HRAPF
HUMAN RIGHTS AWARENESS AND PROMOTION FORUM

HOW LAWS THAT PROMOTE HUMAN RIGHTS IMPACT ON ACCESS TO HIV AND TB SERVICES FOR KEY POPULATIONS IN UGANDA

ISSUES PAPER

December 2020

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THE AIDS SUPPORT ORGANISATION
TASO
HIV

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TABLE OF CONTENTS

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1. INTRODUCTION

HRAPF undertook a study aimed at determining the impact of laws that promote human rights on access to HIV and TB services for Key Populations, with a particular focus on Men who have Sex with Men (MSM), Transgender Persons, sex workers and Persons who use and Inject Drugs (PWUIDs). The study focused on districts that had Drop In Centres (DICs) operated by the Most at Risk Populations Initiative (MARPI) and, for comparative purposes, districts that had no MARPI DICs, in order to show trends on access to services. The study was intended to highlight how laws that promote the rights of Key Populations have been used in practice to enable access to HIV/TB services in Uganda. Data was collected from a total of 26 districts and across 32 study sites spread out in all the different regions of the country. This paper summarises the findings of the study and makes a case for stakeholders to ensure increased access to HIV/TB services for MSM, transgender persons, sex workers and PWUIDs.

2. BACKGROUND TO THE STUDY

'Key Populations' (KPs) in terms of HIV are those particular groups which are the most vulnerable to HIV, while at the same time often lacking access to adequate HIV services.[1] The KPs currently considered to be the main focus of the global HIV response are gay men and other MSM; sex workers; transgender people; People Who Inject Drugs and prisoners and other incarcerated people.[2] Globally, more than half of new HIV infections occur among members of these KPs and their sexual partners.[3]

Human Rights Awareness and Promotion Forum (HRAPF) works for the promotion and protection of the rights of minorities and disadvantaged groups, including selected Key Populations (KPs), through legal aid service provision, research, advocacy, awareness raising and community capacity enhancement. The four KP groups which HRAPF works with are MSM, transgender persons, sex workers (SW) and PWUIDs.

Laws and policies in Uganda that have a bearing on prevention and care for HIV/AIDS often fail to specifically address the vulnerability of key population groups such as MSMS, transgender persons, sex workers and PWUIDs to HIV infection. In some cases, the laws themselves increase the vulnerability of these groups

1 UNAIDS 'Key Populations' available at https://www.unaids.org/en/topic/key-populations (Accessed on 13th December 2019).
2 As above.
3 As above.

by directly discriminating against them. Some of these laws include provisions of the Penal Code Act which criminalise sex work ('prostitution') as well as consensual same-sex sexual conduct.[4] Individual drug use and possession is also criminalised with heavy penalties prescribed by the Narcotic Drugs and Psychotropic Substances (Control) Act, 2016. In order to design appropriate responses to these challenges, it is important to understand how KPs are affected by the existing laws in their pursuit of HIV/TB services. The study thus sought to establish how existing laws are currently impacting KPs' access to HIV services in various districts in the country.

3. STUDY OBJECTIVES

The main objective of the study was to determine the impact of laws which promote human rights on KPs' access to HIV and TB services in Uganda.

The specific objectives of the study were the following:

1. To analyse the laws, bye-laws, regulations, ordinances and policies that promote access to health services for KPs.
2. To assess the enforcement of laws, bye-laws, regulations, ordinances and policies which promote human rights at the local level through key informant interviews and the monitoring of HIV and TB service provision to KPs.
3. To make recommendations to different stakeholders on ways in which to improve HIV and TB service provision to KPs in Uganda.

4. STUDY METHODOLOGY

The study adopted a cross-sectional design and employed qualitative research methods. A desk review was conducted in order to determine the laws, bye-laws, regulations, ordinances and policies that promote access to HIV/TB services for KPs both at the national level and in the study districts.

Monitoring the delivery of HIV/TB services to KPs was also done at the 32 selected sites throughout the country. Monitoring Assistants, selected from members of the MSM, transgender, sex workers and PWUIDs communities at different health centres in all regions of the country, were placed at the different facilities and were able to observe service delivery and compile a monitoring report for a continuous period of 26 days per site between 7th September 2020 and 30th November 2020.

4 See Secs 136-139; 145 of the Penal Code Act.

The 18 health centres hosting MARPI DICs that were included in the study were:

No.	District	Health Centre
1.	Arua	Arua Regional Referral Hospital
2.	Bugiri	Bugiri Municipal Council Health Centre IV
3.	Buikwe	Kawolo General Hospital
4.	Busia	Busia Red Cross Health Centre IV
5.	Gulu	Gulu Regional Referral Hospital
6.	Jinja	Jinja Referral Hospital
7.	Hoima	Hoima Hospital
8.	Kabale	Kamuganguzi Health Centre IV
9.	Kabarole	Fort Portal Regional Referral Hospital
10.	Kampala	Mulago National Referral Hospital
11.	Kasese	Kasese Municipal Council Health Centre III
12.	Lira	Lira Regional Referral Hospital
13.	Lyantonde	Lyantonde Hospital
14.	Mbale	Mbale Regional Referral Hospital
15.	Mbarara	Mbarara Regional Referral Hospital
16.	Nakasongola	Nakasongola Health Centre IV
17.	Tororo	Tororo General Hospital Malaba Health Centre III

For other districts, this exercise was done at 14 heath centres, namely:

No.	District	Health Centre
1.	Amolatar	Amolatar Health Centre IV
2.	Apac	Apac General Hospital
3.	Bugiri	Bugiri Municipal Council Health Centre IV
4.	Buvuma	Buvuma Health Centre IV
5	Kaberamaido	Kaberamaido Health Centre IV

No.	District	Health Centre
6.	Kampala	Kawaala Health Centre IV, Rubaga Division Kisenyi Health Centre IV, Central Division Kisugu Heath Centre IV, Makindye Division Kiswa Health Centre III, Nakawa Division
7.	Manafwa	Bubulo Health Centre IV
8.	Mayuge	Mayuge health centre IV
9.	Masaka	Masaka Hospital TASO DIC
10.	Wakiso	Wakiso Health Centre IV Kakiri Health Centre III, Wakiso

Primary data was also collected through a series of In-depth Interviews and Focus Group Discussions (FGDs) in the various study sites in Central, Eastern, Western and Northern Uganda. This was done in a total of 9 districts which were purposively selected - Mbarara and Kasese in the Western region, Mbale and Mayuge in the Eastern region, Gulu and Amolatar in the Northern region, Masaka, Nakasongola, and Kampala in the Central region. A total of 187 participants were reached through in-depth interviews and FGDs. These included 156 KPs, 6 District Health Officials (DHOs), 4 District HIV Focal Persons, 14 health workers, 5 superintendents of hospitals / health center in-charges, 1 representative of the Ministry of Health and 1 representative of the Uganda AIDS Commission, as key informants.

Ethical approval for the study was obtained through the Research Ethics Committee of The AIDS Support Organisation (TASO).

5. ISSUES AND RECOMMENDATIONS

Overall, Uganda's legislative environment is generally not KP-friendly. The right to health has been held to be justiciable in Uganda as it is protected under Objectives XIV and XX of the National Objectives and Directive Principles of State Policy (NODPSP) in Uganda's Constitution, which are buttressed by Article 8A of the Constitution which makes the NODPSP justiciable.[5] As such, the state is under obligation to put in place legislative and other measures

5 Centre for Health Human Rights and Development (CEHURD) & 3 others v Attorney General, Constitutional Petition No. 16 of 2011.

to ensure full realisation and enjoyment of the right to health by everyone, including for KPs. The UN Committee on Economic, Social and Economic Rights (ESCR Committee) interprets the right to health as defined in article 12(1) of the International Covenant on Economic, Social, and Cultural Rights, 1966 (to which Uganda is a State Party) as 'an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health …'[6] The Committee identified four interrelated and essential elements of the right to health: availability, accessibility, acceptability and quality.[7] These parameters are used in this issues paper to analyse the extent to which KPs access HIV/TB services in Uganda.

a) Availability of specialised goods and services for Key Populations

Availability requires that goods, services and information are available in sufficient quantities.[8] The products required to be available may vary from country to country but they include the underlying determinants of health, such as hospitals, clinics and other health infrastructure, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs.[9]

In terms of availability of KP specific goods, services and information, the Ministry of Health has partnered with non governmental institutions to ensure availability of goods, services and information. One of these is MARPI, a private entity, with which the government has engaged to provide KP specific HIV/TB services at different health centres in the country. With the pioneer clinic at Mulago National Referral Hospital's Sexually Transmitted Infections (STI) Clinic, MAPRI has opened up Drop In Centres (DICs) in government hospitals and health centres across the country. MARPI has a presence in 24 other districts across the country – Arua, Bugiri, Buikwe, Busia, Dokolo, Gulu, Hoima, Jinja, Kabale, Kabarole, Kalangala, Kanungu, Kasese, Kumi, Lyantonde, Mbale, Mbarara, Mukono, Nakasongola, Nwoya, Serere, Tororo, and Wakiso.[10]

The study team monitored service delivery for a total of 26 consecutive days per site at 18 of these centres, and found them in existence and providing services, although some were barely operational, such as the one in Mbarara. MARPI DICs cater to KPs in particular and for this reason, they have KP specific

6 Committee on ESCR General Comment 14: 'The right to the highest standard of physical and mental health' HRI/GEN/1/Rev 9 (Vol I) (2000) para 11.
7 Above, para 12.
8 Above, para 12(a).
9 Above.
10 Most at Risk Populations Initiative 'Our geographical coverage' https://www.marpi.org/geographical-coverage (accessed 6th December 2020)

services and goods in stock, including condoms, KP specific counseling services, health workers who are specialised in handling KP issues, HIV testing and care services and Anti-Retroviral Treatment (ART), and lubricants. However, such services as hormonal replacement therapy for transgender persons as well as dental dams, are not available. Lubricants particularly usually run out of stock. MARPI centres also do not specifically have services tailored for PWUIDs, such as needle and syringe exchange programs and Medication-Assisted Treatment (MAT) programs. Another challenge with MARPI centres is that the clinics get overwhelmed by the numbers of KPs seeking services because they feel more welcome, free, and supported at MARPI. As a result, sometimes services are not enough for everybody that visits the clinic, as the health workers are also few – in some cases only one. Also some respondents reported that the space at some MARPI clinics is limited and can only serve up to five persons at a time.

The other partners that the government works with at different health centres to provide HIV/TB services are the Infectious Diseases Institute (IDI), at Makerere University; Mild May Uganda; the AIDS Support Organisation (TASO) and Rakai Health Sciences Project (RHSP). These operate in different districts, and all provide ART services, including to KPs. The main model used involves using peer leaders and KP Focal persons at the different hospitals. Wherever these operate, KPs are generally able to access services, and usually goods and services are available including condoms and lubricants as well as counseling services.

Since these services largely cater for everyone, sometimes KPs do not get the specialised services that they would need, and also sometimes feel a sense of discrimination. It is important to note that female sex workers more freely access services at these health centres, as compared to MSM, transgender persons and drug users. Monitoring Assistants reported that many of the MSM and transgender persons reported feeling stigmatised even among fellow KPs, and this may explain why they may not as actively seek the services, as sex workers would do. In some cases, sex workers are said to send their friends to pick drugs or condoms for them and this further exposes the other KPs in such mixed settings.

For health centres without MARPI clinics or clinics operated by any of the other partners, the situation is very different, with no system to cater for KPs. Monitoring assistants in places such as Manafwa, Amolatar, Kaberamaido, Mayuge and Buvuma reported observing less or no focus on KPs in these places, and that even health workers were largely unaware of KP needs and specialisedservices. For example, an HIV Focal Person from one of these districts in an interview repeatedly referred to sex workers as 'prostitutes.' There were no KP peer educators or KP focal persons in such districts. Whereas

ART, condoms and counselling services were largely available, lubricants were not, and neither were there dental dams or specific services for PWUIDs. Many usually only have condoms and pain killers, and even ART runs out.

> *"The supplies are sometimes there and sometimes not. At times there is shortage of testing kits and yet testing kits are key." (IDI, Health worker in a rural district).*
>
> *"Of the medication we get, there are guys like me who don't do Panadol. When I come here and you are giving me Panadol, it's like you are adding me more headache. Yeah? So, the type of medication that we get is not what works better for us. But what works better for us cannot be found in these facilities". (KP FGD, Kampala)*
>
> *"The main challenge is some drugs, some commodities being out of stock… To be specific, these people sometimes fail to get commodities that they would wish to use by their choice … we give them what we have sometimes." (IDI, KP Focal Person)*

There is also a noticeable difference in availability of goods and services between more urban areas and largely rural areas. In Kampala, Wakiso, Gulu, Hoima, and Kasese, which are big towns, monitoring assistants and KPs observed that goods and services are easy to access, and yet those from more rural districts such as Amolatar, Buvuma, Kalangala and Kaberamaido reported there being less in terms of goods and services. Indeed, many of the partners including MARPI, IDI, Mild May and TASO were most likely to be found in more urbanised districts. Therefore where you are as a KP determines a lot in terms of whether HIV/TB goods services would be available or not.

The COVID-19 epidemic changed the dynamics on availability as focus by health centres was mainly on COVID-19 and therefore in many instances KPs were not adequately catered for, even when they could manage to access the health centres. Under the Ministry of Health's 'COVID-19 Infection Prevention and Control Guidance For HIV Services Delivery', health centers were required to maintain skeletal staff for ART and emergency services, but sometimes in practice, there would be no one to attend to KPs as the few health workers on duty were engaged. One health worker noted:

> *"But now this COVID. Some partners have withdrawn a bit so we are not doing as much as we used to…"*

Recommendations

1. *Extend the MARPI model to all districts in the country so that KPs can have tailored goods and services.*
2. *MARPI centres and government health centres should have tailored goods for transgender persons and PWUIDs that cater to their specific needs*
3. *The government should, through the Ministry of Health, increase funding to MARPI to enable them adequately cater for all KPs that seek their services.*
4. *Other partners such as IDI, TASO, Mildmay and RHSP should also extend their services to more rural areas in order to reach KPs in these areas*
5. *More KP specific goods such as lubricants should be available at health centres all the time, including in centres operated solely by the government, as these are key in the fight against HIV*

b) Accessibility of goods and services

Accessibility is the second principle under the right to health. Accessibility requires that health facilities, goods and services are accessible to everyone without discrimination.[11] Accessibility has 4 aspects: non discrimination, physical accessibility, economic accessibility, and information accessibility.[12]

i) Non discrimination

This aspect requires that discrimination is eliminated both in terms of laws and in fact. In terms of laws, whereas the Constitution of Uganda promotes equality and non-discrimination for all, legislation that should draw their authority under it continue to discriminate or more specifically, simply ignore KPs. The HIV Prevention and Control Act, 2014, the main law on HIV/AIDS in the country, imposes an obligation upon the government to ensure the right of access to equitable distribution of health facilities, goods and services including essential medicines on a non discriminatory basis.[13] Indeed the state is enjoined to give priority to most at risk populations.[14]

The challenge however is that the definition of most at risk populations falls short as it only includes 'fishing communities, prisoners, and migrant populations

11 ESCR Committee General Comment 14, n 6 above, para 12(b).
12 Above.
13 HIV Prevention and Control Act, 2014, section 24,(1) (a), (b),(f) and (g).
14 Above, section 24(k).

and others as may be determined by the Minister.' As such MSM, transgender persons, sex workers and PWUIDs are not recognised expressly under the Act as KPs, and this gap legitimises the state's inaction with regard to the obligation to specifically cater for their needs in HIV/ TB prevention, testing, treatment and care.

Indeed, Uganda has passed a number of laws that run contrary to the obligation to protect these specific Key Populations. Regarding MSM, the Penal Code remains the most problematic law, as it criminalises consensual same–sex relations, defined as "having carnal knowledge againsty the order of nature" and punishable with life imprisonment.[15] In 2014, the state took steps to further criminalise LGBT persons when the Anti-Homosexuality Act became law, criminalising consensual same-sex relations, giving legal immunity to anyone who committed a crime while "defending themselves from homosexuality" and criminalising 'promotion' of homosexuality. Initially, the Bill for the Act proposed imposing an obligation on any professionals (including healthcare professionals) to report anyone who they got to know was a homosexual to the authorities within 48 hours.[16] The Act was however later struck out by the Constitutional Court for being unconstitutional.[17]

The Registration of Persons Act, 2015 does not recognise transgender individuals, and only recognises two genders- male and female. The Act specifically provides for change of gender markers only upon medical proof of a gender reassignment for intersex children, but not for transgender persons, particularly those who have not had sex change surgeries. This makes it difficult to accord proper services for transgender persons. In addition, transgender persons are also prone to arrests under the Penal Code Act on such vaguely framed charges as being rogue and vagabond, being a common nuisance and personation. The reason why transgender persons are often victimised under nuisance offences and other petty offences is that, whereas it is not a crime to be transgender in Uganda, the law also does not recognise transgender persons, thus exposing them to the vagaries of the subjective judgment of individual law enforcement officers as to their desirability.

Sex work also continues to be criminalised under section 138 and 139 of the Penal Code Act, punishable with up to seven years' imprisonment, and sex workers are routinely harassed by law enforcement officers under the vagrancy offences of the Penal Code Act. The Narcotic Drugs and Psychotropic

15 Penal Code Act, Cap 120, Section 145.
16 The Anti-Homosexuality Bill, 2010, clause 14.
17 Prof. J Oloka-Onyango & 9 Others v Attorney General Constitutional Petition No. 008 of 2014.

Substances (Control) Act, 2016 also criminalises possession of narcotic drugs, and thus continues to be used as a tool for harassment of PWUIDS, alongside the ubiquitous offences of "being idle and disorderly", being a "rogue and vagabond" and being a "common nuisance". This criminalisation is often used to justify refusal to provide services to these groups, as service providers conveniently use the excuse that doing so would be supporting or abetting criminal acts. These laws guide the approach of district authorities towards these groups and they thus stand in the way of service provision.

At policy level, the Ministry of Health has passed a number of policies that do recognise at least some of the KP groups. These include: The Service Standards for Reproductive Health Services (2001); The Investment Case/ Revised Sharpened Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health (2016); The National Comprehensive Condom Programming Strategy and Implementation Plan (2017 – 2021); The National HIV and AIDS Strategic Plan (NSP) 2015/16 – 2019/20; and The Roadmap for HIV Prevention (2018). However, these do not have specific provisions that address specific HIV and AIDS and TB services for the specified KPs. For example, the HIV/AIDS Strategic Plan III recognises that there is a higher HIV prevalence among men who have sex with men,[18] and yet little has been done to address this situation.[19]

The Strategic Plan specifically considers `ensuring access to health services to MSM and other groups,'[20] yet it also specifically excludes information on sexual orientation in data to be collected in health service delivery.[21] The 2014 Ministerial directive on access to health services without discrimination requires health care service providers not to discriminate on grounds including sexual orientation in provision of services. [22]Nevertheless, gaps remain, with health workers often claiming that the legal and policy framework is not very clear, and that they would not want to condone crime by catering for such groups. Not surprisingly, therefore, discrimination continues as regards access to services for KPs. The MARPI centres are however largely seen by KPs as non discriminatory and as fully embracing of KPs. According to one respondent:

> *"But MARPI you can come like you have come for eye checkup, and so on" (KP, FGD, Gulu).*

18 Ministry of Health 'National HIV and AIDS Strategic Plan 2015/2016 - 2019/2020' 5.
19 Above, 10
20 Above, 8.
21 Above, 15.
22 Republic of Uganda, Ministry of Health 'Ministerial directive on access to health services without discrimination' (2014).

The same is generally true for health centres where the other partners do operate. However, it is a completely different story for health centres that do not have the MARPI or other partners. A number of respondents from the Key Population communities indicated that they were deterred from going to access medical services especially from the government hospitals because of the stigma and discrimination they experienced from the health workers:

> *"It is not easy for us to openly go to the medical personnel mainly because the way they talk to us is not a good way to talk to patients. That's one barrier" (IDI, KP, Kampala).*
>
> *"KPs only disclose to particular health workers they are comfortable with or know will keep confidentiality. Even those KPs who are vocal and always seek to articulate their concerns" (IDI, KP, Mbarara).*
>
> *"…one of our members was referred to a certain hospital and was discriminated against. You know how we dress... And this side you know it's a village so health workers don't want to know. They will tell a transman such things as '…Go and put on a dress then I will work on you'" (IDI, KP, Kasese).*

One of the health workers interviewed concurs with KPs on the issue of lack of information on KPs for health workers:

> *"We really need training because most of us right now treat them badly".*

These kinds of experiences are said to instill fear in the members of the KP communities and to discourage them from going to access treatment because they do not want their identity to be exposed by health workers without their consent, especially considering that when they are making such insensitive comments to the KPs, there are other patients within hearing and view.

Many members of the KP communities had immense fears when it came to accessing HIV treatment or prevention services from general health facilities and/or health facilities that do not have KP focal persons, expressed thus;

> *"Any clinic! No. Even here there is one person I disclose to…Because sometimes you want to trust them and you tell them. But the moment you step out like this, they turn you into a topic" (IDI, KP, Kasese).*

Another member of the Key Population community from Gulu District had this to say about fearing to disclose their identity as a PWUID;

> *"Also, instead of seeing a doctor I do not know in a place like MARPI where I usually come for services, it is better I go somewhere else when the doctor I know is busy. So, we need more people" (KP, FGD, Gulu).*

Recommendations

1. *Repeal provisions of the laws that criminalise consensual same sex relations, sex work and possession of narcotic drugs for individual users*
2. *The Minister of Health should sign a statutory instrument expressly recognising MSM, Transgender Persons, Sex workers and PWUIDs as Key Populations under the HIV/ AIDS Prevention and Control Act to ease their integration into HIV/ TB prevention, testing, treatment, care and support service delivery systems*
3. *Adequately disseminate and draw attention to the 2014 Ministerial directive on access to health services to all health facilities in the country and police stations.*
4. *Train more health workers on KP specific treatment and care and engage them as KP focal persons at different health centres*
5. *Train more KP peer educators and employ them in more districts to ensure that KPs have easier access to services even when KP specific services do not exist.*

ii) Physical accessibility

Physical accessibility requires that 'health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and portable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.'[23]

It was found that friendly health facilities, being the MARPI centres and those where other partners operate are often physically inaccessible to KPs because

23 ESCR General Comment 14, Para 12(b).

of the distances involved in traveling to these centres. There are only a few districts with MARPI centres in Uganda, with entire regions being served by as a few as two centres. This makes it difficult for KPs to access the services available. An example is Kasese district, which has only one MARPI clinic, despite its large size. This issue was further exacerbated during the COVID-19 lockdown, where transportation of persons became an even bigger challenge.

It was also found that the physical location of the clinic within the heath facility is crucial. Placing the KP clinic in full view of other patients increases stigma as in some places, it is known that those who go to the MARPI clinics are KPs. Most MARPI clinics were commended by KPs who participated in the study for ensuring their privacy and ultimately being a driver for them to go to access treatment. However, there were also some MARPI clinics in other districts whose locations were said not to be strategic enough as people felt exposed. An example was given of the stigma attached to going to a TASO facility as they are only known to cater to HIV positive persons.

> *"Places like TASO, the moment you get in and come out, stigma starts from there. This one is HIV positive, is what?" (KP, FGD, Gulu).*

MARPI clinics on the other hand were reported to deal with more than HIV and in many instances also to cater for skin problems, for instance, and thus someone may not easily be labeled when they access the facility.

The time for accessing services is also an issue. For example TB and HIV services over the weekend at government referral hospitals were said to be largely unavailable, and health centres as the HIV units rarely work on weekends. As such, when KPs get emergencies during weekends, they are expected to wait until when the facilities open on Monday.

> *"Access to TB and HIV services is not possible over the weekend" (KP, FGD, Gulu).*

Another participant concurred;

> *"Yes, it is true because on the weekend, I think they don't work on the weekend" (KP, FGD, Gulu".*

Another aspect is the ease with which one can get services after moving to a new area. KPs who shift and go to live in areas other than the ones from which they were initially accessing TB and HIV prevention and treatment services find

it difficult to access these services. Many health service providers are not open to adjusting for these KPs to access their treatment so they ask them to go back to their previous access points where they registered from, which in most of the cases is not possible considering that the distances are sometimes prohibitive. Some of the Key Population community members end up not accessing these services as there may not be more than one health facility in their new location.

> *"You see if me I am not coming from within the district, well it's like I am from Jinja but I shifted to Mayuge. I have been getting my medicine from Jinja but when I came here in Mayuge, getting medicine from here is very difficult" (IDI, KP, Mayuge).*

The COVID-19 pandemic dynamics however helped to address this barrier a little when the Ministry allowed health centers to cater for everyone who seeks HIV treatment and care services at all facilities. Nevertheless, it was not easy for many health facilities to immediately adjust, and thus KPs who migrated as a way of managing the strain caused by the restrictions imposed to manage the spread of the COVID-19 pandemic often had a very difficult time accessing HIV/ TB treatment and care services.

Recommendations

1. *All government health facilities should be able to provide HIV/ TB prevention, testing, treatment and care services on a routine basis as with all other health services*
1. *MARPI and other ART facilities should be housed in parts of the health centre that are not exposed to every one visiting the health centre to protect the identities of KPs who seek their services and thus encourage access to HIV/ TB treatment and care services by KPs*
2. *KP HIV/TB services should be made available even over the weekends in those health centres where they are not.*
3. *A system should be put in place that enables KPs to easily access services at other MARPI clinics or government health centre using their reference details in order to ease access to essential medicines for HIV/ TB care*

iii) Economic accessibility (affordability)

According to the ESCR Committee, 'health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of

equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.'[24]

The study found that all KP services at MARPI and at the different government health facilities were free, when available. However, there was a challenge with services that could not be obtained at the government facilities and during times of stockouts, which KPs are often forced to pay for in private facilities.

Recommendations

1. *The government should ensure that KP specific goods and services are available to all free of charge, including those for groups that are usually ignored, such as PWUID.*
2. *Regulate the prices of goods and services for KPs that are not available in government facilities, so that KPs can have cheaper access to them.*

iv) Information accessibility

According to the UN ESCR, accessibility 'includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.' [25]

KP specific information for HIV and TB was available at the different MARPI DICs as they specifically catered to KPs. This was however different for non MARPI facilities, where the information generally available was for everyone, and not KP specific.

Many KPs are disadvantaged due to illiteracy and thus unable to adequately utilise information even when it is available. As such KPs are not aware of the rights including their right to health, and many are not able to read. One of the KP Peers had this to say;

> *"Illiteracy hinders KPs' access to health services. They do not know their rights and can't even read. How many - let me say this - that chart may be there but they cannot even read it. Not even in the local language, because*

24 Above.
25 Above.

> *there is both English, and the local language…But if someone cannot even write their name, how can they read a chart on rights?!" (IDI, KP Peer).*

Further, it was noted that in some of the districts such as Kasese, not much was being done in as far as sensitising Key Populations on these issues is concerned. It was said to be possible that some KPs do not even know where to access HIV and TB services.

> *"Few know but the majority don't know their rights. And, however much we call for sensitisation in these regards, there is nothing happening. So, however much you talk for this year after year, no results" (IDI, KP, Kasese).*

Therefore, access to information largely depends on how much the KPs already know and how much they are willing to stand up for their rights. Those who have information are able to demand for their rights more than those who do not. Some KPs revealed that when they go to hospitals and find new doctors, they are able to articulate their needs, and assert themselves to the health worker so that they are also given treatment like the rest of the general population. They said that they were aware that every Ugandan by law had a right to access medication, and so did not see why they would shy away from getting medication even from health facilities which are not exclusively tailored to KP, or in those without doctors trained to handle KPs.

Below are some of the expressions they shared in this regard;

> *"While for me I can express myself freely with any other doctor, there might be KPs who can't".*
>
> *"It is because I am not used to them; they are new people. If someone is new, getting used to him or her is not easy. I cannot come to you and start telling you, you know this is who I am, I am this and that. It is not easy." (IDI, KP, Mayuge).*

There was a more nuanced determinant of access to health services for KPs, which is the level of awareness of their rights. KPs who had attained some considerable level of awareness about their rights were more likely to approach "new" health workers and get treatment without discrimination compared to those that were not as literate. Some of the participants who had undergone sensitisation by human rights organisations such as HRAPF had more confidence in going to general hospitals and asking to be served, even by "new" doctors,

than their peers who had not. Additionally, it was found that this self-confidence did not necessarily depend on levels of education as there were some KPs who had Bachelors' Degrees that confided that they feared going to access TB and HIV services from "new" doctors because they did not know how to go about it and feared stigmatization. On the contrary, some KPs who were uneducated but understood that health care is their right were confident enough to go and access medical services.

Based on the intricate web of factors that relate to literacy levels and levels of self-confidence, approaches aimed at promoting Key Populations' access to health services need to be multi-faceted to be able to achieve as the desired end. Beyond the general issues, different KPs, depending on the factors prevailing in their specific geographical setup, have peculiar needs.

Recommendations

1. *Have KP specific information for HIV and TB services available at all the different government health facilities*
2. *There should be deliberate efforts to sensitise KPs on their rights, and ways through which they can access health services*

c) Acceptability of HIV/TB goods and services

Acceptability is the third component of the right to health. According to the UN ESCR Committee, "All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.' As concerns KPs, this requires provision of goods, services and information that is respectful and thus acceptable to them.

To many KPs, the goods, services and information received from MARPI are acceptable, while those from many other government facilities are largely not. The difference lies in the acceptable treatment that is provided by MARPI facilities, which usually do not discriminate as already discussed above.

d) Quality of HIV/TB goods and services

The UN ESCR Committee further emphasises that, 'As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled

medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and portable water, and adequate sanitation.'

There was no complaint around quality of the goods provided by the state to KPs when they were available. The quality of services however was largely affected by the attitudes of the health workers in many government health centres. Whereas KP focal point persons were respectful of KPs, other health workers were largely not, and yet they could also be required at times to provide services to the KPs. The attitude and hostility they gave to the KPs therefore affected the quality of the services.

Recommendations

1. *The government should continue providing quality goods for KPs*
2. *The government should train health workers in quality service provision for KPs*

6. GENERAL RECOMMENDATIONS

A number of more general recommendations were made by different study participants from all the field sites to different stakeholders on how TB and HIV service provision to KPs in Uganda could be improved. These recommendations were captured in the following priority clusters:

i). Training more health service providers, and sensitising communities: Ensuring that health service providers understand the peculiar context and needs of KPs in accessing TB and HIV health services is considered by many to be paramount in improving service provision to KPs in Uganda. Because of the stigma, discrimination and name-calling that KPs experience while accessing treatment, both health workers and the KPs who participated in the study highlighted that training health workers to better handle KPs would "motivate" many KPs to go and access health services.

There are a few health workers that were trained to handle KP issues by organisations such as HRAPFd, but more trainings are needed so that even DICs can have more than one trained health worker. KPs also indicated that the name-calling and stigma which they face from the communities when they go to access health services from health facilities that are in 'non-strategic' locations are due to lack of awareness about the

existence (and 'full humanity') of KPs. Recommendations were made for institutions like HRAPF and other human rights organisations to sensitise communities about who KPs are and the need to fully integrate them in the communities and live with them without discrimination.

ii). Putting Drop-in-Centres (DICs) in strategic locations to ease access: The study participants (both health service providers and Key Population members) underscored the need to strategically locate clinics that give TB and HIV prevention and treatment services to KPs in isolated and enclosed places in order to avoid unwanted exposure of KPs visiting the facility. It was noted that KPs feel free and comfortable to go and access treatment from health points that do not expose them to stigmatization. Most of MARPI DICs were said to be strategically positioned to allow KPs privacy but there are quite a number of others that expose them to public view. Such need to be relocated to more strategic private places to ensure that KPs feel free to access TB and HIV prevention and treatment services.

iii). Need for more KP specific Drop-in-Centres (DICs): One of the key issues marked as a hindrance for KPs in accessing HIV and TB prevention and treatment services is the question of the distances that KPs have to travel to health facilities. It was recommended that more DICs be put in each district to minimise of the distances between KPs' homes and their nearest health facility. This would not only enable all KPs willing to get treatment to access it within reasonable distances, but would ease the burden from the few MARPI DICs that some stakeholders say are overwhelmed by the numbers of KPs that visit them. District needs should be integrated in national programming to ensure that particular needs of KP communities in various districts are addressed.

iv). Boosting medical stocks at health facilities: The study highlighted that many health facilities run out of stock of goods, especially some drugs that are key for Key Populations and lubricants. Some of the MARPI Drop-in-Centres and those run by other partners out of Kampala were also said to grapple with stock-outs sometimes. This is a concern because many KPs have to first gather courage before they go to access health services and so when they go and cannot get treatment, it becomes difficult for them to go back hence losing out on it. Sex workers particularly are torn between frequenting the health facilities and staying at their job to ensure they have a livelihood. The government of Uganda through its Ministry of Health and National Medical Stores needs to boost stocks at Health centres that give health services to KPs, and DICs should be upgraded to one-stop-centres for KPs health needs.

v). Addressing legal barriers: Many stakeholders articulated the need to enhance the effectiveness of the legal redress mechanisms when it comes to matters of Key Populations in the country. Issues such as arbitrary arrests of sex workers and PWUIDs by police and detention without trial greatly disrupt service provision and push KPs further into the closet. Human Rights organisations need to take this on seriously to ensure that KPs are treated with dignity and respect. Laws that criminalise consensual same sex relations, sex work and possession of drugs need to be revised/ repealed to ensure better legal protection for KPs and address their systemic marginalisation, and the government should ensure that its law-enforcement officers do not arrest KPs' for merely being.

vi). Training more Peer educators and facilitating them: The need to train more peer educators in the field of health services for KPs with regards to TB and HIV is huge. This will ease service delivery to KPs both in terms of geographical scope and time. To make this possible, these peers will need to be equipped with means of transport so that they can access KPs from the different environs and reduce on the stigma they experience at many health facilities. They also need to be well paid so that they can be able to do this on a full time basis.

vii). Providing more specific services for PWUIDs: Sex workers, MSM, and transgender persons have been catered for in the HIV response, but specific goods and services for PWUIDs are still lacking. There is thus need to pay special attention to this KP category and avail the necessary services to ensure effective enjoyment of their right to health.

viii). Supporting the community DIC model for KPs: Many organisations of KPs have established their own DICs catering for the needs of the specific KPs that they serve. These include: Spectrum Uganda, Icebreakers Uganda, Children of the Sun Foundation, Kuchu Shiners Uganda, Trans Equality Uganda, Trans Network Uganda for MSM and transgender persons, Women's Organisation Network for Human Rights Advocacy (WONETHA), Alliance for Women Working for Change (AWAC), Lady Mermaid Bureau, Men of the Night for sex workers, and Uganda Harm Reduction Network (UHRN) for PWUIDs. These should be supported to continue with this model as KPs feel more comfortable access services from such facilities than from health centres that also cater to the general population.

ix). Need to refocus on KPs due to the disruptions caused by COVID-19: The COVID-19 pandemic disrupted service provision for KPs just like for other groups. However due to the higher prevalence rate among KPs,

many were much more badly affected. There is need to refocus on HIV/TB service provision even amidst the COVID-19 pandemic response. The state has to prioritise services for KPs in line with the guidelines issued by the Ministry of Health to continue HIV services during the COVID-19 response.

x). The government should reduce on its dependence on donors and partners to provide HIV/TB services for KPs: In many of the heath centres where KPs were able to get tailored services, these were mainly provided by partners – MARPI, Mildmay IDI, RHSP, TASO and others. The danger is lack of sustainability when such projects come to an end. As such the government needs to take more charge of these services if they are to be sustainable,

7. CONCLUSION

Access to HIV/TB goods and services is very crucial for all persons, and more so for Key Populations. The state thus has to pay special attention to the needs of these groups. Laws that criminalise consensual same sex conduct, sex work or drug possession should be repealed and laws that protect KPs given more prominence. The MARPI model for service provision for KPs as well as where partners like IDI, TASO, Mildmay and RHSP are active, has proven to be effective and popular and should thus continue to be supported and expanded to cover the whole country.

ABOUT HRAPF

Background

Human Rights Awareness and Promotion Forum is a voluntary, not for profit, and non-partisan Non-Governmental Organisation. HRAPF works for the promotion, realisation, protection and enforcement of human rights through human rights awareness, research, advocacy and legal aid service provision, with a particular focus on minorities and disadvantaged groups. It was established in 2008 with a vision of improving the observance of human rights of marginalised persons in Uganda.

Legal Status

HRAPF is incorporated under the laws of Uganda as a company limited by guarantee.

Vision

A society where the human rights of all persons including marginalised persons and Most at Risk Populations are valued, respected and protected.

Mission

To promote respect and protection of human rights of marginalised persons and Most at Risk Populations through enhanced access to justice, research and advocacy, legal and human rights awareness, capacity enhancement and strategic partnerships.

HRAPF's Objectives

1. To create awareness on the national, regional and international human rights regime.
2. To promote access to justice for marginalised persons and Most at Risk Population groups.
3. To undertake research and legal advocacy for the rights of marginalised persons and Most at Risk Population groups.
4. To network and collaborate with key strategic partners, government, communities and individuals at national, regional and international level.
5. To enhance the capacity of marginalised groups, Most at Risk Populations and key stakeholders to participate effectively in the promotion and respect of the rights of marginalised persons.
6. To maintain a strong and vibrant human rights organisation.

Our target constituencies

1. Lesbian, Gay, Bisexual and Transgender (LGBT) persons
2. Intersex Persons
3. Sex Workers
4. Women, girls and service providers in conflict with abortion laws
5. People who use drugs
6. People Living with HIV and TB (PLHIV/TB)
7. Poor women, children and the elderly with land justice issues
8. Refugees

HRAPF Values

- Equality, Justice and Non-Discrimination
- Transparency, Integrity and Accountability
- Learning and Reflection
- Quality and Excellence
- Teamwork and Oneness
- Passion and Drive
- Networking and Collaboration

Slogan

Taking Human Rights to all

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