

⁶⁹ Article 2 of the Universal Declaration of Human Rights (UN 1948)

⁷⁰ Office of the High Commissioner for Human Rights website, accessed on 18 December 2018 <http://www.ohchr.org/en/professionalinterest/Pages/InternationalLaw.aspx> .

4.1.4 The right to a family

The right to marriage and to found a family is also established in human rights frameworks at different levels. The Universal Declaration on Human Rights (1948) provides in Article 16 that men and women, without any limitations, have a right to marry and to found a family. The right to a family is also provided for under the Ugandan Constitution (Article 31). As noted in the previous sections, LGBT persons who fail to access information about how they can get children, or who because of cost cannot access fertility services such as in vitro fertilisation (IVF) are unable to realise their right to found a family. Similarly, the restrictions on same sex marriage limit the enjoyment of one's right to found a family of their choice.

4.1.5 The right to life and the right to dignity and personal integrity

The Universal Declaration on Human Rights (1948) provides in Article 3 for the right to life, liberty and security. Similar provisions to the right to life are provided in other international human rights treaties such as the African Charter on Human and Peoples' Rights (Article 4). Principle 4 of the Yogyakarta Principles (2006) states that 'Everyone has the right to life. No one shall be arbitrarily deprived of life, including by reference to considerations of sexual orientation or gender identity.' The Ugandan Constitution under Article 24 also guarantees the right to human dignity. Lack of access to SRHR and HIV&AIDS services or denial of such services to LGBT persons can have adverse health effects, some of which can be life threatening. For instance, an LGBT person who fails to access abortion services following 'corrective' rape and resorts to unsafe abortion risks losing their life. Similarly, an LGBT person who fails to access HIV preventive services or ARVs due to stigma in health care settings or fear of such stigma risks their life to AIDS-related death. Clearly therefore, inadequate access to SRHR / HIV and AIDS services for LGBT persons compromises their right to life and dignity.

4.1.6 The right to privacy

Article 12 of the Universal Declaration of Human Rights (1948) provides for the right to privacy. It states that 'No one shall be subjected to arbitrary interference with his privacy, family, home, or correspondence, nor to attacks on his honour and reputation'. Similarly, Principle 6 of the Yogyakarta Principles states that 'Everyone, regardless of sexual orientation and gender identity, is entitled to the enjoyment of privacy without arbitrary or unlawful interference, including with regard to their family, home or correspondence as well as to protection from unlawful attacks on their honour and reputation. The right to privacy ordinarily includes the choice to disclose or not to disclose information relating to one's sexual orientation or gender identity as well as decisions and choices regarding both one's own body and consensual sexual and other relations with others'. Article 27 of the Ugandan Constitution also provides for the right to privacy. In this respect, situations where LGBT persons are required to disclose their sexual practices, or are required to attend medical services in the company of their sexual partners violates their right to privacy. This is especially of concern in the context where disclosure or revelation that one is in a same-sex relationship is likely also to raise stigma and other discomfoting responses from health service providers.

4.1.7 The right to freedom of expression, association, participation and assembly

The Universal Declaration of Human Rights in Articles 19 and 20 provide for the right to associate and freely express one's self. Similarly, this right is guaranteed under Article 8 of the African Charter on Human and People's Rights. The Yogyakarta Principles 19 to 21 address the rights to express oneself, one's identity and one's sexuality based on sexual orientation and gender identity, without state interference. This also includes the right to freely participate in peaceful assemblies and to associate. The right to freedom of conscience, expression,

assembly and association is also guaranteed by the Ugandan Constitution under Article 29. It is revealed from our findings that gaps in the legal and policy framework inevitably limit the enjoyment of the right to associate and free expression for LGBT persons.

... when they passed the anti-homosexuality bill, most people were threatened. Those who were willing to welcome or embrace the LGBT community shied away, even the LGBT people themselves feared to come out of the closet and stand. So this ends up to suffering in silence and fear that when they come out they will be arrested. And the same, people who would want to help out on LGBT thought they would be arrested too (Key Informant, LGBT organization).

When people do not associate, there is little in terms of sharing information, including on SRHR in general and HIV/AIDs in particular. This thus affects access to information and even services for LGBT persons.

4.1.8 The Sustainable Development Goals (SDGs) principle of ‘Leaving no-one behind’

The 17 SDGs are all based on the guiding principle of ‘leaving no one behind’. Essentially this means that service provision and sustainable development as such should benefit all people, without excluding some. The relevant goals such as Goal 3 “Good health and wellbeing” and Goal 5 – “Gender Equality” target to benefit all persons without exclusion. This implies that LGBT persons who fail to access SRHR / HIV and AIDS services are being left out of the government efforts to achieve sustainable development.

4.2 Implications of policy and policy implementation gaps on HIV among LGBT persons

Existing evidence shows that HIV prevalence among key populations is much higher than in the general population. Among LGBT persons, statistical data is more readily available about HIV prevalence among the MSM compared to other LGBT sub-categories. Data from Uganda shows that HIV prevalence among MSM is well above the national average at around 13.7%.⁷¹ HIV prevalence among MSM is even higher in other African countries (over 20% in major towns of South Africa, and average of 17% in Botswana).⁷²

Whereas no data exists about the magnitude of the HIV problem among other LGBT sub-categories, the factors that increase the spread of HIV among other key population groups are also prevalent among LGBT persons. These include use of drugs, exchange of sexual fluids, having multiple sexual partners among others.

Literature shows some of the HIV risk factors for transgender and lesbian women. While the biological risk of HIV transmission through female-to-female sex remains unclear, there is documented risk that vaginal and other secretions such as menstrual blood and blood from trauma during rough sex have potential to transmit infections.⁷³ Oral and vaginal exposure to these secretions can lead to infection with HIV and other infections.⁷⁴ Other risk factors include injecting drug use among lesbian women, as well as sexual encounters with high risk heterosexual men. Some lesbian women also have transactional sex with men. Lesbian

⁷¹ Crane Survey, ‘HIV Infection among Men Who Sex with Men in Kampala’ (2010) 3.

⁷² UNAIDS ‘Now more than ever: Targeting Zero human rights violations of LGBT people in Africa’ (2013) 3.

⁷³ SK Chan, LR Thornton, KJ Chronister et al ‘Likely female-to-female sexual transmission of HIV’ Centres for Disease Control (2014) 1.

⁷⁴ Women’s Institute ‘HIV risk for lesbians, bisexuals and other women who have sex with women’ (2009) 3; Beyrer et al ‘An Action Agenda for HIV and Sex Workers’ (2015) 385:9964 Lancet 287-301.

women are also vulnerable to homophobic sexual assault or ‘corrective’ rape.⁷⁵ There is also evidence of a higher prevalence of STIs among women who have sex with women.

Data from other countries shows that HIV prevalence among transwomen can be as high as 49 times higher as in the general population.⁷⁶

Preventative tools such as dental dams and finger condoms for women who have sex with women (WSW) and condom-compatible lubricants are not always available in public health facilities.

From the primary data collected for this study, study participants were also able to point out some of the risks for HIV infection associated with an unsupportive policy environment.

I think that lack of a policy framework that is favorable to LGBT persons affects the spread of HIV/AIDS in many different ways. For instance, if there is no supportive policy, then it means issues of budgeting, planning and procurement are also affected. Basically, lack of policy affects all aspects of service provision (Key Informant, SRHR CSO).

We are at a risk of getting infections the same way heterosexuals acquire those infections because we also experience fluid exchange during sexual activity (Key Informant, LGBT Organisation).

4.2.1 Ignorance about one’s HIV status

It was found that most LGBT members have not tested for HIV and do not know their HIV status.

... we just sleep with each other and we do not get time to test them (FGD, Women who have Sex with Women).

The ignorance about their HIV status can partly be attributed to inadequate access to information and HIV testing services.

4.2.2 Non-treatment / Non-adherence to HIV treatment

It was found that because of the stigma against LGBT persons, many who may be HIV positive may not enrol for treatment or continue with treatment, hence increasing the risk of infecting others.

In terms of stigma, these people are afraid of coming to these facilities to pick access services because of their sexual orientations. So they are definitely not going to be on medicine and they are going to infect their partners due to stigma that they experience when they go to facilities to access services. That has an impact on the progress that has been gotten in combating HIV AIDS spreading the country (Key Informant, Human Rights CSO).

⁷⁵ As above.

⁷⁶ T Poteat et al ‘HIV risk and preventive interventions in transgender women sex workers’ (2015) 385:9964 Lancet 275.

4.2.3 Lack of protective tools

Study participants argued that due to lack of access to condoms and lubricants, LGBT persons end up having unprotected sex and may end up acquiring HIV and other infections.

Concerns were raised that unlike heterosexual sex which can be made safe through condom use, lesbian sex still goes on largely unprotected. As a result, lesbian women are exposed to a high risk of infecting each other with HIV and other infections.

Lesbian sex has not had any protection and there's a possibility of these women acquiring STIs. There's a lot of product usage and these products are always of poor quality and they also need to be protected. They are of poor quality because the government doesn't mind about the quality. The fact that we were women before lesbians our vaginas can easily acquire STIs as any other woman does acquire STIs, sexual organs of women are prone to STIs because there's a lot of fluid exchange through both menstrual periods, risks of being raped are very high and therefore risks of getting unwanted pregnancies hence abortions, cervical cancer, fibroids. We also acquire them as lesbians the way other women acquire them (Key Informant, LGBT Organization).

4.2.4 'Corrective' rape

It was reported that lesbian women face a great risk of corrective rape which exposes them to the risk of HIV and other sexually transmitted infections. Rape might also result in unwanted pregnancies and other related consequences such as unsafe abortions and the risk of cervical cancer.

Lesbians are at a risk of being raped and it's very common for lesbians to be raped by men. They say that "ehhh you dress like men and pretend to be men. Let's rape you and see if you'll continue to dress like that". After that rape, we face unwanted pregnancies which influence us to do abortions and then get other infections (FGD, Women who have Sex with Women).

Corrective rape was believed to be fuelled by the public's lack of recognition, understanding and acceptance of LGBT status and issues as well as the prejudices that people hold about gender, specifically, the belief that everybody should either be male or female and behave accordingly.

The consequence of unsafe abortion is occasioned by the fact that abortion in Uganda is illegal, and therefore even those who got the pregnancy through rape may resort to unsafe abortion due to the difficulties and risk of being arrested associated with procuring safe abortion.

4.23 Conclusion

From the above discussion, it is evident that inadequate access to SRHR/HIV and AIDS services leads to human rights violations against LGBT persons. It also keeps LGBT persons at a great risk of acquiring infections including HIV, and makes it difficult for them to access care and support services if they get infected.

5 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The results of this study have indicated the progress so far made in the inclusion of LGBT persons in SRHR/HIV and AIDS – related policies in Uganda. The results show that Uganda has formulated numerous policies and guidelines that address SRHR / HIV and AIDS issues. Most of such policies, especially the recent ones, address key populations as a category of priority. What emerges from the data, however, is that most Ugandan policies and guidelines tend to provide for key populations in general but are silent on LGBT persons as a specific category. The silence about LGBT persons also means that no specific service packages are provided for in these policies and guidelines for LGBT persons. However, it is concluded that learning from the experiences of some service providers such as MARPI, it is possible to provide a range of SRHR/HIV and AIDS services to LGBT persons using the current policy frameworks. Overall the challenges appear to be more at implementation level, rather than the policies per se. Some questions emerge, e.g. whether progressive policies can be implemented within an unfavourable legal framework. The second issue is that health services in Uganda generally have multiple challenges, and therefore the question is whether there can be good services for LGBT persons when the general services for everybody are poor. On the other hand, Uganda can also learn from countries such as South Africa where deliberate and bold steps have been taken to provide policies that specifically address the needs of LGBT persons.

5.2 Recommendations

To the Government of Uganda / The Ministry of Health

- GOU/MOH should make SRHR / HIV and AIDS policies more inclusive of sexual and gender minorities, and use more explicit language that specifies LGBT sub-populations as target groups for SRHR / HIV and AIDS interventions. Learning from countries such as South Africa, Uganda should formulate specific policies to address the needs of sexual and gender minorities.
- The on-going efforts to train health workers to provide KP-friendly services are commendable and should be scaled up. MOH and partners should train health workers about different kinds of sexes, gender and how to handle persons with different gender identities and sexual orientations. The MOH and partners should provide more funding to support these activities.
- MOH should scale up the availability of all services included in the minimum package of services for key populations and the additional services tailored to the specific needs of different LGBT sub-groups including PrEP, SMC and UTT to ensure they are readily accessible.
- MOH in collaboration with CSOs should create greater awareness about the availability of PEP and PrEP services.
- GOU/MOH should ensure procurement and availability of commodities that reduce the risk of transmission of HIV and other sexually transmitted infections, as well as commodities such as hormones for gender affirmation. Lubricants and drugs for the management of drug addictions should be included on the essential medicines list.
- GOU/MOH should also recognise LGBT organisations as partners in the campaign to improve SRHR and to fight HIV and other infections.

To human rights and LGBT CSOs

- Effective policy reform and implementation cannot be achieved in a restrictive legal and political environment. Human rights organisations should continue the advocacy and legal efforts to improve the legal and political environment surrounding LGBT issues in Uganda.
- LGBT organisations and partners should conduct more research and generate evidence to facilitate planning, advocacy and policy making that is inclusive of LGBT issues. Evidence is needed to understand the HIV risks associated with the sexual practices of LGBT persons and to demonstrate the HIV burden posed by sexual behaviour amongst LGBT persons in order to justify investment in and prioritisation of LGBT issues by government and donors. Research is also needed on awareness of, use and demand for lubricants in HIV prevention.
- LGBT-focused CSOs should train LGBT persons about their sexual and reproductive health status, needs, risks and services available in order to promote demand and utilisation of services.
- Human rights organisations and LGBT-focused CSOs should engage more with communities, local leaders, law enforcement officials, and other stakeholders to change attitudes towards LGBT persons and reduce stigma and discrimination.

To Health Service Providers (CSOs, Health Facilities)

- Even as advocacy efforts for more inclusive policies continue, LGBT organisations and service providers should utilise the positive aspects in the existing policy frameworks to scale up services for LGBT persons and reach the unreached.
- SRHR / HIV and AIDS service providers should scale up the use of tested approaches that work well with LGBT persons such as peer-led and community outreach approaches in order to reach LGBT persons.

To Parliament of Uganda

- The Parliament of Uganda should reform laws that negatively impact the environment for LGBT persons to seek and access services including those that criminalise sex work, same-sex marriage, and same-sex sexual acts.
- The Parliament of Uganda should allocate more financial resources towards scaling up HIV and SRHR services across the country, including those for training health workers in working with key populations, procurement of necessary commodities and supplies, and expansion of services geographically.

To other sectors

- Other relevant sectors, namely, JLOS, the Social Development Sector, Education and others should, as part of their roles provided for under the Multi-Sectoral HIV and AIDS framework developed by the Uganda AIDS Commission, work to remove barriers to access to services for LGBT persons.

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Annex 1: HIV Prevention Intervention Packages and Enabling Interventions for Key Populations outlined in the Uganda HIV Prevention Roadmap (2018)⁷⁷

Social cultural / structural prevention package along the life cycle (with additional package for key populations)

- Support programmes for increasing comprehensive HIV knowledge among KPs.
- Condom promotion using peer-to-peer mechanisms.
- Anti-stigma and anti-discrimination programs for KPs, general public and health workers.
- Combined skills building activities, peer support and opportunities to discuss stigma and its effects.

Legal and policy enablers

- Promote social rights and dignity for sex work, drug use, and MSM; and review by-laws that promote stigma.

Institutions and workplaces

- Establish and/or build the capacity of existing community / hotspot peer mechanisms or structures to support KPs to access HIV prevention services
- Conduct public dialogues on HIV-related stigma and discrimination against KPs

Socio-Economic enablers

- Cash transfers and income generating activities

Health system structural enablers

- HIV testing, ART and viral load suppression
- Expand condom distribution outlets for KPs and special groups using facilities, hotspots, and commercial outlets (lodges, bars and hotels)
- Expand social marketing of condoms to all urban areas and hotspots
- Develop a strategy and implement concerted condom distribution for KPs
- Outreach or dedicated clinics for mobile KPs in hotspots and hard-to-reach areas.

⁷⁷ Uganda AIDS Commission 'Acceleration of HIV Prevention in Uganda: A Road Map towards Zero New Infections by 2030' (2018) 48–50.

Annex 2: Package of services for Key Populations outlined in the MOH Trainer's Guide for Health Service Providers to provide KP- friendly Health Services in Uganda⁷⁸

Service Package Special considerations

Provide HTS services within health facilities and through community-based or venue-based outreaches with repeat HIV testing for those testing negative.

- Repeat HIV testing every three months for those testing negative for SW, MSM and PWID.
- Provide HTS services at health facilities or using mobile clinics for transport and migrant workers.
- HTC in accordance with national and harmonized guidelines.
- HTC/PITC for partner and linkage to care and early ART initiation.
- PITC should be offered to all women and girls attending health care settings.

Linkage of those testing HIV positive to ART care, early ART initiation and adherence support.

- Enrolment in or effective referral/ provision for ART for people in correction facilities.
- Access to ART for those eligible and support for adherence for HIV negative partners on discordant relationships.

HTS services for sexual partners.

- Includes confirmation of HIV infection for partners in discordant relationships.

Counselling on condom negotiation skills and provision of messages on dual protection and support for correct and consistent use of condoms.

Demonstration and distribution of male and female condoms (both male and female),

- Provision of condom-compatible (water- based) lubricants for SW and MSM

⁷⁸ Ministry of Health 'Training guide for health service providers to provide key, vulnerable and priority population-friendly health services in Uganda' Draft, May 2018.

Activities to reduce the stigma and discrimination faced by SW, MSM, PWUD.

Counselling on family planning (FP) methods and provision of emergency contraceptives and other short-term methods and referral for Long acting permanent methods (LAPM) of FP.

Delivery of targeted IEC materials and BCC and other materials for key, vulnerable and priority populations and their sexual partners delivered through peer-based outreach.

- At major stops along the transport corridors for transport and migrant workers.
- Delivery of targeted IEC materials at major fishing landing sites for fishing communities.
- For preventing infectious diseases for people in correctional facilities.
- Delivered through peer-based outreach, using social networking and modern technology that is appealing to this group for vulnerable women and girls.

Empowerment through development of a peer-based network.

Education on prevention of sexually transmitted infections (including HIV) and diagnosis and treatment of STIs.

- Include conducting ano-rectal and pharyngeal examinations for diagnosis and treatment of ano-rectal and pharyngeal infections for MSM.

Symptom-based and other TB screening with effective referral for diagnosis and treatment.

Post-sexual and gender-based violence (SGBV) care including general history, physical examination, trauma counselling, provision of PEP, emergency contraceptives, pregnancy test, and management of soft-tissue injury, collection of samples, psychological support and referral for legal aid.

- Specifically, for populations at risk of SGBV including SW, MSM, PWUD, AGYW, people in correctional facilities and others.

Provision of pre-exposure prophylaxis (PrEP).

- Especially for SW, MSM, PWID, Transport and Other Migrant Workers and negative partners in discordant relationships

Provision of post-exposure prophylaxis (PEP).

- For those at risk of accidental exposure to HIV or as a result of SGBV.
- Provision of information on safety procedures and access to PEP for people in correctional facilities.

Provision of drop-in centres with IEC and BCC materials and condom vending machine should be included.

- Recreation room/drop-in centre, a room with television and pool tables, at major stops and landing sites for fishing communities and transport and other migrant workers and other where it is feasible.

Screening for pregnancy with referral for antenatal care (ANC) with emphasis on four ANC visits, delivery by skilled birth attendants, postnatal care (PNC) and referral for prevention of mother-to-child transmission of HIV (PMTCT).

- Especially for SW, PWUD, vulnerable women and girls, female negative partners in discordant relationships.
- Pregnancy test/examination to initiate, continue or refer for ANC including PMTCT for people in correctional facilities.

Response to violence. This violence may occur at the place of work or stay. This may include violence from managers, support staff, clients or co-workers in establishments where sex work takes place (e.g., brothels, bars, hotels), or by other power structures.

- Especially for SW, MSM, PWUD and vulnerable women and girls.

Regular outreach and contact through peer-based education, treatment and support.

- Especially for SW, MSM, PWUD and vulnerable women and girls.

Risk-reduction counselling, skill building and encourage behaviour change.

- Include counselling on risk associated with substance use, sharing drug-injecting paraphernalia and duration of use for PWUD.
- Include provision of risk-reducing commodities such as condoms, clean needles and syringes and other paraphernalia (for PWID).

Referral for specialized counselling, medically assisted therapy and other drug-dependence treatment.

- Specific for PWUD.

Provision of Cotrimoxazole prophylaxis.

- For those living with HIV.

Screening and counselling on substance and alcohol abuse including education on the dangers of sharing syringes and needles. Referral for needle and syringe exchange program and medically assisted therapy.

- For PWUD.

Screening for non-communicable diseases including;

- Diabetes mellitus and referral for management (history, physical exam, blood test).
- Hypertension history, physical exam, treatment and/or referral depending on stage of hypertension.
- Specifically for transport workers

Mass deworming against schistosomiasis and soil-transmitted helminths.

- Specifically for fishing communities.

Eye screening using Snellen chart and ear screening.

- Specifically for transport workers

Road safety education to transport workers.

- Specifically for transport workers.

Periodic screening for all communicable diseases, in accordance with national guidelines.

- Especially for people in correctional facilities.

Psychosocial support.

- Especially for people in correctional facilities.

Isoniazid preventive therapy for eligible prisoners.

- For those with HIV and eligible prisoners.

Positive health, dignity and prevention: psychosocial assessment and counselling, support for partner disclosure, alcohol and substance abuse.

- Specifically for those with HIV.

Referral for cervical, breast and prostate cancer screening.

Annex 3: Objectives and Targets of the South African LGBT HIV Plan 2017 - 2022⁷⁹

Service Packages Objectives and Targets

Health

To reduce HIV by 63%; TB by 30% and increase detection of STIs by 70% with comprehensive prevention

To treat HIV, TB and STIs among LGBT people through:

- Providing a package of LGBT-appropriate HIV, STIs and TB-related health care services to 200,000 LGBT people
- Initiating 5,000 MSM and trans people on PrEP
- Ensuring that 95% of the LGBT community have access to and use condoms and condom-compatible lubrication correctly and consistently
- Ensuring that all LGBT persons have access to comprehensive health services:
 - 90% of LGBT persons living with HIV, STIs or TB know their status
 - 90% of LGBT persons who test HIV, STIs or TB positive are linked to treatment
 - 90% of MSM and trans women who test HIV negative are offered combination prevention packages, including PrEP
 - 90% of LGBT persons on ART are virally suppressed and those on TB treatment complete their treatment
 - LGBT people have access to and are retained in care

Empowerment

To empower LGBT populations through a peer-led programme that will strengthen community networks and LGBT organisations to address the social and economic factors that restrict economic opportunities

Psycho-social support

To reduce internalised and external stigma and discrimination against LGBT persons and to offer or refer for counselling and harm reduction support

Human rights

⁷⁹ SANAC (n 55 above).

To develop and implement effective mechanisms to deal with human rights abuses and violence from the public, police, and health care providers; sensitization of police and prosecuting authorities; and legal literacy and paralegal support to reduce violence against LGBT persons.

Evaluation

To establish a participatory and evidence-based plan for the delivery of acceptable, accessible, appropriate and available services for LGBT people.

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