IMPROVING THE LEGAL ENVIRONMENT FOR PROVISION OF HIV AND TB SERVICES TO KEY POPULATIONS, PERSONS LIVING WITH HIV AND THOSE WITH TUBERCULOSIS IN UGANDA

POLICY BRIEF – MAY 2019

"Categories of people that have the highest risk of getting infected with HIV ironically have the least access to HIV prevention, care and support services – and consequently are the main source of new infections to the general population[1] . Basing on results from a rapid assessment of the legal and policy environment for access to HIV and TB services by these 'key populations', this brief highlights areas that interventions are needed to improve the legal and policy environment to address this challenge.

1. KEY POPULATIONS AND HIV

Key populations are categories of people that are, for various reasons, most likely to be exposed to HIV[2]. The National HIV and AIDS Strategic Plan (NSP) 2015/16-2019/20 defines 'key populations' as those with very high prevalence of HIV, contribute highly to new HIV infections and have high risk of acquiring and rapidly transmitting HIV among themselves and to the general population.

The NSP identifies the existing key populations as sex workers, long-distance truck drivers, men who have sex with men (MSM), fisher-folk and uniformed services personnel; emerging key populations as prisoners, miners, plantation workers, boda-boda men, brick-layers, and salt extractors; and the vulnerable populations as migrant and mobile populations, young women, adolescents, HIV-discordant couples, pregnant women and persons with disabilities (PWD). On its part, World Health Organization (WHO) identifies five key populations: MSM, people who inject drugs (PWID), people in prisons and other closed settings, sex workers and transgender people. [3]

The prevalence of HIV among key populations is disproportionately high. While the overall prevalence among adults aged 15 to 64 years is estimated at 6.2%[4] , among sex workers, it is as high as 35-37%; fisher-folk 22-29%; long-distance truck drivers 25%; uniformed forces (army, police, prison warders, security guards) 18.2%; and MSM 13.7%.[5] TB/HIV is the most common coinfection, and groups that are highly affected by HIV have a high burden of TB as well. An estimated 22% of TB deaths are of persons living with HIV (PLHIV) [6]. TB occurs as the first manifestation of AIDS in more than 50% of PLHIV[7] , and in Uganda up to 60% of TB patients have HIV[8] .

Some of the vulnerabilities are common across the different key populations, while others are unique to a few or even individual population groups.[9] For instance, while all the key populations are at increased vulnerability to HIV, four of them (MSM, PWID, sex workers and transgender people) are unique in the sense that they are criminalized in many countries (including Uganda).[10]

Nature of vulnerability	Affected population
Criminalization and punitive laws	MSM, PWIDs, sex workers, transgender
Unsafe practices	MSM, sex workers, transgender women, PWID
Sexual violence	Sex workers, PWID, prisoners, uniformed forces
Nature of work (mobile, dangerous)	Sex workers, fisher folk, truckers, bo-da-boda, uniformed forces
Stigma and discrimination	MSM, sex workers, PWIDs, transgender
Lack of access to HIV services	Prisoners, fisher folk, truckers

1 *UAC and UNAIDS, 2009. Uganda HIV prevention response and modes of transmission analysis report.*
2 *UNAIDS, 2015. UNAIDS terminology guidelines.*
3 *World Health Organization, 2017. Policy brief: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016 update. https://apps.who.int/iris/bitstream/handle/10665/258967/WHO-HIV-2017.05-eng.pdf;jsessionid=F4B2BF3EA0F21D0DCAE21A4C298CA693?sequence=1*
4 *Ministry of Health, 2018. Uganda population-based HIV impact assessment 2016-2017. Preliminary findings.*
5 *Uganda AIDS Commission, 2015. National HIV and AIDS strategic plan 2015/16-2019/20*
6 *WHO. Global tuberculosis report 2015*
7 *WHO, 2004. Interim Policy on Collaborative TB/HIV Activities*
8 *Ministry of Health. TB/leprosy control program. https://health.go.ug/programs/tb-leprosy-control-program*
9 *International AIDS Society. Ibid*
10 *International AIDS Society. A decision framework for antiretroviral therapy for key populations. www.differentiatedservicedelivery.org*

Vulnerability of any key population results from several factors. The lifestyles and sexual practices of MSM, PWID, sex workers and transgender are illegal under Uganda's laws and society generally regards them as morally inappropriate. This leads to their harassment by law enforcers, stigmatization by society and health care providers, powerlessness and withdrawal [11] – leading to poor uptake of HIV services. Some vulnerabilities are mutually reinforcing, e.g. while homosexuality is illegal, but being a receptive MSM is the riskiest sexual activity because the rectum's lining is thin and vulnerable to HIV penetration.[12]

Sex workers are vulnerable because sex work is illegal, but also because they face sexual violence from their clients and law enforcers, and tend to use drugs. Sex workers are up to 13 times more at risk of HIV infection compared to the general population [13], because they tend to be economically vulnerable, have intercourse with an indefinite number of partners, yet they are unable (or even uninterested) to negotiate and insist on condom use.

The "war on drugs" approach, which criminalizes and uses aggressive policing, crackdowns and stiff penalties against drug users, has the effect of sending them underground and away from healthcare and harm reduction services.[14] In these circumstances, access to sterile syringes – and even information – is lacking, leading to rampant sharing of needles by PWID, for which reason their risk of HIV infection is 22 times higher than the general population .[15]

Transgender people are one of the groups most affected by the HIV epidemic and are 49 times more likely to get HIV than the general population.[16] A high proportion of transgender people engage in sex work, and their clients tend to pay more for unprotected sex; their ability to insist on condom use is undermined by low self-esteem; and transgender women are vulnerable to unprotected anal sex.[17] Transgender people also tend to share needles in administering injectable hormones.[18]

2. KEY POPULATIONS AND POLICY

The policy framework has been relatively progressive in facilitating service provision and access by key populations. There are several policy guidelines that have pointed out the importance of providing services to persons most at risk of acquiring and transmitting HIV and other sexually transmitted infections (STIs). In 2013, amid the debate on the Anti-Homosexuality Bill, Ministry of Health issued guidance on the provision of non-discriminatory services to key populations. This directive emphasized the rights of Ugandans to health, including the minority groups to access health services based on the principles of inclusion, non-discrimination, privacy and confidentiality, accountability and transparency in health care.[19] The directive references the legal and institutional frameworks to govern and regulate the delivery of health services to its population.[20]

In addition, the National Strategic Plan (NSP) 2015/16-2019/20 recognises that targeting services to key populations is critical to the success of the national response. The National HIV Prevention Strategy 2011-2015, recognizes key populations and prescribes tailored services for them. The Multi-Sectoral HIV Response for MARPS in Uganda Programming Framework 2014 2016, defines a common planning framework and the Most-At-Risk Population priority action plan. Through these strategic and action plans, MoH provides for scale up of services key, vulnerable and priority populations and to eliminate stigma and discrimination.

Key populations are represented on the Uganda's Global Fund Country Coordinating Mechanism (CCM), the MoH technical working groups at the Ministry of Health, including for HIV, TB and Differentiated Service Delivery (DSD). In addition, MoH has a dedicated key population focal person and a key population technical working group that engages partners to develop strategic plans and guidelines that address key population, PLHIV and those with TB for prevention, and treatment of HIV and TB, and key populations have been actively involved in developing policy and implementation guidelines as well as in the actual implementation of HIV pre-exposure prophylaxis (PrEP). The Ministry has established facility and out-of-facility drop-in centers where key populations access friendly services. These canters are active in Mulago hospital, and 33 other regional hospitals, district hospitals and health centers across the country.

The Ministry of Health with other partners have developed a national curriculum for training health service providers of key population friendly services delivery and has a team of trainers at regional level. Service providers and key population peers have been trained in the delivery of KP-friendly services.

3. KEY POPULATIONS AND THE LAW

A fair, prosperous, secure and sustainable future is only possible if the rights of every person are recognized in practice and in law. The Universal Declaration of Human Rights (UDHR)

11 STAR-East, 2017. Ibid
12 Centers for Disease Control and Prevention, 2018. Anal sex and HIV risk
13 UNAIDS, 2018. Miles to go: Closing gaps, breaking barriers, fighting injustices
14 UNAIDS, 2016. The prevention gap report
15 UNAIDS, 2018. Miles to go: Closing gaps, breaking barriers, fighting injustices
16 UNAIDS, 2016. The prevention gap report
17 APTN/UNDP, 2012. Lost in Transition: Transgender People, Rights and HIV Vulnerability in the Asia-Pacific Region
18 Herbst JH, et. al, 2008. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. AIDS and Behavior
19 Ministry of Health, Ministerial Directive on Access to Health Services without Discrimination (June 2014);
20 Ministry of Health, Ministerial Directive on Access to Health Services without Discrimination (June 2014); section 4

proclaims "the equal and inalienable rights of all members of the human family". However, Uganda is one the countries where national laws criminalize and penalize behaviors of some key populations and are used arbitrarily arrest and detain them and their health care providers.

3.1 Laws relating to sex work

The Penal Code Act (s.131-139) prohibits prostitution and provides that any person who practices or engages in prostitution, or procures or attempts to procure a woman or girl to become, either in Uganda or elsewhere, a "common prostitute" commits an offence and is liable to imprisonment for seven years. The Code defines a prostitute as "a person who, in public or elsewhere, regularly or habitually holds himself or herself out as available for sexual intercourse or other sexual gratification for monetary or other material gain", and prostitution as "shall be construed accordingly".

These provisions are so broad that they can be used to arrest and level criminal charges or – as has in practice been the case – intimidate or harass real or presumed sex workers and their accomplices. The provision works against men and women deemed to engage or to have attempted to engage in or procure transactional sex; proprietors of places where transactional sex is practiced, including operators of the widely popular budget guest houses/ lodging facilities; persons who can be judged to knowingly live wholly or partially on earnings from prostitution; people who live with or are habitually in company of a prostitute; and other persons who can considered to aid or abet prostitution.

In addition, a sex worker can be arrested and charged with being idle and disorderly under section 167 of the Penal Code for behaving in a disorderly or indecent manner in any public place, a crime that attracts a prison term of three months and/or a fine. This particular provision has been used liberally by law enforcers to harass, abuse and intimidate actual and presumed prostitutes and their accomplices.

3.2 Laws relating to same sex relationships

The Constitution marriage between persons of the same sex (Art.31(2a).

Homosexuality and bestiality are illegal under the Penal Code Act (s.145), which makes provisions and gives sanctions against "unnatural offences". It specifically provides that any person who has carnal knowledge of any person against the order of nature, including carnal knowledge of an animal, or permits a male person to have carnal knowledge of him or her against the order of nature, commits an offence and is liable to imprisonment for life.

The Penal Code Act (s.148) further outlaws indecent practices, providing that "Any person who, whether in public or in private, commits any act of gross indecency with another person or procures another person to commit any act of gross indecency with him or her or attempts to procure the commission of any such act by any person with himself or herself or with another person, whether in public or in private, commits an offence and is liable to imprisonment for seven years." In 2000, the Penal Code Amendment (Gender References) Act was passed, changing references to "any male" to "any person" and thereby criminalizing grossly indecent acts between women.

The Anti-Homosexuality Act 2014 briefly made the legal environment for same sex relationships even more hostile before the Constitutional Court annulled it in August 2014.

3.3 Laws relating to gender identity and expression

Uganda's laws are conspicuously silent about transgender persons, which makes transgender persons to lack recognition in law as a specific category of persons that is entitled to rights and protection. It also makes it easy to confuse transgender persons with homosexuals and thus transfer the stigma that homosexuality carries in Uganda to transgender persons too.[21]

3.4 Laws relating to drug use

The legal and regulatory framework for drug use and possession is set out in the National Drug Policy and Authority Act 2006 and the Narcotic Drugs and Psychotropic Substance (Control) Act, 2019. The National Drug Policy and Authority Act (s.47) prohibits the possession of any narcotic drug or psychotropic substance under international control "without lawful excuse, the proof of which shall lie on him or her". The possession of narcotic drugs is allowed for license holders, such as medicine dealers.

The Act (s.29) requires medical practitioners to keep a record of all persons who are addicted to certain drugs and to make a report to the Minister at least every year, specifying the names of those persons and the drugs to which they are addicted. This provision is a threat to the privacy and confidentiality of drug users.

The Act (s.48) further prohibits the smoking of opium or Indian hemp or frequent any place used for the smoking of opium or Indian hemp; the provision of premises for such purposes; and the possession of pipes or other utensils for use in such smoking.

On its part, the Narcotic Drugs and Psychotropic Substance (Control) Act, 2019 prohibits the possession of narcotic drugs and psychotropic substances, except under license from National Drug Authority (NDA). It further prohibits trafficking in narcotic drugs and psychotropic substances and cultivation of plants from which narcotic drugs and psychotropic substances without written permission from the Minister.

The penalties are stiff, ranging between 5-25 years and fines equivalent to three times the value of the narcotic drugs or psychotropic substances found in possession of the culprit.

21 Human Rights Awareness and Promotion Forum, 2017. A quick scan of the laws and policies affecting the HIV response among transgender persons in Uganda

Trafficking in narcotic drugs and psychotropic substances is punishable by life imprisonment.

The Act (s.6) further criminalizes the manufacture, production, sale, distribution, consumption and promotion of narcotic drugs and psychotropic substances, and stipulates punitive sanctions against owners of premises, and possession of pipe or other utensil used in the production or consumption of drugs.

The Act (s.52) provides for the establishment of rehabilitation centers for the provision of treatment, care and rehabilitation of persons addicted to narcotic drugs or psychotropic substances. It further provides (s.58) that court may commit part of a term of imprisonment to a rehabilitation center, if it is satisfied that the convict is an addict of the substance he or she was found in possession and that it was for personal consumption.

The implications of these legal provisions for access to HIV services by people who use drugs are far reaching. The harsh penalties for even possessing a small quantity of narcotic drug or psychotropic substance for personal consumption is likely to force persons who use drugs underground, yet it has been estimated that PWIDs are up to 22 times more likely to acquire HIV than among the rest of the population.[22] The availability of public rehabilitation care is only accessible through the criminal justice system creates another challenge. PWIDs could instead keep away from these facilities for fear of being arrested, and away from critical harm reduction services that are necessary for mitigating HIV vulnerability.

The breadth of the law also poses a challenge for service providers who need to provide differentiated services for PWIDs, including community outreaches and follow-ups. The criminalization of venues where drugs are prepared, produced or consumed, including the owners of such premises, deters service providers from reaching PWIDs in their dens, and undermines efforts to mobilize people who use drugs for services.

3.5 Cross-cutting laws

The more recently enacted HIV and AIDS Prevention and Control Act 2014, which ideally should have been more sensitive to standard human rights norms, disappointingly criminalizes the intentional transmission of HIV and prescribes 10-year imprisonment and/or a hefty fine for any person who wilfully and intentionally transmits HIV to another person. The Act (s.12) further provides for the compulsory testing of persons apprehended for sexual offences for purposes of criminal proceedings and investigations.

The overall effect of these provisions is that the criminal provisions relate to crimes that, in theory and practice, can be challenging to prove, and as such, have been abused by law enforcers – while sending a chilling or intimidating effect to key populations and human rights defenders.

4. THE HUMAN RIGHTS-BASED RESPONSE TO HIV AND TB

The current laws against homosexuality, drug abuse and prostitution, and the way they are enforced has fueled widespread human rights violations against sex workers, sexual minorities and people who use drugs, compounding the multiple vulnerabilities to HIV that these and other key populations already experience. The purpose of a human rights based approach is to ensure that relevant laws, policies and interventions contribute to progressive realization of the right to health for all the people, including the vulnerable.

Interventions need to follow the principles of human rights, including universality and inalienability, indivisibility, interdependence and interrelatedness, non-discrimination and equality, participation and inclusion, accountability and the rule of law.

The mainstay of TB infection control is early and rapid diagnosis, and correct management of TB patients and their infected close contacts. The focus on infection control has to TB management approaches that violate the rights of TB patients. These include confinement, coerced treatment, and directly-observed treatment (DOT). DOT involves a patient being allocated an individual in the community to witness the patient swallow medicines on a daily basis to ensure adherence to the treatment. This compromises the confidentiality of the patient.

HIV and TB interventions, including harm reduction interventions, should designed and implemented with the participation of key populations. Policy makers, program managers and service providers need to be answerable to their clients and avoid being judgmental when handling key populations. All people are entitled to the same human rights and should not be subjected to any form of discrimination and stigmatization while seeking health care. Laws and policies should be consistent with international human rights principles and norms.

5. CONCLUSION

Health policies and guidelines indicate progress in addressing the HIV and TB service needs of keep populations, but the full realization of their potential calls for improvement in the legal environment for provision of services, information and support to key populations. Uganda Law Reform Commission (ULRC) should undertake a review of the criminal laws with a view of recommending reforms in line with international best practice, to reflect reality and achieve consistency with established human rights standards. Police, local leaders and other law enforcement agencies should desist from abusing the law, and using archaic legislation to harass, intimidate and violate the rights of sex workers, sexual minorities (MSM and transgender women), and PWD. MoH and civil society should scale up harm reduction advocacy and interventions for key populations.

22 *UNAIDS, 2018. Miles to go: closing gaps, breaking barriers, fighting injustices*