

No One Left Behind?

A Study on the Intersection of Women's Rights and
HIV/AIDS in Uganda



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Acronyms

ABC	Abstain, Be Faithful, Use a Condom
ACTs	Artemisinin-Based Combination Treatments
ADI	Addis Tax Initiative
AGHA	Action Group for Health Human Rights, and HIV/AIDS
AHO	African Health Observatory
ART	Antiretroviral Therapy
ARV	Antiretroviral
ATI	Addis Tax Initiative
CBOs	Community-Based Organizations
CCCC	China Communications Construction Company Limited
CCM	Country Coordinating Mechanism
CDC	Center for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEDOVIP	Center for Domestic Violence Prevention
CEHURD	Center for Health, Human Rights and Development
CHAs	Community Health Advocates
CSF	Civil Society Fund
CSOs	Civil Society Organizations
CSR	Corporate Social Responsibility
CSWs	Commercial Sex Workers
Danida	Danish International Development Agency
DFID	Department for International Development
DHMT	District Health Management Team
DHO	District Health Officer
DREAMS	Determined, Resilience, Empowered, AIDS-free, Mentored, and Safe
DRM	Domestic Resource Mobilization
EWPIR	Empowerment of Women living with HIV on Property and Inheritance Rights
EWS	Early Warning System
FBOs	Faith-Based Organizations
FIDA	Federation of Women Lawyers
FDCF	Financial Deepening Challenge Fund
FDI	Foreign Direct Investment
FFP	Female Future Program
FIDA	International Federation of Women Lawyers
FSW	Female Sex Workers
FUE	Federation of Uganda Employers
FY	Financial Year
GDP	Gross Domestic Product

GBV	Gender-Based Violence
GLISS	Great Lakes Institute for Strategic Studies
GoU	Government of Uganda
HEPS-Uganda	Coalition for Health Promotion and Social Development
HIRB	Homewood Institutional Review Board
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HRAPF	Human Rights Awareness and Promotion Forum
HRDs	Human Rights Defenders
HRE	Human Rights Education
HTC	HIV Testing and Counseling
HURINET	Human Rights Network Uganda
HWAF	Health Workforce Advocacy Forum
ICCPR	International Covenant on Civil and Political Rights
ICER	International Centers for Excellence in Research
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICWEA	International Community of Women Living with HIV Eastern Africa
IDA	International Development Association
IPs	Implementing Partners
IPV	Intimate Partner Violence
IFIs	International Financial Institutions
IMF	International Monetary Fund
ILO	International Labour Organization
IOM	International Organization for Migration
KABHURO	Kapchorwa- Bukwo Human Rights Organization
LGBT	Lesbian, Gay, Bisexual, and Transgender
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex
LLCs	Local Council Court
LRA	Lord's Resistance Army
MDG	Millennium Development Goals
MJAP	Makerere University Joint AIDS Program
MoFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MSM	Men Who Have Sex With Men
MSMEs	Micro, Small, and Medium Enterprise
MTCT	Mother-to-Child Transmission
M&E	Monitoring and Evaluation
NACWOLA	National Community of Women Living with HIV/AIDS
NAFOPHANU	National Forum of People Living with HIV/ AIDS in Uganda
NDA	National Drug Authority
NDPII	Second National Development Plan
NGO	Non-governmental organization

NGO Act	Non-Governmental Organizations Act
NMS	National Medical Stores
Norad	Norwegian Agency for Development Cooperation
NOTU	National Organization of Trade Unions
NRA	National Resistance Army
NRM	National Resistance Movement
NSP	National HIV and AIDS Strategic Plan
ODA	Official Development Assistance
OIG	Office of Inspector General
OSIEA	Open Society Initiative for Eastern Africa
OSF	Open Society Foundations
PEAP	Poverty Eradication Action Plan
PEPFAR	The United States President’s Emergency Plan for AIDS Relief
PLGHA	Protecting Life in Global Health Assistance
PLHIV	People Living with HIV
PNFP	Private Not-For-Profit
POMA	Public Order and Management Act
PPPs	Public-Private Partnerships
PR	Principal Recipient
RAIN	Rakai AIDS Information Network
REC	Research Ethics Committee
RHSP	Rakai Health Sciences Program
SAGE	Strengthening School-Community Accountability for Girls Education
SAIS	Johns Hopkins University School of Advanced International Studies
SASA!	Start, Awareness, Support, and Action
SCE	Self Coordinating Entities
SDGs	Sustainable Development Goals
Sida	Swedish International Development Cooperation Agency
SRHR	Sexual and Reproductive Health and Rights
STF	Straight Talk Foundation
STIs	Sexually Transmitted Infections
SWID	Slum Women’s Initiative for Development
TASO	The AIDS Support Organisation
TB	Tuberculosis
ttC	Timed and Targeted Counseling
UAC	Uganda AIDS Commission
UAFU	Uganda African Farmers’ Union
UDC	Uganda Development Corporation
UGANET	Uganda Network on Law Ethics and HIV/AIDS
UHRC	Uganda Human Rights Commission
UIA	Uganda Investment Authority
UMDPC	Uganda Medical and Dental Practitioners Council

UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/ AIDS
UNAPH	Uganda National Association of Private Hospitals
UNASO	Uganda Network of AIDS Service Organisations
UNC	Uganda National Congress
UNCST	Uganda National Council for Science and Technology
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
UNJPGE	United Nations Joint Programme on Gender Equality
UNPF	United Nations Population Fund
UNYPA	Uganda Network of Young People Living with HIV&AIDS
UPR	Universal Periodic Review
URA	Uganda Revenue Authority
USAID	United States Agency for International Development
UVRI	Uganda Virus Research Institute
UWEP	Uganda Women Entrepreneurship Programme
UWOPA	Uganda Women Parliamentary Association
VAW	Violence Against Women
VHT	Village Health Team
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WJP	World Justice Project
WLHIV	Women Living with HIV
WPHRE	World Programme for Human Rights Education
YWCA	Young Women’s Christian Association

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Executive Summary

The institutionalization of women’s marginalization in Uganda has dangerous implications for women’s ability to cope and thrive in the face of the HIV/AIDS epidemic. 36.7 million people worldwide are living with HIV/AIDS, over half of whom are women. In 2016, women aged 15-24 were almost twice as likely to contract HIV than their male counterparts.¹ In Uganda alone there are around 1.4 million HIV-infected persons, with women disproportionately affected; 7.6 percent of the female adult population is infected with HIV/AIDS, compared to 4.7 percent of men.² In the mid-1980s, Uganda was one of many countries to be impacted by HIV/AIDS, and was one of the first countries in Africa to acknowledge the existence of an AIDS epidemic and prioritize it as a public health and development problem. From the initial reported cases, the scale of the epidemic grew to 6,000 cases by 1988. Soon more than 30 percent of the population contracted the virus. From the late 1990s onward, Uganda would transform into a public health international success story as the first country in Sub-Saharan Africa to reverse the trend of the epidemic. Programming from the Ugandan government, foreign donors, international organizations, private institutions, and civil society organizations (CSO) flooded the space. By 2003, the collective response had reduced the rate of new infections to 4-6 percent. Eradicating HIV/AIDS remains a priority for the government of Uganda (GoU) and is enshrined in its national development goals.

However, despite some progress over time,

1 “Global HIV and AIDS Statistics.” AVERT. September 01, 2017. <https://www.avert.org/global-hiv-and-aids-statistics>

2 “HIV and AIDS in Uganda.” AVERT. March 26, 2018. <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/uganda>

recent trends are troubling and underscore the complexity of factors on which success depends: the strength of Uganda’s healthcare system, the availability of adequate funding, the roles of and coordination between various actors involved, favorable legislative and regulatory frameworks, and socio-cultural norms. The implications of how these factors take shape are individualized. For some groups that are already socially marginalized and economically disadvantaged, the challenges are particularly great. Women constitute one such key population. As they currently stand, the interplay of institutional dynamics and socio-cultural norms jeopardizes the fundamental rights of women in Uganda, leaving them more vulnerable to both HIV infection and negative consequences of an HIV-positive status.

For the 2017- 2018 academic year, the SAIS International Human Rights Clinic studied the intersection of women’s rights and HIV/AIDS in Uganda. Initially, the clinic set out to study the situation of human rights defenders working on HIV/AIDS in Uganda, in commemoration of the 20th anniversary of the Declaration on Human Rights Defenders. After consulting with experts, the clinic decided to focus on a narrower topic with less political resistance, but also significant value – women’s rights in the context of HIV/AIDS. Through desk research, meetings with key stakeholders, and in-field observations, this study sought to analyze the underlying factors that contribute to the disproportionate impact of HIV/AIDS on women, including the social, economic, political, cultural, and legal landscapes impacting the HIV/AIDS response. This study further concludes with policy recommendations for improving the HIV/AIDS response through a human rights focused lens.

Part I of the report provides an in-depth anal-

ysis of the history of HIV/AIDS in Uganda and identifies key demographic and social groups that have been found to be particularly vulnerable to the effects of HIV/AIDS or the risk of infection. This part further examines Uganda's national development goals and their relation to the United Nations (UN) Sustainable Development Goals (SDGs). The added and broadened goals of the SDGs are expected to build a more conducive environment to ending HIV transmission. Next this part provides insight into the legal framework that govern women's access to health and other human rights at the domestic, regional, and international levels. Then, it identifies stakeholders, from foreign donors, and multilateral institutions, to civil society and the private sector. Subsequently, this part details the structure of Uganda's healthcare system. Finally, it identifies several of the cultural factors that shape women's experiences in the HIV/AIDS context, including patriarchy, domestic relations, and religion.

Part II serves to identify specific challenges that result from deeply ingrained social norms and patriarchal structures, including stigma, violence against women, and gendered differences in health-seeking behavior. These challenges further manifest themselves in women's economic marginalization, which this report examines in relation to land ownership and property rights. In examining women's economic marginalization, this part further highlights a case study on the prevalence of commercial sex work within the fishing village of Kasensero. The part concludes with an in-depth assessment of the human rights issues with foreign companies investing Uganda.

Part III discusses the structural barriers that women, women living with HIV/AIDS (WLHIV), or other similarly situated persons may face in attempting to realize their rights. This part further analyzes the effectiveness of the current strategies of policymakers and foreign donors in the HIV/AIDS response. This analysis first addresses issues related

to access to justice, specifically concerning land and property rights, gender-based violence (GBV), and labor rights. It further examines structural problems in the Ugandan healthcare system, including governance failures, unsustainable funding, ineffective distribution of resources, and HIV-related discrimination. The part concludes with a discussion on contemporary Ugandan policies, such as restrictive legislation and their implications for the country's international, regional, and national pledges to improve both health care services and human rights.

Part IV examines the strategies and approaches that stakeholders have previously undertaken to combat HIV/AIDS and to promote women's rights within Uganda. The part first surveys the Government of Uganda's policies on HIV/AIDS, including the "combination HIV prevention approach", "test and start", Voluntary Counselling and Testing, Routine Medical Service Provision, and the "Abstinence, Be faithful, use a Condom" (ABC) approach to HIV/AIDS prevention. It then details current programs and interventions by foreign governments and international organizations, targeting issues surrounding HIV-related stigma, economic marginalization, GBV, and inadequate access to healthcare. Common strategies include sensitization, research and documentation, policy development, legal advocacy, capacity building, financial support, and technical assistance. Subsequently, the part concludes with an overview of Uganda's vibrant civil society working to address the interrelated issues of women's rights and HIV/AIDS. Non-governmental organizations (NGOs) and community-based organizations (CBOs) employ a rights-based community engagement approach to empower individuals and communities to take greater control of their health and rights.

Part V combines the research team's discussions with stakeholders, field experience, and desk research, to generate policy recommendations for Ugandan policymakers, foreign government

donors, NGOs, and the international community. These recommendations, rooted in a rights-based framework, cover a range of topics, such as education, international and national funding, donor coordination, as well as access to justice. While these recommendations are far from comprehensive, the team hopes they will serve as a starting point and will be of use to relevant stakeholders. As Uganda chases its ambitious development goals, these recommendations are aimed at ensuring that women are not, in fact, left behind.

Methods

Design and Sampling

This descriptive study discusses the intersection of women's rights and HIV/AIDS in Uganda. The report is the culmination of a year-long academic research course through the Johns Hopkins University Paul H. Nitze School of Advanced International Studies (SAIS). The research team consists of nine graduate student researchers with concentrations or minors in International Law and Organizations, International Development, and American Foreign Policy. They were guided by the Associate Director of the SAIS International Law and Organizations Program, who served as Principal Investigator (PI).

The team undertook an exploratory study initially designed to focus on the experiences of women living with HIV/AIDS (WLHIV). As research progressed, it became clear that women's inferior social status and the burden of HIV/AIDS operate as mutually reinforcing factors: the social and physical implications of HIV further marginalize women, and that marginalization raises their vulnerability to contracting HIV or impedes access to treatment. The report thus takes a broader lens.

Researchers used qualitative methods to identify relevant dynamics and determining factors and examined recent developments in women's rights and HIV/AIDS in Uganda. Specifically, they conducted desk research, meetings with key stakeholders, and in-field observations to examine how a seropositive status affects women's access to human, economic, social and cultural, and civil and political rights. Understandably, the study also revealed how a lack of respect for human rights

impacts women's vulnerability to contracting HIV. Going further, the study considers the implications of these outcomes for Uganda's progress towards its national development goals.

A preliminary review of primary and secondary sources begun in the fall of 2017 provided essential background information to guide subsequent phases of research. The literature review took stock of existing information from a variety of sources, including: the GoU, foreign embassies and development agencies; UN agencies (UNAIDS, UNDP, UNICEF, WHO); the African regional system; international financial institutions (African Development Bank, International Monetary Fund (IMF), World Bank); national, regional, and international NGOs; local and international media outlets; academia; and the private sector. Team members studied the history of and response to HIV in Uganda on the one hand, and women's social role and rights on the other. In addition to preparing for a visit to Kampala, researchers identified two rural areas for field visits: Kalisizo and Kasensero in Rakai District and Fort Portal in Kabarole District. Criteria for selection included the prevalence of HIV, ongoing interventions to treat and prevent HIV, and logistical considerations. The visits shed light on the impact of cultural norms and rural underdevelopment to women's vulnerability to HIV and ability to access their rights, as well as the implications for interventions around prevention and treatment. However, given the limited time spent in Rakai and Fort Portal, researchers did not make the divide between urban and rural sites a focus of this report. This remains an area for possible future exploration.

In addition to the literature review, the team conducted background interviews with experts, refined its research question, and identified relevant stakeholders for meetings. In October 2017, the PI and two student researchers met with H.E. Mull Sebuja Katende, Ambassador of the Republic of Uganda to the United States, and members of

his staff to discuss their research. All student researchers took and passed the Institutional Review Board Ethics Training for research using human participants. The team submitted its final research proposal for review by independent expert Marine Buissonniere³ and the Homewood Institutional Review Board (HIRB) of Johns Hopkins University. In December 2017, the HIRB granted approval conditional on final approval from the Uganda National Council of Science and Technology (UNCST). In accordance with Ugandan law, the team sought the endorsement of an NGO registered in Uganda to act as its local organization of affiliation. The International Community of Women Living with HIV Eastern Africa (ICWEA), a regional advocacy network for and by WLHIV, served this role. Subsequently, the team submitted its proposal to the accredited Research Ethics Committee (REC) of The AIDS Support Organization (TASO) for local ethics review and approval. The REC granted approval in early January 2018. Finally, the proposal was submitted for review by the UNCST Committee which, upon approval in April 2018, forwarded it to the Office of the President for final registration. The HIRB granted final approval in April 2018.

Bureaucratic delays, logistical challenges, and changing requirements significantly complicated the team's ability to secure final UNCST approval prior to its fact-finding mission. As such, researchers did not directly conduct interviews with WLHIV, as intended. Instead, the team focused on arranging meetings with key stakeholders who work on issues related to women's rights and HIV/AIDS in Uganda

and could speak to the team in their professional capacity. Researchers used a purposive sampling method to identify these individuals, then contacted them by electronic communication to explain the research project and request an interview.

The team traveled to Uganda for approximately one week, from January 17-25, 2018. The full team spent five days in Kampala; it divided into two smaller groups to spend two working days in Rakai District and Fort Portal, respectively. In Rakai, the team was hosted by Rakai Health Sciences Program (RHSP), a research organization and HIV service provider established as a collaboration with the Ministry of Health through Uganda Virus Research institute (UVRI); researchers at Makerere, Columbia, and Johns Hopkins Universities; and the Division of Intramural Research at the National Institutes of Allergy & Infectious diseases through the International Centre for Excellence in Research (ICER). In Fort Portal, the team was hosted by Fuel Uganda. Over the course of the week, the team conducted three dozen meetings with professional participants. They included: GoU officials, foreign embassy officials in Uganda, representatives of NGOs and CSOs, UN agency representatives, medical providers, police officers, and researchers. Interviews were guided by questions prepared by the research team in advance.

Each meeting began with a restatement of the project, the role of the researchers, the voluntary nature of the meeting, and the research goals. Interviewees gave express consent to be included in the study and indicated whether the meeting could proceed on the record. Audio recording was not used but, where allowed for, researchers took written notes. Data was subsequently electronically transcribed and stored in a secure platform accessible only to the research team. Meetings were conducted in English and typically took place for about an hour. The number of researchers in each meeting varied from two to nine, depending on availability.

3 Marine Buissonniere is an independent non-profit consultant and researcher with twenty years of senior leadership and management experience working with marginalized populations in the fields of health, human rights, and humanitarian action. Buissonniere holds an MPP and a health and health policy graduate certificate from Princeton University's Woodrow Wilson School of Public and International Affairs, as well as a diploma (maîtrise) in international management. She is fluent in English, French, and Mandarin.

They met either with single representatives of an organization or with groups of staff. Individuals were compensated for transport costs associated with their participation in the study, if necessary.

No meetings took place with individuals: 1) without professional or personal knowledge of the rights of women living with HIV/AIDS in Uganda; 2) who did not give or were not capable of giving informed consent; 3) who would be put at risk as a result of their participation; or 4) who wished that all the information provided, i.e., responses to interview questions or general discussion, remained off the record. The research was determined to present no more than minimal risk to the professional participants as the risks associated with participation were no greater than those encountered in daily life. Nor were members of the following populations recruited for interviews: children (younger than 18 years old), Johns Hopkins University students, Johns Hopkins University employees, emancipated minors, wards of the state, individuals with cognitively impaired/impaired decision-making capacity, pregnant women, critically ill or injured patients, or prisoners.

In late January, the research team returned to Washington, D.C. and undertook a situational analysis of the meeting and field notes to ensure consistency in collected data. In addition, they wrote blog posts describing their experiences and preliminary findings that were published on the group's website. Then, informed by follow-up communications with meeting participants and further desk research as necessary, researchers jointly developed this report. In April, a draft version of the report was circulated to all individuals with whom the team had met over the course of its study to solicit feedback. Comments from all those who responded were duly incorporated into the final version of the report. In May 2018, the research team published the report and presented its findings and recommendations to a group of stakeholders in at the Johns Hopkins

University School of Advanced International Studies in Washington, D.C.

Research Limitations

Due to resource and academic schedule restraints, the team could not spend more than approximately one week in Uganda. This limited the number and depth of its engagements. Nevertheless, team members sought to arrange meetings with a diverse array of individuals representing all key stakeholder perspectives. The most significant exception was the ability to interview WLHIV. This was impossible for the research team given the delays and challenges in securing UNCST approval, as noted above. Researchers thus strove to identify and meet with professional individuals who work closely with WLHIV and could credibly speak to their experiences and interests. Certainly, direct insight from WLHIV is critical to ensuring that this study accurately and faithfully represents their perspectives and that it serves as a platform to lift their voices. At the same time, researchers realized that, given the sensitive nature of the topic, interviews with WLHIV are, in fact, best conducted by experienced professionals who have existing relationships with the women. To that end, the team plans to work with trusted organizations that serve the affected population – namely, ICWEA and RHSP – to facilitate interviews. These organizations are best capable of hiring local researchers who can identify eligible interviewees and administer the semi-structured interview questionnaire developed by the research team. The interview sample will consist of adult WLHIV who can voluntarily and safely speak openly about their experiences. The minimum number of participants is 20, with at least ten interviews taking place in Kampala and Rakai each. Interviewers will transfer their notes to the

research team, which will assess how the findings support or challenge this report's analysis. These conclusions will be shared in an addendum to be issued in the summer following the report's initial publication.

Another challenge arose from limitations in the access to reliable, up-to-date data. Health, spending, and other statistics are not always readily accessible nor consistently measured by different actors. Whenever possible, researchers used the most current figures available and sought to cross-verify them. In addition, the data – particularly around gender-based violence and discrimination – likely suffers from underreporting given the sensitive nature of these matters and deterrents to reporting.



Part I:

Background

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“They called it ‘Slim’ disease,” Eddy Migeero explains as he holds up faded newspaper clippings.⁴ It is easy to see why – below the alarmist headlines are photos of emaciated men and women, victims of a mysterious illness that had rapidly claimed countless lives in this rural Ugandan district of Rakai. Kasensero, a nearby fishing village on the western shores of Lake Victoria, was the site of the first reported case of “Slim” disease in 1982. Searching for an explanation, locals blamed witchcraft;⁵ desperate for a cure, some turned to prayer and the advice of mystics and prophets.⁶ In 1985,

4 Meeting with Eddy Migeero, Founder of Rakai AIDS Information Network on January 23, 2018, Rakai, Uganda.

5 Christine W. Wanjala, “Kasensero: Where Uganda’s First Aids Cases Were Reported,” *Daily Monitor*, November 29, 2013.

6 Mary Battiata, “Ugandans, Ravaged by AIDS, Look to Prophets and Miracles; Africa,” *Sydney Morning*

and by 2003 to as low as 4-6 percent.¹¹

President Yoweri Museveni's top-down leadership has been widely praised by the international community for fueling the turnaround, principally through the ABC Campaign. In 1986, Uganda's Ministry of Health began the AIDS Control Program in coordination with the WHO, which would become the leading national AIDS program in Africa. During the 1990s, the GoU continued to expand its partnerships in the fight against HIV/AIDS with both international organizations and NGOs.¹² To better coordinate this multi-sectoral approach, in 1992 it established the National AIDS Commission, responsible for joint planning, monitoring and evaluation, and information sharing around HIV/AIDS prevention and control.¹³

The HIV/AIDS epidemic contributed to Uganda's low life expectancy: just 44.3 years in 2000. However, the response to the outbreak succeeded in raising that figure to 63.35 years in just 15 years.¹⁴ Uganda is also on course to achieve the "90-90-90" goal. Initiated by UNAIDS, this treatment target entails having 90 percent of people living with HIV know their status, 90 percent receiving antiretroviral therapy (ART), and 90 percent of those on ART having viral suppression by 2020.¹⁵ By December 2016, the number of diagnosed in Uganda was 77 percent of the estimated 1.35 million people living with HIV/AIDS (PLHIV), and national treatment

coverage was 68 percent. Treatment coverage is projected to expand to 95 percent by 2018, with approximately 1.3 million Ugandans receiving ART in 2017 alone. Uganda has also succeeded in reducing the MTC transmission rate to less than 5 percent, with 98 percent of HIV-positive pregnant women on ART.¹⁶

However, challenges remain to adequately addressing the scale of the crisis. While the number of new infections has demonstrated a downward trend since 2009, the number of PLHIV within Uganda has been increasing since 2004, a disconcerting reversal after a decade of decline. In 2016, the HIV prevalence rate in adults (aged 15-64) was 6.2 percent, with an estimated 1.2 million adults living with HIV in Uganda. For women specifically, the prevalence of HIV was 7.6 percent, compared to 4.7 percent among adult males. Additionally, HIV prevalence has been found to be higher among women living in urban areas (9.8 percent) than those in rural areas (6.7 percent).¹⁷ Cultural practices, limited education, and economic opportunities have all fueled gender inequalities within the country, which has further exacerbated the divide in HIV prevalence rates. Gender disparities also exist within testing for HIV/AIDS. Only 61 percent of estimated HIV-positive men were diagnosed as of 2017, with only 54 percent of this population receiving ART.¹⁸

Clearly, despite its early successes, Uganda is now in a precarious situation. A weak healthcare system, inadequate financing, lack of accountability, and persistent stigma, especially against already-marginalized populations, create significant obstacles for Uganda to address its HIV/AIDS cri-

11 "Country Profile- Uganda: A Complicated Story." *The Age of AIDS*. PBS. Accessed March 2018, <https://www.pbs.org/wgbh/pages/frontline/aids/countries/ug.html>.

12 Slutkin, et al. "How Uganda Reversed Its HIV Epidemic."

13 Ministry of Health Uganda, *An Overview of HIV/AIDS in Uganda*, Accessed March, 2018. <http://library.health.go.ug/publications/service-delivery-diseases-control-prevention-communicable-diseases/hiv/aids/overview>

14 PEPFAR, *Uganda: Country Operational Plan 2017: Strategic Direction Summary*, July 28, 2017, <https://www.pepfar.gov/documents/organization/273638.pdf>

15 "90-90-90: An ambitious treatment target to help end the AIDS epidemic." UNAIDS. January 1, 2017. <http://>

www.unaids.org/en/resources/documents/2017/90-90-90.

16 PEPFAR, *Uganda: Country Operational Plan*.

17 "Uganda Population-Based HIV Impact Assessment." UPHIA. August, 2017. <http://www.afro.who.int/sites/default/files/2017-08/UPHIA%20Uganda%20fact-sheet.pdf>

18 PEPFAR, *Uganda: Country Operational Plan*.

sis.¹⁹

Key Populations

Certain demographic and social groups are particularly vulnerable to the effects of HIV/AIDS or the risk of infection. UNAIDS defines these “key populations” as sex workers, people who inject drugs, transgender people, prisoners, gay men, and other men who have sex with men (MSM), and their sexual partners.²⁰ Though they face many of the same challenges generally, it is important to distinguish between the unique challenges that each group faces. Writing in 2011, the Open Society Initiative for Eastern Africa (OSIEA) noted that, while Uganda was once “a model country in HIV/AIDS prevention,” institutional discrimination against socially-marginalized groups through “the introduction of policies driven by morality concerns rather than health and safety” might have contributed to the reversal in the declining infection rate.²¹ In Uganda, the United States’ President’s Emergency Plan for AIDS Relief (PEPFAR) defines key and priority populations as female sex workers (FSW), men who have sex with men (MSM), fishermen, members of uniformed services, and prison inmates.²² In stark contrast to the rest of the population, these groups face prevalence rates of 15-37 percent.²³

The number of FSWs in Uganda is estimated to be 195,623 with an HIV prevalence rate of between 33 percent and 37 percent. PEPFAR estimates that 16 percent of new infections within the

country come from FSWs, their clients, as well as the clients’ sexual partners. Provision of HIV/AIDS prevention and treatment services by the international community and civil society to this population is particularly tricky, as sex work is illegal in Uganda.²⁴ Additionally, the exact number of FSW is difficult to ascertain, as many work clandestinely.²⁵

A survey in Kampala indicated a population of MSM of between 7,000 and 13,000. This population had an HIV prevalence rate of 13.7 percent. Like FSWs, MSM are highly stigmatized, and the current legal environment in Uganda prevents non-discriminatory delivery of services.²⁶ The transgender community is also highly stigmatized and often resorts to sex work due to marginalization.²⁷ For these transgender persons, the issues are compounded between the overlap with sex work, social isolation, and ostracization from even the gay community.²⁸

Finally, fishing communities living around Lake Victoria have been found to have a prevalence rate of 14.9-35 percent. Due to the dominant commercial activity in these areas, many of the estimated 2,000,000 individuals living there are migratory; fishermen come and go seasonally to conduct their business, and sex workers follow likewise. With disposable income and no family ties on site, the fishermen provide a client base that even draws women from faraway Kampala in search of income.²⁹ In this environment, social structures

19 Ibid.

20 “Feature Story: HIV Prevention among Key Populations,” *UNAIDS*, 22 November 2016, http://www.unaids.org/en/resources/presscentre/featurestories/2016/november/20161121_keypops.

21 “Amplifying Voices: The Uganda Issue.” The Open Society Initiative for East Africa (OSIEA). n.d. http://osiea.org/wp-content/uploads/2017/07/amplifyingvoices_vol2_web1.pdf

22 PEPFAR, *Uganda: Country Operational Plan*.

23 Ibid. p. 4.

24 Ibid.

25 Meeting with Annet Nannungi and Dennis Bataringaya on January 17, 2018 in Kampala, Uganda.

26 PEPFAR, *Uganda: Country Operational Plan*.

27 Meeting with Taitan Rollis on January 22, 2018 in Kalisizo, Uganda; *see also* Kenneth Dickerman, “The Harsh Reality of Being Transgender in Uganda,” *Washington Post*, August 17, 2016, https://www.washingtonpost.com/news/in-sight/wp/2016/08/17/the-harsh-reality-of-being-transgender-in-uganda/?utm_term=.47a2844d1432.

28 Dickerman, “The Harsh Reality of Being Transgender in Uganda.”

29 Meeting with Kasensero Clinic In-charge, Francis Kato on January 23, 2018 in Kasensero, Rakai District,

resource mobilization strategy focused on becoming less dependent on external sources of funding. The National HIV Trust Fund, created by the HIV and AIDS Prevention and Control Act passed in July 2014, is one of the mechanisms UAC hopes will ensure domestic resource provision for the epidemic.³⁶ The GoU called for a two percent tax on alcohol and soft drinks to finance the Fund at a rate of USD 2 million each year. Unfortunately, parliament has yet to approve the regulations necessary to make the Fund operational.

Foreign Donors



United States

The President's Emergency Plan for AIDS Relief (PEPFAR) is the predominant bilateral donor program targeting HIV in Uganda. Proposed by President George W. Bush in January of 2003, PEPFAR was created to target the global AIDS crisis in 15 "focus countries," including Uganda, and remains the largest initiative to fight a single disease.³⁷

Out of the more than \$840 million in U.S. assistance specifically provided to Uganda in 2016, PEPFAR's allocation was \$371 million to address the HIV/AIDS epidemic. Since 2003, PEPFAR has directed this aid towards providing service delivery and technical assistance in coordination with the GoU and development partners including The Global Fund. In 2016, PEPFAR-supported programs provided approximately 850,000 Ugandans with antiretroviral (ARV) therapy, or roughly 94 percent of HIV-positive Ugandans. Additionally, PEPFAR

initiatives helped to test 8.1 million Ugandans for HIV/AIDS and have promoted efforts to increase voluntary medical male circumcision (VMMC), which can help prevent new infections.³⁸

In response to the disproportionate impact that the HIV/AIDS epidemic has had on women and girls, PEPFAR and its private sector partners have created the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) partnership to reduce new HIV infections in adolescent girls. In Uganda, the \$31 million program intends to reach 335,000 young women through initiatives addressing gender-based violence, condom use and availability, and educational and economic opportunities.³⁹

However, the most recent budget cuts proposed by President Donald Trump's administration have called into question the future for global health programs like PEPFAR. In his 2018 budget, Trump proposed an \$800 million cut to U.S. bilateral HIV/AIDS programs, with an additional \$225 million cut for The Global Fund.⁴⁰ In regards to the country-specific impact of the budget cuts, PEPFAR will eliminate funding to seven countries, and reductions will cut across 17 additional recipients. Remaining PEPFAR funds will then refocus on the Department of State's new Epidemic Control Strategy, which concentrates resources within 13 "priority countries," including Uganda. The Department's new Epidemic Control Strategy aims at strengthening cooperation within these high-priority areas, in areas related to HIV testing and treatment, prevention programs for young women and men, and renewed engagement with faith-based organizations and the private sector. Resources will concentrate on scaling-up successful programs such as DREAMS, as

36 Meeting with Enid Wamani from Uganda AIDS Commission's Director of Partnerships, on January 15, 2018, in Kampala, Uganda.

37 "About Us." The United States Emergency Plan for AIDS Relief (PEPFAR), N/D, <https://www.pepfar.gov/about/270968.htm>

38 "Report to the Ugandan People." United States Mission to Uganda. 2016.

39 Ibid.

40 Michael Gerson, "Trump wants to gut America's progress against AIDS," *The Washington Post*, November 30, 2017.

well as VMMC.⁴¹

While Uganda will remain a priority country for PEPFAR funding in the future, the Mexico City Policy, widely known as the “global gag rule” may also jeopardize efforts to combat HIV/AIDS. The policy, which President Trump re-named “Protecting Life in Global Health Assistance” (PLGHA), requires NGOs to attest that they will not perform or promote abortions or abortion-related services anywhere in the world as a condition for U.S. funding, even if they use their own funds from non-U.S. sources for these abortion-related services.⁴² President Trump expanded the policy to include restrictions on NGOs from providing information or referrals for abortion, even in countries where abortions are legal and also restricts NGOs from advocating for liberalizing abortion laws.⁴³ Currently no USAID or PEPFAR program was cut due to an implementing partner’s refusal to sign the PLGHA provision. Further, USAID is not currently funding any Reproductive Health Uganda activities. However, the PLGHA prevents PEPFAR from providing future funding to those connected to reproductive health.⁴⁴

Sweden

The Swedish International Development Cooperation Agency (Sida) emphasizes the support of the Ugandan healthcare system through the delivery of services and preventive health work. Through its focus on primary healthcare, Sweden helping to

achieve better results in child and maternal health-care, sexual and reproductive health and rights, and the prevention of HIV.⁴⁵ Of the \$48.9 million spent in 2017, Sida spent \$11.9 million towards promoting public health within the country.⁴⁶

Sweden works closely with the Ugandan Ministry of Health (MOH) in the execution of Uganda’s national strategy against the spread of HIV/AIDS. It provides technical assistance to strengthen MOH capacity for planning and management within the health sector. While Sida’s funding no longer goes directly to the Ugandan government, Sweden channels financial support through both civil society organizations and international organizations operating within the country.⁴⁷

In coordination with other major donor organizations including USAID, the World Bank, and UNICEF, Sweden runs several programs that address child and maternal health care. In the more contested area of sexual and reproductive health, Sweden is also using its influence to lobby for better access to contraception and safe, legal abortions.⁴⁸ In partnership with NGOs, Sweden also helps to expand reproductive health education programs and supports health clinics that target the most vulnerable populations in the country, including sex workers, drug users, LGBTQ individuals, and island populations.⁴⁹

41 U.S. Department of State, *PEPFAR: Strategy for Accelerating HIV/AIDS Epidemic Control (2017-2020)*. September 2017. <https://www.pepfar.gov/documents/organization/274400.pdf>.

42 Sarah Boseley, “How Trump Signed a Global Death Warrant for Women,” *The Guardian*, July 21, 2017.

43 “Trump policy harming Uganda’s health services, says rights body,” *The Daily Monitor*, October 30, 2017, accessed on April 21, 2018,

44 Meeting with the Embassy of the United States, on January, 17, 2018, in Kampala, Uganda.

45 Meeting with representatives from Embassy of Sweden, on January 19, 2018, in Kampala, Uganda.

46 Swedish International Development Cooperation Agency (Sida), “Development cooperation with Uganda,” February 23, 2016, <https://www.sida.se/English/where-we-work/Africa/Uganda/Cooperation-in-figures/>

47 Sida, “Our work in Uganda,” April 14, 2015, <https://www.sida.se/English/where-we-work/Africa/Uganda/Our-work-in-Uganda/>

48 Sida, “Development cooperation with Uganda.”

49 Meeting with representatives from Embassy of Sweden, on January 19, 2018, in Kampala, Uganda.

Norway

Health is a leading priority among the five thematic areas that guide Norway's development policy. Within the health portfolio, the Norwegian Agency for Development Cooperation (Norad) has a specific mandate to focus on reducing health inequalities by reaching the poorest and most marginalized communities. Norway works to provide political, financial, and technical assistance to actors engaged in global health and health aid. In 2016 alone, 80 percent of the approximately \$6 billion Norwegian channels global health budget through multilateral organizations and global funds.⁵⁰ In Uganda alone, Norway supported the development of the nation's healthcare sector with more than \$2 billion.⁵¹

In Uganda, the Embassy of Norway works towards four strategic goals. The embassy's second strategic goal focuses on human rights and democracy. Through this lens, the Norwegian Embassy addresses gender equality in general and more specifically gender-based issues that relate to health and GBV. From improving maternal health to reducing child mortality, the spread of HIV/AIDS, and to actively engaging on the policy level, Norway plays a leading role in global health efforts in Uganda.⁵²

To reduce health inequalities, Norway works in close coordination and cooperation with multilateral organizations and the Government of Uganda. Norway channels its funding through multilateral organizations and global funds (core budget sup-

port), primarily. Norway's strategy serves to ensure alignment to one agenda, hereunder the SDGs that are in line with national aspirations. On another level, the Embassy is chairing the Gender Development Partners' Group, which looks at gender from many different perspectives and furthermore serves as a coordinating mechanism among donors and multilateral organizations.⁵³

Denmark

The Danish International Development Agency (Danida) has provided over three decades of development support to Uganda. Danida's top development priorities include contributing to poverty reduction through economic growth, promoting democracy and good governance, and supporting Uganda's stabilizing role in the region. Denmark's development program is based on Uganda's national priorities, and is aligned closely to the National Development Plan (NDP II) through consultations with GoU, private sector, civil society, and other development programs.⁵⁴

Between 2007-2012 Denmark was the leading donor to the AIDS Partnership Fund, providing approximately \$4 million in assistance. The Partnership Fund is responsible for coordinating government and non-government sectors in prevention, control and management of the HIV epidemic. Denmark was also one of the leading donors to the Civil Society Fund (CSF) during the same time period, contributing \$21 million, or 23 percent of the organization's funding. CSF was established in 2007 and continues to offer grants and capacity building to scale up effective, comprehensive HIV prevention and care services.⁵⁵

50 Norwegian Agency for Development Cooperation (Norad), "How Norway works with global health," Norad, February 23, 2018, <https://www.norad.no/en/front/thematic-areas/global-health/how-norway-works-with-global-health/>.

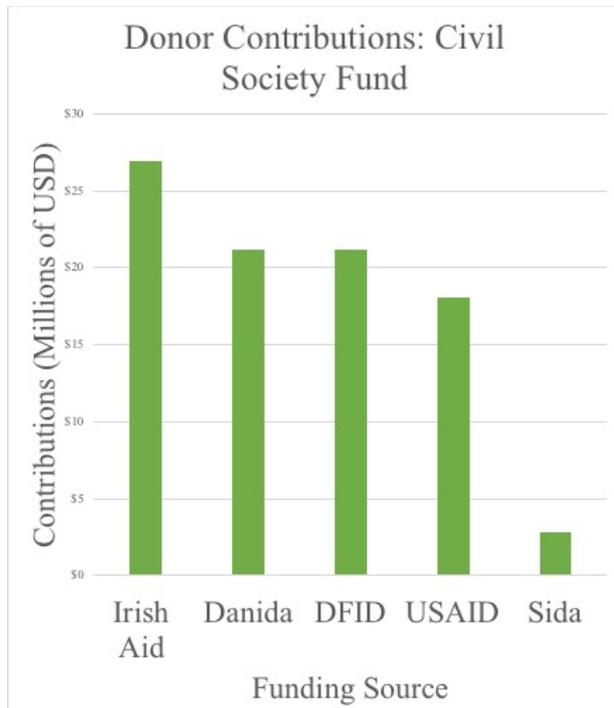
51 Norad, "Norwegian Aid Statistics," Norad, <https://www.norad.no/en/front/toolspublications/norwegian-aid-statistics/?tab=geo>

52 Meeting with Nadia El Ouargui from the Embassy of Norway, on January 19, 2018, in Kampala, Uganda.

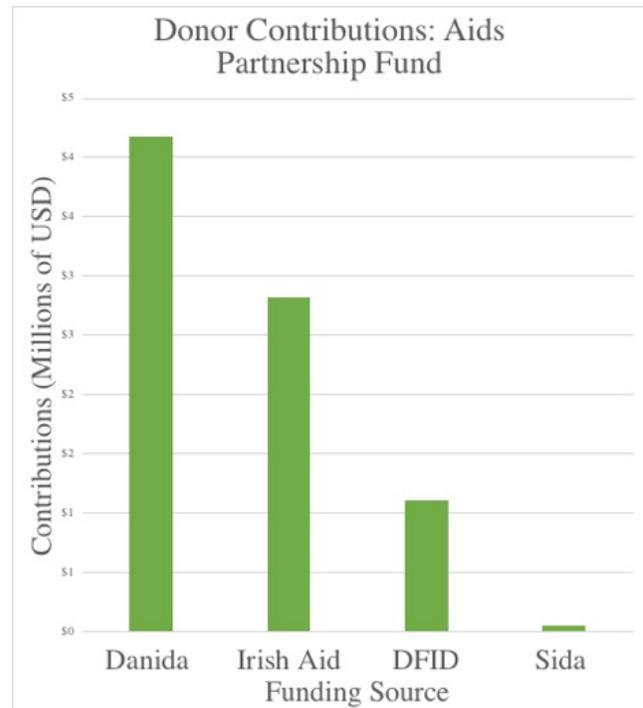
53 Ibid.

54 Ministry of Foreign Affairs of Denmark, *Denmark-Uganda Partnership: Country Programme Document 2018-2022* (October 6, 2017), <http://uganda.um.dk/en/danida-en/country-programme-for-uganda-2018-2022/>

55 Ministry of Foreign Affairs of Denmark, "Joint



Danish Ministry of Foreign Affairs, "Joint Evaluation."



Danish Ministry of Foreign Affairs, "Joint Evaluation."

While Denmark’s direct funding of HIV/AIDS is gradually being phased out, Denmark continues to prioritize its engagement with the health sector through its focus on young people and women. Danida’s current health sector programs promote inclusion, healthy lives, economic well-being and productivity with respect for human rights. Danida programs are aimed at increasing the access and utilization of quality sexual and reproductive health rights and gender-based violence services, hoping to link health with Uganda’s broader economic development.⁵⁶

Ireland

Irish Aid, Ireland’s international development program, has gradually expanded its partnership with Uganda. Ireland’s development program re-

mains in line with Uganda’s National Development Plan, and priority intervention areas include social protection, HIV/AIDS, education, and governance and accountability. While Ireland works at Uganda’s national level to influence policy change, their development programs also maintain a specific focus on the region of Karamoja.⁵⁷

Ireland was the third largest donor to the AIDS Partnership Fund between 2007-2012, providing over two million is assistance. Further, Irish Aid’s contribution of over \$26 million to the Civil Society Fund, made up approximately 30 percent of the organization’s funding.⁵⁸ As other development partners move away from the HIV/AIDS response, Ireland has asserted the continued added value of its programs, and ability to influence change with the Ugandan government. Overall, Ireland’s focus on HIV/AIDS, particularly within the region of

Evaluation: Support to the National Response to HIV/AIDS in Uganda 2007-2012,” January 2014, Accessed May 2018, <https://www.oecd.org/derec/denmark/Support-to-the-national-response-to-hiv-aids-in-uganda.pdf>.

56 Ministry of Foreign Affairs of Denmark, *Denmark-Uganda Partnership*.

57 Irish Aid, *Uganda Country Strategy Paper 2016-2020*, February 2016, <https://www.irishaid.ie/media/irish-aid/allwebsitemedia/20newsandpublications/FINAL-Uganda-CSP-print-version.pdf>

58 Ministry of Foreign Affairs of Denmark, “Joint Evaluation.” . .

Karamoja, hopes to address the disproportionate impact that HIV/AIDS has on Uganda's poorest, as well as girls and adolescents.⁵⁹

International Multilateral Organizations

UNAIDS

Since its establishment in 2001, the Joint United Nations Program on AIDS (UNAIDS) gradually evolved to become the leading international agency to address the HIV/AIDS crisis. UNAIDS provides both vision and strategic direction for the global AIDS response, supporting affected countries, civil society, and most importantly the communities of people living with HIV. UNAIDS works in close collaboration with funders including the Global Fund and PEPFAR.⁶⁰ Ultimately, UNAIDS is in charge of guiding the international management of HIV/AIDS response. UNAIDS designs and monitors policies and programs, while other UN agencies are charged with implementing them.⁶¹

The work of UNAIDS is guided by a shared vision of eliminating new HIV infections, discrimination, and AIDS-related deaths, as well as the 2016–2021 Fast-Track Strategy. The Strategy, approved in October of 2015, was the first to be adopted following the adoption of Agenda 2030 and the Sustainable Development Goals (SDGs). It is aligned with the SDGs, and provides guidance for the SDG target of ending AIDS as a public health

crisis by 2030.⁶²

The Global Fund to fight AIDS, Tuberculosis and Malaria

The Global Fund was founded in 2002 as a public-private partnership and international financing institution focused on engaging governments, civil society, the private sector in addressing the HIV/AIDS, Tuberculosis and Malaria epidemics. The Global Fund's core role remains as a financing institution, raising and investing nearly \$4 billion annually to support programs targeting all three epidemics. While the Global Fund does not implement programs on the ground, the organization does provide support to countries in their national response to the diseases. The organization's funding supports programs run by local experts in countries and communities most in need.⁶³

As of November, 2017, the GoU has signed grant agreements with the Global Fund to ensure \$478 million in funding for 2018-2020, to support Uganda's work in eliminating HIV/AIDS, Tuberculosis, and Malaria. The Global Fund has increased Uganda's funding by \$57 million from that received under previous grants.⁶⁴

UN Women

UN Women works to empower women throughout Uganda in regards to both economic rights and health rights. In terms of economic rights,

59 Irish Aid, *Uganda Country Strategy Paper*.

60 UNAIDS, *UNAIDS 2018-2019 Budget*, (Switzerland) June 9, 2017, http://www.unaids.org/sites/default/files/media_asset/20170609_PCB40_2018-2019-Budget_17.9_EN.pdf

61 Meeting with Sarah Nakku, Country Community Mobilization and Networking Advisor from the UNAIDS, on January 18, 2018 in Kampala, Uganda.

62 UNAIDS, *UNAIDS 2018-2019 Budget*.

63 The Global Fund, "Global Fund Overview," November 17, 2017, <https://www.theglobalfund.org/en/overview/>

64 Ministry of Health Uganda, "Uganda Receives New Global Fund Grant to Fight HIV/Malaria, and Tuberculosis," November 23, 2017. <http://cancerplatform.com/welcome/news/UGANDA-RECEIVES-NEW-GLOBAL-FUND-GRANT-TO-FIGHT-HIV-MALARIA-AND-TUBERCULOSIS>

the majority of Ugandan women do not work and live in rural areas. Women living in urban areas are also relegated to working in the outskirts of the city. UN Women seeks to promote women's economic wellbeing, as independence. In addition, UN Women works to provide opportunities for HIV+ women to participate in the policy process, such as through organizing events, creating new platforms for dialogue online, or through training mentors.⁶⁵

UN Women provides technical assistance to the Ugandan government, such as by mobilizing resources. However, it has no role in coordinating donors, as this falls under the jurisdiction of the Ministry of Health. UN Women is part of the larger UN Working Group on HIV/AIDS, which includes participants of other UN agencies, embassies and foundations to develop strategies to target the issue.⁶⁶

United Nations Development Programme (UNDP)

The pillars of UNDP's mandate include both governance, and sustainable and inclusive economic development. UNDP ensures that human rights issues are target by each of the pillars and areas of focus. UNDP works through its government and civil society parties to engage with Ugandan communities on the issue of HIV/AIDS.⁶⁷

Through their partnerships, UNDP works to improve access to justice. Working with the non-governmental organization UGANET, UNDP helps to train paralegals to work in 8 districts throughout the country to help protect the property

rights of widows and orphans. In addition, UNDP also works on intellectual property rights related to HIV/AIDS drug laws. The UNDP partnership with CEHURD, a national NGO, focuses on advocating for access to less expensive drugs.⁶⁸

Finally, UNDP emphasizes legal and policy reform, identifying specific laws that should be fast-tracked, and providing national budget considerations. For example, while Uganda's vision 2040 sets the goal of seeing the country become a middle-income country by the year 2040, questions have been raised regarding the prioritization of infrastructure over public health issues like HIV/AIDS. UNDP hopes to further analyze where resources are being allocated, in the hopes of lobbying for larger investments in the health sector.⁶⁹

International Labour Organization (ILO)

The International Labour Organization (ILO) works with various partners within Uganda, including workers' groups, employers, the Ministry of Foreign Affairs, and the private sector to address gender inequality within the workplace. Through this emphasis on non-discrimination, the ILO addresses the problem of HIV/AIDS by developing a national policy with guidelines on which to legitimize the management of HIV in the workplace. By working closely with the private sector to generate policies to remove discrimination and stigma, the program was also able to explore sensitization, access to treatment and care, and testing.⁷⁰

The National Policy on HIV/AIDS and the World of Work was officially adopted in 2007. The policy uses rights-based language to articulate

65 Meeting with Elizabeth Mushabe, National Consultant on Gender-HIV/AIDS, from UN Women, on January 22, 2018 in Kampala, Uganda.

66 Ibid.

67 Meeting with James Muge, Officer for Institutional Effectiveness, from UNDP, on January 19, 2018 in Kampala, Uganda.

68 Ibid.

69 Ibid.

70 Meeting with David Mawejje Muddu, National Coordinator for HIV/AIDS, from ILO, on January 17, 2018, in Kampala, Uganda.

both the responsibilities and rights of employers and employees, related to confidentiality, access to treatment, allowing for continuous work, and stable employment. While the passage of the law is a promising start to addressing HIV/AIDS discrimination in the workplace, implementation will take time. In the future, the ILO intends to complete an impact evaluation of the policy, as well as conduct an analysis to better understand stigma, in its many forms.⁷¹

International Organization for Migration (IOM)

With respect to public health, the International Organization for Migration (IOM) works with migrant populations and seeks to identify vulnerable groups at greater risk of HIV/AIDS infection. As a result of a lack of economic opportunities and social set-ups, certain groups within Uganda are most commonly identified to be higher risk, including border communities, commercial sex workers, fishermen, and truck drivers.⁷²

The two entry points for IOM engagement in the Ugandan public health sector. The first includes the CDC-accredited clinic at the IOM headquarters. This clinic provides medical checks for both refugees moving for resettlement, as well as migrants who need to obtain medical clearance. The second, includes health promotion through the training of medical and non-medical personnel in health-sensitive issues. IOM is also involved in sensitization programs, as well as community dialogues.⁷³

IOM does not specifically target women migrants living with HIV/AIDS, as the population is relatively small and hard to map. However, all

IOM programs prioritize vulnerable groups based on their needs assessments, which includes women living with HIV/AIDS. However, as the probability of HIV/AIDS disclosure is extremely low, IOM has found it difficult to run programs for this population of refugees, as existing social institutions within host-communities are not yet contextualized to accommodate the new-comers.⁷⁴

Civil Society Organizations

CSOs play a large role in the promotion of human rights of women living with HIV/AIDS in Uganda. The World Bank defines CSOs as the “wide array of non-governmental and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations.”⁷⁵ In his case study on civil society in Uganda, Kevin Makokha further defines CSOs as organizations that work to improve the relationship between the state and individual, and are integral in holding the state accountable. The most influential actors in civil society in Uganda are FBOs and NGOs, all with a wide variety of mandates.⁷⁶

Though NGO Act of 2016 (See Part I: Uganda’s Legal Framework) currently regulates civil society, it has a complicated history in Uganda. CSOs first emerged under colonial times for local Ugandans to demand better services and treatment from their rulers. The lack of European settlers in

71 Ibid.

72 Meeting with the International Organization for Migration (IOM), on January 24, 2018 in Kampala, Uganda.

73 Ibid.

74 Ibid.

75 World Bank Group, “Defining Civil Society.” July 22, 2013. <http://www.worldbank.org/en/about/partners/civil-society>

76 Kevin Teopista Akoyi Makokha, *Working with Community Organizations and Civil Society: The Case of Uganda*, Proceedings of European Forum on Rural Development Co-operation, (Montpellier, France, September 4, 2002).

Uganda made the development of civil society much slower than in Kenya or Tanzania because CSOs were not needed to fight for land or administration rights in the face of encroachment from settlers.⁷⁷ Civil society also faced developmental difficulties due to ethnic and religious divisions. The first attempt at forming a national political party was by the Uganda National Congress (UNC), spurred by the UAFU, which was founded by Bugandan Protestants. Due to the Bugandan role in colonialization and Uganda as a majority Catholic nation, the UNC failed to unify its following. Civil society faced developmental challenges in the post-independence era as well. The oppressive governments of Milton Obote (1962-1971, 1980-1985) and Idi Amin Dada (1971-1979) severely restricted any groups from organizing to influence policy or participate in collective bargaining. When the National Resistance Army (NRA) captured power in 1986, they liberated civil society and prioritized political participation on all levels of society. In the direct aftermath of the takeover in 1986, most CSOs focused on poverty alleviation, provision of basic services, and HIV/AIDS support services.⁷⁸

In the last 30 years, CSOs have transitioned to providing more community development projects and have formed networks of community-based organizations (CBOs) to meet the specific needs of small rural communities.⁷⁹ Traditional civil society is involved in many aspects of community development. However, Uganda's political environment remains repressive, which has caused a chilling effect for many areas of civil society, though some aspects remain surprisingly robust. The robust nature will be discussed first, followed by analysis of the chilling effect.

77 Karugire, Samwiri Rubaraza. *A political history of Uganda*. Nairobi, Kenya: Heinemann Educational Books, 1987.

78 Makokha, *Working with Community Organizations and Civil Society*.

79 Ibid.

CSOs now play significant roles in program design, planning, implementation, monitoring and evaluation, policy dialogue, capacity building, and civic education. CSO consultation is necessary for national sectoral program design and planning due to their wealth of experience and knowledge of the day-to-day struggles of the targeted population; their involvement was vital to the development of the national Poverty Eradication Action Plan (PEAP) of 2000.⁸⁰ The inclusion of CSOs in this national plan is significant, because it shows cooperation between the government and civil society, and that the GOU valued their knowledge and experience.

The GoU or foreign donors often subcontract CSOs due to their specialized knowledge and cost-effectiveness.⁸¹ As discussed in Part I: Key Stakeholders, the DREAMS program is a regional program involving ten countries in East and South Africa to reduce rates of HIV/AIDS among adolescent girls and young women. They conduct their work through local CSOs and FBOs to address these challenges, as these organizations are specially equipped to work with the target population.⁸² Use of local partners is more effective than employing teams of expatriates as the local organizations can better connect with the communities, understand the problems they face on a deeper level, and can communicate such issues back to DREAMS supervisors to improve programming.

CSOs are involved in conducting quantitative or qualitative research, either self-funded or donor-funded projects that require a program evaluation.⁸³ ICWEA is one of the leading research and advocacy organizations which gives visibility to the

80 Ibid.

81 Ibid.

82 "DREAMS: Partnership to Reduce HIV/AIDS in Adolescent Girls and Young Women." U.S. Agency for International Development. March 7, 2018. <https://www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/dreams>.

83 Makokha, *Working with Community Organizations and Civil Society*.

issues and concerns of WLHIV.⁸⁴ They ensure that WLHIV are leading their programs and research, as they better understand the target population. They publish reports, policy briefs, and position papers based on their research of the unique challenges faced by WLHIV and the best policies to mitigate such problems.

CSOs face harsh restrictions in political activism from the government, though are strongly involved in researching current policy gaps.⁸⁵ The Center for Health, Human Rights, and Development (CEHURD) is a research and advocacy organization founded in 2007 in response to the unaddressed high rate of maternal mortality. CEHURD works in three main areas: (1) strategic litigation, (2) community empowerment, and (3) research, documentation, and advocacy. They have previously examined policy gaps related to domestic violence and the rights of sex workers and health workers. CEHURD continues its work in the face of opposition from the GoU and other international donors. In fact, when U.S. President Donald Trump signed the Protecting Life in Global Health Assistance, more commonly known as ‘The Global Gag Rule’, they refused to stop providing information on women’s reproductive rights.⁸⁶

CSOs are prioritizing a rights-based approach in civic education and have many programs focused on educating the population on their rights and the legal mechanisms available to protect them.⁸⁷ The Uganda Network on Law Ethics and HIV/AIDS (UGANET) does significant work in this respect by

training women and men to understand and advocate for women’s right to own and inherit property. UGANET also provides legal services through trained paralegals and lawyers for women to fight for those rights. They have additional programs to combat cultural biases towards women with HIV/AIDS by educating communities through dialogue, debate, and dramatizations.⁸⁸

Due to the harsh restrictions civil society—including the NGO Act and the Public Order Management Bill discussed in Part I: Uganda’s Legal Framework—there has been a chilling effect on their work and activism. These restrictions stem from President Museveni’s moves to consolidate his authoritarian hold on power including the removal of presidential term limits in 2005, his re-elections in 2011 and 2016,⁸⁹ and the lifting of the presidential age limit in late-2017.⁹⁰ The ruling party, The National Resistance Movement (NRM), is restricting the work of NGOs to control their ability to influence public opinion of the party, Museveni, and state allocation of funds.⁹¹ The national and local government has cracked down on CSOs by “closing meetings, reprimanding NGOs for their work, and demanding retractions or apologies, as well as occasional resort to threats, harassment, physical violence and heavy-handed bureaucratic interference to impede the registration and operations of NGOs.”⁹² Additionally, the government is limiting CSO access to communities and resources from donor-funded projects from international donor

84 Meeting with the International Community of Women Living with HIV Eastern Africa (ICWEA), Executive Director, Lillian Mworeko, on January 25, 2018 in Kampala, Uganda.

85 Makokha, *Working with Community Organizations and Civil Society*.

86 Meeting with representatives of the Center for Health Human Rights & Development (CEHURD) on January 23, 2018 in Kampala, Uganda.

87 Makokha, *Working with Community Organizations and Civil Society*.

88 Meeting with representatives of UGANET on January 18, 2018 in Kampala, Uganda

89 Human Rights Watch, “Uganda: Growing Intimidation, Threats to Civil Society,” Human Rights Watch, August 21, 2012, <https://www.hrw.org/news/2012/08/21/uganda-growing-intimidation-threats-civil-society>

90 “Uganda Enacts Law Ending Presidential Age Limits,” *Al Jazeera*. January 2, 2018, <https://www.aljazeera.com/news/2018/01/uganda-enacts-law-presidential-age-limits-180102182656189.html>.

91 Human Rights Watch, “Uganda: Growing Intimidation.”

92 Ibid.

agencies, because the state says this is absorbing Western culture. The state creates more obstacles by requiring multi-level registration with both local and national administration, which is unique to the civil society sector.⁹³ Any CSO works in areas that the government sees as threatening has come under attack, especially those working on governance, human rights, land rights, or transparency in oil; however, those working on community development, service delivery, rural healthcare, and public health do not face such restrictions because they compensate for the failure of the state to provide those services.⁹⁴

To combat this repression, there has been a new push in civil society for creative activism. The two most notable examples are The Jobless Brotherhood and Dr. Stella Nyanzi, who intentionally used radical tactics and rhetoric to grab media attention, so that they could have a platform to discuss political repression. The Jobless Brotherhood snuck two yellow-painted pigs into the Parliament in 2014 to symbolize the ruling party's greed. Dr. Stella Nyanzi called President Museveni a 'pair of buttocks' to criticize his administration and has used the momentum to focus on the right to education and reproductive health for girls. This type of activism is coming from a push within civil society to be less dependent on government or donor approval for initiatives. These activists see the difficulties faced by traditional civil society and have found new methods of advocacy. Traditional civil society still has a large role to play, though they can learn from this new wave by allowing themselves to take a stand irrespective of the potential backlash from the government or donors.⁹⁵

93 Meeting with the Human Rights Network-Uganda (HURINET), Director of Programs Stephen Odong, on January 25, 2018 in Kampala, Uganda.

94 Human Rights Watch, "Uganda: Growing Intimidation."

95 Arthur Larok, "Uganda's New Civic Activism: Beyond Egos and Logos," Carnegie Endowment for International Peace, (Washington, D.C., 2017).

Private Sector

In recent years we have seen increased prioritization of corporate social responsibility (CSR), especially with the growth of foreign direct investment and use of offshore production. CSR aims to hold businesses accountable for upholding legal and ethical compliance. The UN Global Compact started in 2000 as an initiative to urge member businesses to adopt environmentally sustainable and socially responsible practices. There are ten principles divided into four categories: human rights, labor, environment, and anti-corruption. The most relevant to this work are: Principle 1—businesses should support and respect the protection of internationally proclaimed human rights, Principle 2—make sure that they are not complicit in human rights abuses, Principle 6—the elimination of discrimination in respect of employment and occupation, Principle 10—businesses should work against corruption in all its forms, including extortion and bribery. There are over 13,000 companies who have signed on since 2000 in over 170 countries, and they agree to prioritize the 10 Principles, and engage in work that fulfills broader UN priorities such as the Sustainable Development Goals.⁹⁶ The private sector has an important role to play in the protection and promotion of human rights in demanding fair labor practices in all stages of the supply chain. This work will first provide Ugandan private sector development, then the influence of CSR on donor-funded projects and foreign governments, finishing with a discussion on the challenges that WLHIV face in Uganda.

The British colonizers did not actively push for industrialization of their colonies until their

96 "The United Nations Global Compact." The Ten Principles | UN Global Compact. <https://www.unglobalcompact.org/what-is-gc/mission/principles>

economic downturn after WWII. Their strategy was twofold: to “increase exports of primary commodities and increase production in dollar-earning and dollar-saving industries.”⁹⁷ To realize these goals, in 1945 the British amended the Colonial Development and Welfare Act of 1940 to include 120 million pounds to develop rural processing industries and urban manufacturing enterprises.⁹⁸ In the years leading up to independence, British rule established Worthington Development Plan for Uganda⁹⁹ and The Ugandan Development Corporation (UDC).¹⁰⁰ By independence in 1962, the colonial government had established valuable infrastructure, though the economy had not developed integrated markets or supply chains. At independence, Uganda mainly exported cotton and coffee, though in the aftermath of decolonization the country developed its manufacturing exports including textiles, wood, and leather. However, when Idi Amin rose to power 1971, and during the political turmoil until the mid-1980’s, Uganda’s economy suffered terribly from exploitation and mismanagement. In the 1990’s the World Bank and IMF gave conditional loans to Uganda contingent upon economic restructuring to include liberalization, deregulation, privatization, and priority of agricultural goods as the main export.¹⁰²

Now, the private sector is composed of local,

97 Memorandum from the Colonial Office to Governor of Uganda, *The Colonial Empire and the Economic Crisis*, 6 August 1948, in *Main Papers*, AR MA 5/34, Standing Finance Committee, 1944-49: 1.

98 Marios Obwona et al., *The Evolution of Industry in Uganda*, WIDER Working paper 2014/021, Helsinki: UNU-WIDER, 2014: 1

99 Included major infrastructure investments including the Jinja hydro-electricity power station, mineral extraction in Kilembe and Tororo, and expanding the railroad from Kampala.

100 The UDC was established to absorb risk and encourage investment in the Ugandan economy, and became the major source of public private partnerships.

101 Obwona et al., *The Evolution of Industry in Uganda*, 3

102 Ibid.

regional, and international companies. Micro, small and medium enterprises (MSMEs) play a significant role in Uganda’s economy. The MSME sector accounts for around 90 percent of the entire private sector, 80 percent of manufactured goods, and 75 percent of the national GDP.¹⁰³ MSMEs employ over 2.5 million people, which is over 90 percent of non-farm workers in the adult working population. In an assessment of three USAID-financed microfinance programs in Uganda, a study found that microfinance programs which provide women with credit also give non-formal education on health, nutrition, and HIV/AIDS prevention in eastern rural parts of Uganda. The study concluded that 32 percent of women receiving education about HIV/AIDS prevention through microcredit groups tried at least one prevention practice, compared to 18 percent of non-clients.¹⁰⁴

The UK Department for International Development (DFID) created the Financial Deepening Challenge Fund (FDCF) in 2000, which included private sector financing projects serving the poor. The plan offered affordable health insurance to workers who previously had no access to insurance, where premiums were less than 8 percent of family income for those living on \$1 per person a day.¹⁰⁵ The insurance had a non-discrimination policy against PLHIV and did not require screenings for the virus. AON Uganda Ltd, the local branch of the insurance and reinsurance brokerage company, was responsible for facilitating and managing the transi-

103 “Micro, Small and Medium Enterprises (MSMEs) in Uganda,” *Fortune Of Africa - Uganda*, Accessed April 15, 2018, <http://fortuneofafrica.com/ug/micro-small-and-medium-enterprises-msmes-in-uganda/>.

104 Dunford C, Leatherman S. “Linking health to microfinance to reduce poverty.” *World Health Organization*, November 2009. <http://www.who.int/bulletin/volumes/88/6/09-071464/en/>

105 “Review of DFID’s Financial Deepening Challenge Fund (FDCF),” *Oxford Policy Management*. June 07, 2014. Accessed March 13, 2018. <http://www.opml.co.uk/projects/review-dfids-financial-deepening-challenge-fund-fdcf>.

tion of an NGO health insurance project, Microcare, into a private commercial entity.¹⁰⁶ Microcare has grown to be the largest provider of group health insurance in Uganda, servicing both formal and informal sectors and operating in urban and rural areas. It originated as a community health-financing micro-insurance initiative. Since 2005, Microcare has integrated HIV treatment in its coverage, becoming a private company in 2004.¹⁰⁷ As this example illustrates, the effective use of microfinance can support local communities and generate income and job opportunities as it becomes a private entity.

Uganda has many challenges facing its private sector today, mainly centered around the weak institutions controlled by Museveni. In a desperate attempt for Uganda to succeed on the world stage, Museveni has let economic considerations overshadow ethical ones. The administration has set its priorities on infrastructure and export growth and does not hold foreign companies accountable to fair labor standards or protection of human rights. Though the HIV and AIDS Prevention and Control Act protect people from forced HIV/AIDS testing,¹⁰⁸ most people don't report abuses. As detailed in Part I: Uganda's Legal Framework, they would have to expose their status publicly to seek legal redress. The GoU has not placed a high priority on punishing companies who engage in forced HIV testing, as they want to have an 'open investment climate.' The GoU does not record of holding foreign investors

accountable, passing laws to protect workers, or following through on prosecution.

Despite the disincentives for workers to seek legal redress, some are still filing lawsuits. A recent example currently in the courts is by two Ugandan workers who are suing the China Communications Construction Company (CCCC), a Chinese state-owned company that has been awarded three multimillion-dollar road contracts from the GoU. In 2016 the defendants allegedly were coerced to give blood into a clinic in Kampala for HIV testing, and their manager threatened to fire them if they refused. After testing, the clinic allegedly bypassed the patients and disclosed the statuses directly to the company, who then tried to make the HIV-positive victims sign resignation letters and fired those who refused.¹⁰⁹ A similar case was filed against the Chinese firm Sinohydro, wherein the defendant claims that she and 13 colleagues were forced to be tested for HIV/AIDS, and the five who were positive were fired. The defendant lost the case in court in 2016 and is now in the appeals process.¹¹⁰ These cases will be covered in more detail in Part II: Economic Marginalization.

The private sector has a vital role to play in the protection of human rights of WLHIV. Private sector development with a rights-based approach is critical because they can put pressure on the government to not accept any investment that violates the rights of the Ugandan people.

106 Commonwealth Secretariat, "Eighth Commonwealth Women's Affairs Ministers Meeting," Kampala, Uganda, 11-14 June 2007:38, <http://www.oecd.org/social/gender-development/38831106.pdf>. Accessed 16 October 2017

107 United Nations, "Microcare, Uganda: Financing Health through Communities," *Innovation for Sustainable Development: Local Case Studies from Africa*, 2008: 40, Accessed 16 October, 2017, http://www.un.org/esa/sustdev/publications/africa_casestudies/microcare.pdf.

108 Republic of Uganda, *The HIV and AIDS Prevention and Control Act*, (2014), <https://www.ulii.org/ug/legislation/act/2014/1/HIV%20and%20AIDS%20prevention%20and%20control%20act%202014.pdf>

109 "UGANDA: Fired After Forced HIV Tests, Ugandan Women Head to Court." HIV/AIDS & Reproductive Health. Make Every Woman Count. August 25, 2017.

110 Ibid.

lies within the participation as well as initiation from communities.

Sustainable Development Goal 3 and HIV/AIDS

Goal 3 of the SDGs to “[e]nsure healthy lives and promote well-being for all at all ages.” has a total of thirteen targets, nine directed towards a national level and four (identified with letters) towards the international community. There are two targets, which are directly related to HIV/AIDS. Target 3.3 indicates an aim to end HIV/AIDS transmission by 2030 with its indicator being new HIV/AIDS infections per 1,000 uninfected population, by sex, age, and key populations. Target 3.7 illustrates the goal to ensure access to sexual and reproductive health care services. It identifies the need to include family planning, information and education, and the integration of reproductive health into national strategies and programs.

HIV/AIDS is unlike other communicable diseases because of its attached stigma and discrimination. It is an epidemic that limits people’s ability to receive the services they need to live a healthy and productive life. In other words, HIV/AIDS disrupts quality human capital, which is the most important factor in achieving the sustainable development.

Goal 3 is the basis for other aspects of development. In other words, efforts to reach Goal 3 will enable the achievement of other SDGs. For example, a target to end communicable diseases can positively affect the labor force, making the achievement of the targets related to agricultural productivity and income growth possible.¹¹⁶ Health and human capital are inter-related, which is necessary for economic development. On the other hand, achieving Goal

3 is dependent on the progress of other SDGs.¹¹⁷ For example, economic growth can, in turn, enable an increase in government spending on healthcare.¹¹⁸

Gender plays an important role in explaining the discrimination attached to the disease. Due to the patriarchal nature of Ugandan society, gender inequality is one of the social and economic constraints of the country. Women are assumed to have a passive role. The violation and negligence of women’s rights are not uncommon. Women are subject to gender and sexual-based violence while lacking economic means to sustain themselves. Many of them are afraid to get tested and refuse or are unable to obtain the necessary medical treatment.¹¹⁹

Achievements or progress towards other SDGs are conducive to ending HIV/AIDS transmission. In particular, Goal 5 of the SDGs to “[a]chieve gender equality and empower all women and girls” includes women, who have HIV/AIDS or are prone to be infected. Goal 5 is set to end all forms of discrimination against women and girls and eliminate all forms of violence against women and girls in both public and private spheres, including sexual exploitation. Furthermore, Goal 5 ensures universal access to sexual and reproductive health and rights. It recognizes women’s equal rights to economic resources by national law, which includes rights to ownership and control over land

Healthy Lives and Promote Well-Being for All at All Ages,” *A Guide to SDG Interactions: from Science to Implementation*, International Council for Science, accessed March 3, 2018. <https://www.icsu.org/cms/2017/05/SDGs-Guide-to-Interactions.pdf>

117 “Background Paper for the Regional Technical Consultation on: Monitoring the Health-Related Sustainable Development Goals (SDGs),” World Health Organization (WHO) Regional Office for South-East Asia, accessed March 3, 2018. http://www.searo.who.int/entity/health_situation_trends/background_paper_monitoring_the_health_related_sdgs.pdf?ua=1.

118 Howden-Chapman et al., “Ensure Healthy Lives.”

119 Meeting with David Mawejje Muddu, National Coordinator for HIV/AIDS from ILO, on January 17, 2018, in Kampala, Uganda.

United Nations Uganda, accessed April 21, 2018. <https://www.issuelab.org/resources/22992/22992.pdf>

116 Philippa Howden-Chapman et al., “Ensure

and other forms property, financial services, inheritance, and natural resources. Securing women's economic and health rights does not only reduce the chances of women getting infected, but also allows women, who are already infected to be able to earn income and acquire continuous treatment on their own.¹²⁰ Therefore, pursuing Goal 5 can positively impact WLHIV and reduce HIV/AIDS infection amongst women.

Besides Goal 5, reducing HIV/AIDS transmission depends on progress in other SDGs – e.g., Goal 1 on poverty eradication, Goal 4 on equality and quality of education, Goal 8 on decent work, and Goal 9 on infrastructure. Poverty is one of the causes of GBV in households, contributing to the transmission of HIV/AIDS. For example, some men cope with financial problems and poverty by drinking alcohol. Drinking usually contributes to violence within the household, which can engender GBV.¹²¹ As a result, eliminating poverty (Goal 1) can help reduce sexual violence incidents. Moreover, Goal 8 guarantees equal labor rights and job opportunities between men and women. Employment and stable income for both men and women contribute to the ability of infected persons to maintain their health conditions and human well-being.¹²²

Sex education and equality in education between men and women (Goal 4) play a vital role in preventing HIV/AIDS transmission. Access to education for both males and females contributes to eliminating gender inequality. Proper sex education can also increase knowledge about HIV/AIDS prevention and treatment among Ugandan youth. High

dropout rate¹²³ as well as non-mandatory sex education in Uganda can worsen HIV/AIDS transmission. Lastly, the lack of infrastructure is one of the conditions accentuating HIV/AIDS transmission. Weak infrastructure, such as road conditions can hinder infected persons from getting quality and continuous treatment, as well as disincentivizing health workers to work in remote areas, where the more vulnerable inhabit.¹²⁴ Developing quality, reliable, and resilient infrastructure (Goal 9) can support economic development and human well-being.

SDGs and targets are inseparable, and Understanding the linkages between them will allow the country to implement the development plans, and achieve the SDGs more effectively. Designing programs, which tackle many goals at the same time, can efficiently use the limited financial means and resources Uganda has. However, it is important to ensure that the efforts to try to achieve other goals do not hinder the achievement of Goal 3. Ending the epidemic of HIV/AIDS (Goal 3) certainly relies on the success of other goals.

Uganda National Development Plan and HIV/AIDS

GoU has set health-related priorities in the NDP II in accordance with Goal 3 of the SDGs. NDP II underlines the provision of universal health coverage, access to sexual and reproductive health, reducing maternal mortality rate, ending preventable deaths of newborns and children under five years of age, and ending communicable diseases, including HIV/AIDS. As a result, efforts from all sectors are expected to go towards those targets.

Health is well recognized as part of human capital development in NDP II. The government acknowledges that socio-economic growth in accor-

120 Meeting with Elizabeth Mushabe National Consultant on Gender-HIV/AIDS, from UN Women, on 22 January 2018, in Kampala, Uganda.

121 Meeting with officers of the Kasensero police force on January 23, 2018, Kasensero, Rakai District, Uganda.

122 "HIV/AIDS Workplace Policy." GTZ Uganda, accessed May 4, 2018. <http://library.health.go.ug/publications/service-delivery-diseases-control-prevention-communicable-diseases/hiv aids/hiv aids-6>

123 Meeting with representatives from the Embassy of Sweden on January 19, 2018, Kampala, Uganda.

124 Meeting with OSIEA on January 25, 2018, Kampala, Uganda.

dance with Uganda Vision 2040 requires a healthy and productive population. To achieve that, the government targets “provision of accessible and quality health care [...] through the delivery of promotive, preventive curative, palliative and rehabilitative health care.”¹²⁵

All healthcare players: the government, non-governmental, and private players such as indigenous traditional and complementary health practitioners are included. While the governmental players at the national level provide policy setting, strategic planning, and monitoring, resource mobilization as well as direct health services, local governments are in charge of operational planning and delivery of health services.¹²⁶ The Ministry of Health leads its semi-autonomous affiliates: National Drug Authority (NDA), National Medical Stores (NMS), and National Referral hospitals in providing health services. Private sector and CSOs are playing a more important role as the focus is to have communities take care of their health service delivery.¹²⁷ NDP II recognizes that stronger collaboration between sectors can better improve disease prevention and promotion of health.

As previously illustrated, health is interrelated to other development aspects. Even though NDP II does not include socio-economic aspects into its health mandate, it is aware that major determinants of health such as income, education, sanitation, gender, and cultural beliefs, cannot be overlooked. HIV/AIDS interventions are listed in NDP II as a contribution to the production of healthy human capital. With an emphasis on adolescent boys and girls, HIV/AIDS prevention and treatment should be available for all. Gender discrimination, which can limit some people’s access to health

services, is addressed as a barrier to HIV/AIDS prevention and treatment.

Uganda’s AIDS Commission’s *National HIV and AIDS Strategic Plan (NSP) 2015/16 – 2019/20* and *National HIV and AIDS Priority Action Plan 2015/16 – 2017/18* are roadmaps for Uganda’s response to HIV/AIDS. NSP’s overall goal towards zero new infections, zero HIV/AIDS-related mortality and morbidity, and zero discrimination¹²⁸ corresponds with Goal 3 of the SDGs and shares the same objectives as NDP II. NSP has four sub-goals. Besides reducing new infections, the mortality rate, and mitigating HIV/AIDS impact on PLHIV, sub-goal 4 is having in place an effective and sustainable multi-sectoral HIV/AIDS service delivery, which ensures universal access of services to the targeted population. The framework has four main focus areas following its sub-goals: prevention, care and treatment, protection, and systems strengthening. The total costs in all areas of interventions from 2015 to 2020 are projected to be USD 3,647.9 million¹²⁹ with the costs for care and treatment being the highest over the five-year period.

Furthermore, President Museveni has put HIV/AIDS at the forefront of his national agenda. Recognizing the ability of the HIV/AIDS epidemic to hinder the achievement of Uganda’s Vision 2040, Museveni launched the new *Presidential Fast-Track Initiative on Ending HIV/AIDS* on June 6, 2017.¹³⁰ The first of its kind, the initiative reaffirms the SDG target of ending HIV/AIDS in Uganda by 2030. It lays out a five-point plan to achieve this goal: engaging men in HIV prevention and reducing incidence rates among teenage girls and young women; accelerating implementation of the

125 Second National Development Plan (NDPII) 2015/16-2019/20, accessed March 4, 2018. <http://npa.ug/wp-content/uploads/NDPII-Final.pdf>

126 Ibid.

127 Ibid.

128 National HIV and AIDS Strategic Plan 2015/16-2019/20, Uganda AIDS Commission (2015), accessed March 4, 2018. <http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/22280.pdf>

129 Ibid.

130 “President of Uganda launches fast-track initiative on ending HIV & AIDS in Uganda by 2030,” World

realize the right to health States parties must prevent, treat, and control epidemics.¹³⁶ HIV/AIDS-related stigma and discrimination are major impediments to realizing the right to health, as well as ending the epidemic. More general discrimination against particular populations, such as women, MSM, CSWs, among others, leaves them vulnerable to contracting the virus.¹³⁷ Whereas, as will be discussed in Part II: Stigma in Society, HIV/AIDS-related stigma and discrimination in the Ugandan context, can lead to adherence issues, willingness to get tested or to access treatment – all impediments to stopping the spread of the virus.

The corresponding treaty body for monitoring the implementation of the ICESCR, the Committee on Economic, Social and Cultural Rights observed that the right to health includes promoting gender equity as a “social determinant[] of good health.”¹³⁸ The progressive realization framework that ties rights to available resources, as expressed in article 2(1),¹³⁹ may present a barrier to many aspects of the right to health, but not to the right to non-discrimination. State parties are obliged to immediately ensure that individuals can exercise the right to health on a non-discriminatory basis.¹⁴⁰ As a State party to the ICESCR, Uganda must ensure that PLHIV can exercise the right to health in a non-discriminatory manner.¹⁴¹ Reinforcing this

right, under article 12(1) of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), Uganda has a responsibility to eliminate discrimination against women concerning health care.¹⁴²

The International Covenant on Civil and Political Rights (ICCPR) establishes a right to privacy in that “[n]o one shall be subjected to arbitrary or unlawful interference with his privacy.”¹⁴³ This right includes duties to respect both physical privacy, i.e., informed consent for medical procedures, and confidential personal health information. Forced HIV testing and disclosure violates the right to privacy.¹⁴⁴ Certain provisions of Uganda’s HIV and AIDS Prevention and Control Act (2014) run contrary to the right to privacy, for example, the provision for routine HIV testing of victims of sexual offenses, pregnant women, and partners of pregnant women.¹⁴⁵ Uganda should respect the right to privacy and

cid/3ae6b36c0.html. [hereinafter: ICESCR].

136 Ibid., art. 12(2)(c).

137 “The Right to Health,” Office of the United Nations High Commissioner for Human Rights and World Health Organization, Fact Sheet No. 31, (June 2008): 21, <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>.

138 Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health*, U.N. Doc. E/C.12/2000/4 (2000), para. 16, [available at http://www.refworld.org/pdfid/4538838d0.pdf](http://www.refworld.org/pdfid/4538838d0.pdf).

139 ICESCR, art. 2(1).

140 “The Right to Health:” 24.

141 UN Committee on Economic, Social and Cultural Rights, *General comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the*

International Covenant on Economic, Social and Cultural Rights), July 2, 2009, E/C.12/GC/20, para. 33, [available at, http://www.refworld.org/docid/4a60961f2.html](http://www.refworld.org/docid/4a60961f2.html) (noting that “States parties should ensure that a person’s actual or perceived health status is not a barrier to realizing the rights under the Covenant. The protection of public health is often cited by States as a basis for restricting human rights in the context of a person’s health status. However, many such restrictions are discriminatory, for example, when HIV status is used as the basis for differential treatment with regard to access to education, employment, health care, travel, social security, housing and asylum.”).

142 *Convention on the Elimination of All Forms of Discrimination against Women*, New York, December 18, 1979, *United Nations Treaty Series*, vol. 1249, art. 12(1), [available at, http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article12](http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article12). [hereinafter: CEDAW].

143 UN General Assembly, *International Covenant on Civil and Political Rights*, December 16, 1966, United Nations, Treaty Series, vol. 999, art. 17(1), [available at, http://www.refworld.org/docid/3ae6b3aa0.html](http://www.refworld.org/docid/3ae6b3aa0.html) (accessed May 1, 2018). [hereinafter: ICCPR].

144 “Handbook on HIV and Human Rights for National Human Rights Institutions,” Joint United Nations Programme on HIV/AIDS (UNAIDS) and Office of the High Commissions for Human Rights (OHCHR), HR/PUB/07/3, (2007): 8, http://www.ohchr.org/Documents/Publications/HandbookHIV_NHRIsAug2007.pdf.

145 The HIV and AIDS Preventions and Control

amend the Act in a manner consistent with human rights standards.

Women's Rights

Human rights are interdependent such that gender equality is necessary to realize other rights such as the right to health. CEDAW is the primary global instrument for women's rights. It provides for States parties, to pursue, among other things, policies of eliminating discrimination against women (article 2) and to take measures adjusting social and cultural norms to the end of removing practices that gender-stereotype or rely on ideas of inferiority or superiority of the sexes (article 5(a)).¹⁴⁶ Uganda's patriarchal society and the insidious cycle of GBV and HIV/AIDS makes realizing women's rights of particular significance to addressing the epidemic. Ensuring gender equality would help women negotiate safe sex, avoid economic marginalization, and thereby, help reduce the spread and impact of HIV.

Concerning article 5(a), CEDAW's corresponding treaty body to monitor the implementation of the treaty, the Committee on the Elimination of Discrimination against Women (hereinafter the CEDAW Committee) observed that polygamous marriage is contrary to women's equality.¹⁴⁷ Likewise, the Human Rights Committee¹⁴⁸ found that "[p]olygamy violates the dignity of women . . . [and] is an inadmissible discrimination against women."¹⁴⁹

Act (2014), para. 13, available at <https://www.ulii.org/ug/legislation/act/2014/1/HIV%20and%20AIDS%20prevention%20and%20control%20act%202014.pdf>.

146 CEDAW, arts. 2 and 5(a).

147 UN Committee on the Elimination of Discrimination against Women (CEDAW), *CEDAW General Recommendation No. 21: Equality in Marriage and Family Relations*, 1994, para. 14, available at, <http://www.refworld.org/docid/48abd52c0.html>.

148 The treaty body monitoring the implementation of the International Covenant on Civil and Political Rights (ICCPR).

149 UN Human Rights Committee, *General Comment No. 28: Equality of rights between men and women (article*

Indeed, article 23(4) of the ICCPR provides for equality between spouses in a marriage.¹⁵⁰ Due to multiple sexual partners and the adverse impacts of the practice on women, polygamy in Uganda invariably factors into the HIV/AIDS context.

The CEDAW Committee has recognized GBV as a form of discrimination against women.¹⁵¹ It has further recognized forced sterilizations and the criminalization of abortion, as forms of GBV and thus discrimination against women.¹⁵² As a State party to CEDAW, Uganda is legally obligated to take appropriate measures to eliminate GBV, as well as all other forms of discrimination against women.

Article 16 of CEDAW is also of significance. Article 16(1)(e) sets forth reproductive rights such that men and women have the "[t]he same rights to decide freely and responsibly on the number and spacing of their children."¹⁵³ Women's childcare duties, along with their disproportionate share of those duties, impact their access to other rights, such as education and employment.¹⁵⁴ These current realities make ensuring the right to decide on the number and spacing of children vital for women.

3), CCPR/C/21/Rev.1/Add.10, (2000), para. 24, https://www.nichibenren.or.jp/library/ja/kokusai/humanrights_library/treaty/data/HRC_GC_28e.pdf.

150 ICCPR, 23(4).

151 UN Committee on the Elimination of Discrimination against Women (CEDAW), *CEDAW General Recommendation No. 19: Violence against women*, 1992, para. 6, available at, <http://www.refworld.org/docid/52d920c54.html> ("article 1 defines discrimination against women. The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately.").

152 UN Committee on the Elimination of Discrimination against Women (CEDAW), *CEDAW General Recommendation No. 35: Gender-based violence against women, updating general recommendation No. 19*, 2017, para. 18, available at, http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/CEDAW_C_GC_35_8267_E.pdf.

153 CEDAW, art. 16(1)(e).

154 *CEDAW General Recommendation No. 21*, para 21.

Finally, article 16(1)(h) discusses property rights such that spouses have the same rights to own, acquire, manage, administer, enjoy, and dispose of property.¹⁵⁵ In cases where HIV/AIDS already has impacted the lives of women, the stigmatization surrounding the virus may affect their ability to exercise ownership and use land rights.¹⁵⁶ The backdrop of HIV/AIDS compounds the property rights situation due to the increased vulnerability of women. HIV/AIDS disproportionately impacts women, and economic marginalization puts them at risk of contracting the virus.¹⁵⁷ It follows that protecting women's property rights improves the lives of WLHIV and could decrease the risk of women contracting the virus.

Uganda has not reported to the CEDAW Committee since 2010.¹⁵⁸ In its 2010 concluding observations on Uganda, the CEDAW Committee provided several recommendations related to HIV/AIDS, including to “take continued and sustained measures to address the impact of HIV/AIDS on women and girls, as well as its social and family consequences. It urges the State party to enhance its focus on women's empowerment, include clearly and visibly a gender perspective in its policies and programmes on HIV/AIDS and increase the role of men in all relevant measures.”¹⁵⁹ Of interest to this study, the CEDAW Committee recommends that States parties, in addressing article 12 (health), report on “the effects of AIDS on the situation of

women and on the action taken to cater to the needs of those women who are infected and to prevent specific discrimination against women in response to AIDS.”¹⁶⁰ As such, we would encourage the Ministry of Gender, Labour and Social Development to fulfill the reporting commitment addressing the areas of concern by the CEDAW Committee with all due speed.¹⁶¹

Labor Rights

International human rights law protects PLHIV from discrimination in employment (e.g., the non-discrimination clause of the ICCPR (article 26)).¹⁶² ILO instruments reinforce the right to be free of non-discrimination in employment. ILO Recommendation 200 concerning HIV and AIDS and the World of Work, a non-legally binding instrument, prohibits discrimination and stigmatization of workers based on their real or perceived HIV status.¹⁶³ Of note, given the practice of testing domestic workers for HIV in Uganda,¹⁶⁴ Recommendation 201 to ILO Convention 189 regarding Decent Work for Domestic Workers (C189) reinforces the ban on

155 CEDAW, art. 16(1)(h).

156 “Women Property & Inheritance Rights in the Context of HIV (WPIR-HIV),” UN Women and UGANET, n.d., p.4, <http://uganet.org/wp-content/uploads/2016/06/UGANET-heal-project.pdf>

157 Ibid., p. 2.

158 “Implementing CEDAW in Uganda,” Inter-Parliamentary Union, June 22, 2017, <https://www.ipu.org/news/news-in-brief/2017-06/implementing-cedaw-in-uganda>.

159 UN Committee on the Elimination of Discrimination against Women (CEDAW), *Concluding observations of the Committee on the Elimination of Discrimination against Women: Uganda*, October 22, 2010, CEDAW/C/UGA/CO/7, para. 38, available at, <http://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-UGA-CO-7.pdf>.

160 UN Committee on the Elimination of Discrimination against Women (CEDAW), *CEDAW General Recommendation No. 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, 1990, A/45/38, available at, <http://www.refworld.org/docid/453882a311.html>.

161 “Implementing CEDAW in Uganda.”

162 The Center for HIV Law and Policy, *Employment Rights of People Living HIV/AIDS: A Primer*, (September 2010): 26-27, <https://www.hivlawandpolicy.org/sites/default/files/CHLP%20Employment%20Primer%20sept%202010%20FINAL.pdf>.

163 ILO, *Recommendation concerning HIV and AIDS and the world of work*, 2010 (No. 200), International Labour Office, Geneva (2010): 3(c), http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/normativeinstrument/wcms_142706.pdf.

164 See, e.g., Lizabeth Paulat, *Domestic Workers in Uganda Coerced Into HIV, STI Screenings*, Voice of America, June 22, 2017, <https://www.voanews.com/a/domestic-workers-uganda-hiv-screening/3386776.html>.

required testing, prohibiting domestic workers from being required to take an HIV test or to disclose their HIV status.¹⁶⁵ Although Uganda is not a party to C189, this non-discrimination measure reflects international labor standards and is consistent with Ugandan law that protects PLHIV from workplace discrimination.¹⁶⁶

United Nations Human Rights Council

Special Procedures

The Human Rights Council can appoint both thematic and country-specific special rapporteurs. The special rapporteurs have the capacity, among other things, to conduct country visits, communicate alleged human rights abuses to States, and raise public awareness of human rights issues. Moreover, special rapporteurs issue annual reports to the Human Rights Council.¹⁶⁷

There are several special procedures of relevance to the issue of the intersection of women and HIV/AIDS in Uganda, including, but not limited to, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences. In the broader context of the ability to advocate for human rights in Uganda, likewise, there are special procedures on point, including the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression, the Special Rapporteur on the rights to freedom of peaceful assembly and of association, and the

Special Rapporteur on the situation of human rights defenders.¹⁶⁸

To illustrate the advocacy work of the special procedures, in 2016, several special rapporteurs and the Working Group on Discrimination against Women in Law and in Practice issued a joint statement on the connection between human rights and ending the HIV/AIDS epidemic. The experts recognized the significant “legal and judicial victories against HIV-related discrimination and human rights violations” achieved by PLHIV and human rights defenders.¹⁶⁹ As they further observe, globally advocates for rights and social justice in the HIV/AIDS context continue to encounter discrimination, stigma, and violence. When advocates do not have a protected space to operate in, it weakens the capacity to realize and enjoy human rights. Consequently, the experts expressly called on states to “promote and protect human rights defenders working on HIV-related issues.”¹⁷⁰

Universal Periodic Review

Every four years each UN Member State, including Uganda, goes through a review of their human rights record, called the Universal Periodic Review (UPR) before the UN Human Rights Council. Uganda had its latest review in 2016. Ukraine observed in the Outcome Report the continued account of harmful practices and stereotypes that target, among others, women, sexual minorities, and

165 Domestic Workers Recommendation, 2011 (No. 201), International Labour Office, Geneva (2011): 3(c), http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_ILO_CODE:R201.

166 HIV and AIDS Preventions and Control Act.

167 “Special Procedures of the Human Rights Council,” Office of the High Commissioner for Human Rights (OHCHR), n.d., <http://www.ohchr.org/EN/HRBodies/SP/Pages/Welcomepage.aspx>

168 See “Current and Former Mandate-Holders for Existing Mandates Valid as of 31 December 2017, Office for the High Commissioner for Human Rights (OHCHR), <http://www.ohchr.org/EN/HRBodies/SP/Pages/Currentmandateholders.aspx>.

169 Joint Statement by UN human rights experts on the occasion of the High-Level Meeting on ending AIDS by 2030, Office of the High Commissioner for Human Rights (OHCHR), <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20053&LangID=E> (last accessed May 2, 2018).

170 Ibid.

PLHIV.¹⁷¹ The report further documented several recommendations related to eliminating discrimination against women.¹⁷² Concerning HIV/AIDS, Colombia recommended combating discrimination and stigma of PLHIV to further the fight against the virus.¹⁷³ As such, fellow member states have acknowledged the need to combat both discrimination against women and PLHIV in Uganda.

Regional Law

African Charter on Human and Peoples' Rights

The African Charter on Human and Peoples' Rights (Banjul Charter) protects a range of civil and political, socio-economic, and collective rights. Selected rights of relevance to this report, recognized in the Banjul Charter, include the rights to equality (article 3), non-discrimination (article 2), dignity of all persons (article 5), property (article 14), freedom of expression (article 9(2)), freedom of association (article 10(1)), work (article 15), health (article 16), and the elimination of discrimination against women (article 18(3)).¹⁷⁴ As a State party to the Banjul Charter, Uganda is required to protect these these rights.

There are several special mechanisms created by the African Commission on Human and Peoples' Rights of importance to this study, including the

171 *Report of the Working Group on Universal Periodic Review, Uganda*, Human Rights Council, A/HRC/34/10, December 27, 2016, para. 89, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/441/95/PDF/G1644195.pdf?OpenElement>.

172 *Ibid.*, paras. 115.8, 115.9, 115.32, 115.53, 115.54.

173 *Ibid.*, para. 115.59.

174 Organization of African Unity (OAU), *African Charter on Human and Peoples' Rights*, June 27, 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), *available at*, <http://www.refworld.org/docid/3ae6b3630.html>. [hereinafter: Banjul Charter].

Special Rapporteur on Rights of Women and the Committee on the Protection of the Rights of People Living with HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV.¹⁷⁵ In 2013, the Commission sent a delegation on a promotion mission to Uganda. Concerning women's rights the delegation recommended, among others, that Uganda "implement the laws and policies aimed at promoting and protecting the rights of women . . ." ¹⁷⁶ On the issues of HIV/AIDS, the delegation recommended strengthening legal protections for PLHIV.¹⁷⁷

Maputo Protocol

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) is the only regional treaty to specifically address women's rights in relation to HIV/AIDS and to identify protection from HIV/AIDS as a key component of women's sexual and reproductive rights.¹⁷⁸ Article 14 of the Maputo Protocol stipulates that women have the right to control their fertility, the right to decide when and whether to have children, the right to contraception, and the right to information on family planning.¹⁷⁹ Article 14(1)(d) explicitly requires Member States

175 "Special Mechanisms," African Commission on Human and Peoples' Rights (ACHPR), n.d., <http://www.achpr.org/mechanisms/> (last accessed May 2, 2018).

176 Commissioner Lucy Asuagbor, et.al, Report of the Joint Promotion Mission Undertaken to the Republic of Uganda, presented to the 55th Ordinary Session of the African Commission on Human and Peoples' Rights, held from April 28 – May 12, in Luanda, Angola, p. 63, http://www.achpr.org/files/sessions/14th-ao/mission-reports/uganda-promo-2013/achpr14eos_misrep_promo_uganda_2013_eng.pdf.

177 *Ibid.*, p. 61.

178 African Union, 2003, *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*. Maputo: African Union, http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf. [herein after Maputo Protocol].

179 African Commission on Human and Peoples'

to promote the rights of women to self-protection and protection against sexually transmitted infections (STIs), including HIV/AIDS.¹⁸⁰

The protocol further addresses polygamy (article 6(c)) – encouraging monogamy, but not prohibiting polygamy, violence against women (article 5), child marriage (article 6(b)) – setting the minimum age for women to marry at 18, women’s inheritance (article 21), women’s economic empowerment (article 13), the political participation of women and women in distress (article 11) and situations of armed conflict (article 24).¹⁸¹

Article 14(2)(c) affords women the right to conduct medical abortions in instances of rape, sexual assault, incest and potential hazards of mental and physical health of the mother and the fetus.¹⁸² Uganda signed the Maputo Protocol in 2003, but did not ratify it until 2010 due to the staunch resistance from religious groups opposed to abortion-related clauses. Catholic leaders accused the protocol of being a Western import at odds with Ugandan culture.¹⁸³ Given the outcry, Uganda made a reservation to the article such that “[t]he State is not

bound by this clause unless permitted by domestic legislation expressly providing for abortion.”¹⁸⁴ The African Commission has noted its concern over the reservation such that it “impede[s] the full enjoyment of health and reproductive rights of women particularly the right to medical abortion under the circumstances laid down in the Protocol.”¹⁸⁵ Thus, Uganda should lift the reservation consistent with women’s reproductive rights.

Abuja Declaration

The Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, a non-binding instrument, sets forth a pledge on health sector financing with States parties committing to a target of at least 15 percent of their respective annual budgets.¹⁸⁶ It is not understood why the drafters chose the 15 percent benchmark. Moreover, the benchmark is difficult to support in that “[h]ealth expenditure levels should reflect local health needs, utilization and costs, and so there is no one optimal amount for countries to spend on health care.”¹⁸⁷ Nonetheless, over the past few budget years, Uganda has averaged about 8 percent

Rights, General Comment No.2 on Article 14.1 (a), (b), (c) and (f) and Article 14.2 (a) and (c) of the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa, http://www.achpr.org/files/instruments/general-comments-rights-women/achpr_instr_general_comment2_rights_of_women_in_africa_eng.pdf.

180 African Commission on Human and People’s Rights, General Comments on Article 14(1)(d) and (e) of Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa, http://www.achpr.org/files/instruments/general-comments-rights-women/achpr_instr_general_comments_art_14_rights_women_2012_eng.pdf.

181 Maputo Protocol, arts. 5, 6(b), 6(c), 11, 13, 21, and 24.

182 African Commission on Human and People’s Rights. *Concluding Observations and Recommendations on the 5th Periodic State Report of the Republic of Uganda (2010-2012)*, (Banjul: 2015). http://www.achpr.org/files/sessions/57th/conc-obs/5-2010-2012/concluding_observations_5th_state_report_uganda.pdf

183 Paul Bakyenga, “Concerning the Ratification of the ‘Protocol to the Africa Charter on Human Rights

and Peoples’ Right: on the Rights of Women in Africa,” *L’Osservatore Romano* (2006), <http://www.ewtn.com/library/BISHOPS/letterbpsuganda.htm> (Positing that [n] ever before has an international protocol gone so far! We believe strongly that the people of Africa have no wish to see such a protocol introduced into their laws. We are sure the People of Uganda would never wish it.”).

184 Center for Reproductive Rights, *A Technical Guide to Understanding the Legal and Policy Framework on Termination of Pregnancy in Uganda* (2012), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_UgandaBriefingPaper_v5.pdf.

185 *Concluding Observations and Recommendations on the 5th Periodic State Report of the Republic of Uganda*, para. 77.

186 The Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases (2001), OAU/SPS/ABUJA/3, para. 26, http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

187 S. Witter, A. Jones, and T. Ensor, “How to (or Not To) ... Measure Performance against the Abuja Target for

of their total budget for healthcare, which is both below their internal target and the Abuja target.¹⁸⁸ As will be discussed in Part III: Healthcare Challenges, increasing the percentage of domestic spending is important because of the current donor climate and fatigue regarding HIV/AIDS. Whether the Abuja target is the proper metric for Uganda is debatable.

Domestic Law

Incorporation of International Law into Domestic Law

Uganda does not directly incorporate international law into domestic law; in international law terms, it is a “dualist” country.¹⁸⁹ As such, although Uganda may have horizontal legal obligations to other states, individuals may not necessarily have a domestic cause of action unless there is an act to integrate international law into domestic law vertically. However, the Ugandan Constitution recognizes many of the previously discussed human rights.

Constitution of Uganda

The Constitution of Uganda provides for the right to non-discrimination (article 21), property (article 26), privacy (article 27), freedom of expression and assembly (article 29), work (article 40), equal rights between spouses in marriage,

Public Health Expenditure,” *Health Policy and Planning* 29, no. 4 (2013): 451, doi:10.1093/heapol/czt031.

188 Moses Owori, Briefing Paper, *The 2017/18 Uganda Budget: What is in for the Poorest and Most Vulnerable People?*, Development Initiatives, (November 2017): 8, <http://devinit.org/wp-content/uploads/2017/11/the-2017-18-Uganda-budget-briefing-paper.pdf>

189 Busingye Kabumba, “The Application of International Law in the Ugandan Judicial System: A Critical Enquiry,” in *International Law and Domestic Human Rights Litigation in Africa*, ed. Magnus Killander (Pretoria University Law Press (PULP), 2010), 84.

including the protection of widows and widowers to property inheritance (article 31).¹⁹⁰ Access to health services is part of Uganda’s national objectives and policy directives, but there is no express right to health in the constitution.¹⁹¹ Though there is not an express right, progress is being made on that front. First, in 2015, the High Court of Uganda recognized the right to health as justiciable in *The Center for Health, Human Rights and Development (CEHURD) and others v. Nakaseke District Local Administration*.¹⁹² Second, there is a movement to amend the constitution to expressly include a right to health.¹⁹³ Nonetheless, given the interdependence of rights, it is fair to read the right to health into the constitution by virtue of other enumerated rights, such as the right to life under article 22.¹⁹⁴

Concerning women, article 33 of the constitution establishes the rights of women, including equality with men. The final subsection of the article prohibits “laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status.”¹⁹⁵ Given the inherent indignity and discrimination against women in polygamous marriages, the customary

190 Constitution of the Republic of Uganda, 1995, arts. 21, 26, 27, 29, 31, 40, <https://www.ulii.org/node/23824>. [hereinafter: Uganda Constitution].

191 Ibid., art. XIV(b).

192 *The Center for Health, Human Rights and Development (CEHURD) and others v. Nakaseke District Local Administration* (Civil Suit No.111 of 2012), Judgment, p. 13 – 14. April 30, 2015 https://www.escri-net.org/sites/default/files/full_text_of_the_judgment.pdf; “High Court Declares the Right to Health Justiciable in Uganda,” *Lawyers Alert*, May 7, 2015, <https://lawyersalert.wordpress.com/2015/05/07/high-court-declares-the-right-to-health-justiciable-in-uganda/>.

193 Arthur Matsiko, “MPs Want Constitutional Right to Health,” *The Observer*, January 12, 2018, <http://observer.ug/news/headlines/56613-mps-want-constitutional-right-to-health.html>.

194 See *Centre for Health Human Rights & Development & 3 Ors v. Attorney General* (CONSTITUTIONAL PETITION N0. 16 OF 2011) [2012] UGCC 4 (June 5, 2012), <https://www.ulii.org/node/15860>.

195 Uganda Constitution, art. 33(6).

practice of polygamy is at odds with this subsection. rights standards.

Of specific concern to women's SHRH, the constitution expressly restricts abortion in that "[n]o person has the right to terminate the life of an unborn child except as may be authorised by law."¹⁹⁶ Recalling the Maputo Protocol and CEDAW, Uganda should protect women's sexual and reproductive rights.

The HIV Prevention and Control Act

The HIV and AIDS Prevention and Control Act (2014) prohibits workplace discrimination, as well as discrimination with regards to access to education, access to health care, access to public services, access to credit, and access to insurance services.¹⁹⁷ The legislation also criminalizes intentional transmission and the attempted transmission of HIV. The Uganda Human Rights Commission (UHRC) maintains the position that the transmission of HIV should not be criminalized because it magnifies the stigma surrounding PLHIV.¹⁹⁸ This report would second that position.

The bill includes mandatory HIV testing for certain individuals, such as pregnant women, sex workers and injectable drug users, and allows medical officials to disclose the status of patients to others.¹⁹⁹ These provisions violate the right to privacy and can further stigmatize PLHIV. In sum, the act should be amended consistent with human

Domestic Violence Act

The Domestic Violence Act of 2010 provides for a broad definition of domestic violence, including an perpetrator's act or omission that "harms, injures or endangers the health, safety, life, limb or well-being, whether mental or physical, of the victim or tends to do so and includes causing physical abuse, sexual abuse, emotional, verbal, psychological abuse and *economic* abuse."²⁰⁰ Despite its broad coverage there are several loopholes that inherently undermine the effectivity of the act, including the lenient punishment for committing domestic violence.²⁰¹ Despite the criminalization of domestic violence, it remains underreported.²⁰² As will be discussed in Part III: Access To Justice, Uganda needs to ensure that women have access to justice for gender-based violence.

Legal Restrictions on Human Rights Defenders

To fully realize human rights, human rights defenders need to have the protected space to advocate. In recent years, the Ugandan government has impermissibly encroached on the space of civil

196 Ibid., 22(2).

197 CIII (24) Bill Supplement to the Uganda Gazette, 30 Apr. 2010.

198 Meeting with Ruth Ssekindi, Director of Complaints, Investigations, and Legal Services from the Uganda Human Rights Commission, on January 24, 2018 in Kampala, Uganda.

199 African Commission on Human and People's Rights, *Concluding Observations and Recommendations on the 5th Periodic State Report of the Republic of Uganda (2010-2012)*.

200 The Domestic Violence Act (2010), Part I(2), https://www.ulii.org/ug/legislation/act/2010/2010/domestic_violence_act_2010_pdf_20398.pdf.

201 J. D. Mujuzi, "The Ugandan Domestic Violence Act: The Drafting History and Challenges to Its Implementation," *International Journal of Law, Policy and the Family* 28, no. 3 (2014): 260-263, doi:10.1093/lawfam/ebu009.

202 Editorial, "Encourage People to Report Domestic Violence," April 21, 2017, *Daily Monitor*, <http://www.monitor.co.ug/OpEd/Editorial/Encourage-people-to-report-domestic-violence/689360-3897240-upglwxz/index.html> (noting that "[a]ccording to Police reports, domestic violence still remains one of the least reported cases and thus has far-reaching consequences on victims many of whom remain silent.").

society threatening individuals' rights, the country's development, and the end to the AIDS epidemic. The below discussion highlights two of the restrictive acts.

Public Order Management Act (POMA)

The Public Order Management Act of 2013 (POMA) unduly restricts the freedom of peaceful assembly and association contrary to Uganda's human rights commitments.²⁰³ Such restrictions include providing a written notice of public meetings at least three days in advance with the notification including the names and other identifiable information of the organizers.²⁰⁴ Moreover, authorized officials have wide discretion to "stop or prevent the holding of a public meeting where the public meeting is held contrary to th[e] Act."²⁰⁵ Invariably, these restrictions will have a chilling effect on otherwise permissible speech, as well as creating burdensome administrative hurdles to exercising basic rights.

Non-Governmental Organisations Act (NGO Act)

The Non-Governmental Organisations Act of 2016 (NGO Act) is a further attempt by the Ugandan government to restrict free speech, assembly, and association. The act creates onerous registration requirements for NGOs, restricts the operations of NGOs, and empowers the National Bureau for NGOs with the wide discretion to refuse registration.²⁰⁶ The Executive Director of the Human Rights

Awareness and Promotion (HRAPF), an organization that has experienced break-ins in recent years, observed that the "NGO Act with its imposition of broad and undefined 'special obligations' on NGOs not to do anything prejudicial to the laws of Uganda, interests of Ugandans, or the security of Uganda clearly shows that the state only sees NGOs as threats rather than as partners."²⁰⁷ Uganda needs to protect and empower human rights defenders and NGOs, not obstruct and disregard.

Pending Legislation

The Marriage and Divorce Bill/ Marriage Bill

The Marriage and Divorce Bill, 2009 was an important piece of legislation for women's rights in that it prohibited widow inheritance, defined matrimonial property, and equalized divorce provisions between the sexes.²⁰⁸ This bill with its various iterations has been sitting at the parliament for decades. In 2017, the Uganda Law Reform Commission changed the name to the "Marriage Bill," such that people would not associate it with the idea that "one could marry to divorce."²⁰⁹ The commission also removed cohabitation from the bill, as it proved to be controversial.²¹⁰ Activists have pushed for parliament to discuss and pass the current bill, as it would be a step towards gender equality in Uganda.²¹¹

203 "UN Rights Experts Call on Uganda to Repeal New Bill Restricting Public Assembly," UN News, August 9, 2013, <https://news.un.org/en/story/2013/08/446452-un-rights-experts-call-uganda-repeal-new-bill-restricting-public-assembly>.

204 Public Order Management Act of 2013 (POMA), § 5, <https://www.ulii.org/ug/legislation/act/2013/1/PUBLIC%20ORDER%20MANAGEMENT%20ACT.pdf> [hereinafter: POMA].

205 Ibid., § 8(1).

206 "Civic Freedom Monitor: Uganda," The Interna-

tional Center for Not-for-Profit Law (ICLN), February 18, 2018, <http://www.icnl.org/research/monitor/uganda.html>.

207 Adrian Jjuuko, "NGO Break-ins: State is Failing to Protect Human Rights Defenders," The Observer, March 20, 2018, <http://observer.ug/viewpoint/57253-ngo-break-ins-state-is-failing-to-protect-human-rights-defenders.html>.

208 The Marriage and Divorce Bill, (2009), <https://www.ulii.org/node/25009>.

209 "Marriage & Divorce Bill Changed," Uganda Radio Network, July 6, 2017, <https://ugandaradionetwork.com/story/marriage-divorce-bill-changed>.

210 Ibid.

211 Denis Ongeng, "Women Activists to Petition

The Sexual Offences Bill

Another significant piece of legislation for women's rights also sits in parliament. The Sexual Offences Bill of 2015, aims to consolidate laws concerning sexual offenses, punish perpetrators, set procedural and evidentiary standards for sexual offense trials, and overall, combat sexual violence.²¹² Significantly, the bill criminalizes marital rape.²¹³ Recently, lawmakers renewed attention on the bill due to a controversy involving the sexual abuse of students in exchange for grades.²¹⁴ The parliament should proceed with the bill, keeping in mind that "having a law is one thing but having it work is another."²¹⁵ As such, the proper enforcement landscape needs to be in place to stop sexual violence.

Healthcare Structure

Uganda's referral-based healthcare system is made up of free public hospitals, private not-for-profit (PNFP) hospitals, medicine dispensaries, informal pop-up clinics, national medical stores (NMS), and pharmaceutical companies.

Parliament over Marriage Bill," *New Vision*, September 10, 2017, https://www.newvision.co.ug/new_vision/news/1461294/women-activists-petition-parliament-marriage.

212 The Sexual Offences Bill, (2015), memorandum, <http://parliamentwatch.ug/wp-content/uploads/2016/10/L-14-04-16-The-Sexual-Offences-Bill-2015.-1.pdf>.

213 Yasiin Mugerwa, "Kadaga Okays Law to Jail Rapist Husbands," *Daily Monitor*, April 17, 2016, <http://www.monitor.co.ug/News/National/Kadaga-okays-law-to-jail-rapist-husbands/688334-3161784-elq2bhz/index.html>.

214 Moses Kyeyune, "MPs Decry Government Delay to Enact Sexual Offences Bill," *Monday March*, 5, 2018, <http://www.monitor.co.ug/News/National/MPs-decry-government-delay--enact-sexual-offences-bill/688334-4329524-5vhsmt/index.html>.

215 Mugerwa, (paraphrasing Ms. Jackie Asiimwe-Mwesige, lawyer and human rights activist).

Public Hospitals and Private/NGO-funded facilities

Public hospitals in Uganda face significant criticism due to accusations of corruption and mismanagement. Public hospitals are supposed to be free, yet patients must provide supplies, including gloves and bandages. Government regulation is unreliable, and the government has threatened staff changes on the basis of ethnicity, favor with the President, and other preferential characteristics.²¹⁶ Due to irregular funding, public hospitals frequently face medication stock-outs, expired medication, late deliveries, and doctors and nurses going without pay for months. According to one off-the-record source, "public hospitals are where you go to die." Doctors earn around 500,000 Ugandan shillings while nurses earn around 250,000 shillings per month, \$140 and \$70 respectively. In November 2017 doctors went on strike demanding higher pay and regular medical supplies. Public hospitals are poorly funded, inefficient, and under-stocked, and the population does not trust that they will receive adequate care in a public hospital.²¹⁷

Because the referral process is not effective, people in urban areas go to private hospitals to bypass the system. The state regulates national referral hospitals, which cost around 20 percent-30 percent of the national health budget. This regulation constricts management, so hospitals cannot make independent financial decisions concerning medication, supplies, or personnel. The World Bank argues that public hospitals' lack of autonomy largely drives drug shortages. Additionally, since the quality of

216 Ssenooba, Freddie, Lynn Atuyambe, Barbara McPake, Kara Hanson, and Sam Okuonzi. 2002. "What could be Achieved with Greater Public Hospital Autonomy? Comparison of Public and PNFP Hospitals in Uganda." *Public Administration & Development* 22 (5): 415.

217 Ibid.

care is so poor people resort to bribing hospital or government officials to be seen by a doctor, or to be seen quicker. Most people avoid public hospitals if they can, only using them during emergencies, and choose NGO-run clinics or PNFPs if they have the money.²¹⁸

Private pharmaceutical companies and PNFP hospitals have a restricted role in Uganda's national health plan. The Ministry of Health indicates that the biggest constraint for pharmaceuticals is the lack of technical capacity, suitable laboratories, equipment, and funding for day-to-day research and development activities. The Uganda National Association of Private Hospitals, or UNAPH, represents independently-owned private hospitals and clinics. The association strives to create a competitive marketplace for private hospitals and collaborates with the Ministry of Health to support government programs that fight HIV/AIDS. UNAPH recently indicated that use of private hospitals has increased, especially for "low-risk" patients. The Ugandan government has an opportunity to increase spending and capacity building, equipping the private sector to assist in national health plans and human rights initiatives.²¹⁹

The GoU does not pay sufficient attention to the untapped potential of private hospitals. PNFP and health clinics are rarely involved in planning, implementation, or evaluation of the government's national health programs. The United Nations Joint Programme on Gender Equality and Women's Empowerment (UNJPGE), indicated that private hospitals should contribute health system outputs and healthcare coverage to give women better access to quality healthcare.²²⁰

Public-private partnerships (PPPs) between the Ugandan government and private pharmaceu-

tical companies are mainly utilized to transport medicine and produce drugs.²²¹ The supply of essential medications for HIV/AIDS, malaria, and tuberculosis comes mainly from donor agencies and multilateral organizations. Ninety percent of drugs and health supplies in Uganda are imported, and the donors source their ARVs, ACTs, TB medicine, and other drugs outside of Uganda.²²² The WHO currently calls for an import substitution through gradual investment in manufacturing and quality control of products domestically.²²³ Quality Chemical Industries Limited is one successful private manufacturer in Uganda, though the government has not prioritized PPPs with pharmaceuticals as a means to combat HIV/AIDS prevalence.²²⁴

Uganda has historically had a problem with counterfeit drugs, especially drugs for HIV/AIDS, malaria, and cancer. The poor and rural are more likely to fall victim to counterfeit drugs, as the number of licensed pharmacies is too low to serve the existing population.²²⁵ Around 80 percent of Uganda's drugs are imported from Southeast Asia, which is a hub for producing counterfeit pharmaceuticals. Many counterfeit drugs are diluted versions of the

Equality and Women's Empowerment, UN Women and National Planning Authority. "Final Report on the Development of Gender Responsive Indicators for education & sports sector; health sector; local government sector; public service sector; environment & natural resources sector; agricultural sector; and the justice law & order sector." July-August 2012.

221 National Medical Stores. <https://www.nms.go.ug/>. Accessed 23 September 2017

222 Ministry of Health. "Annual Pharmaceutical Sector Performance Report 2013-2014." Ministry of Health, May 2015.

223 Dunford C, Leatherman S. "Linking health to microfinance to reduce poverty." World Health Organization, November 2009. <http://www.who.int/bulletin/volumes/88/6/09-071464/en/>. Accessed 16 October 16, 2017

224 United Nations Industrial Development Organization. "Pharmaceutical Sector Profile: Uganda." 2007

225 VOA News. "Targeting Counterfeit Drugs in Uganda." October 31, 2009. Accessed April 16, 2018. <https://www.voanews.com/a/a-13-2006-06-15-voa27/399343.html>.

218 Ibid. .

219 Uganda National Association of Private Hospitals. <http://unaph.org/>. Accessed 23 September 2017

220 United Nations Joint Programme on Gender

drug because this can pass chemical tests performed on imported drugs. These tests often do not test the percent of the drug, rather whether the drug is present in the pill. Counterfeit drugs are harmful not only because they don't provide adequate treatment, but also because they can cause drug resistance. Since the microbes are exposed to only low levels of the drugs, they can develop the ability to combat the medication. The National Drug Authority (NDA) works to ensure the quality of drugs both in and outside the country, but counterfeit drugs still pose a dangerous threat.²²⁶

Uganda often experiences shortages of ARVs, resulting in rationing the drugs to high-danger treatment groups. There are around 1.4 million PLHIV in Uganda, 820,000 of whom are receiving treatment, and 240,000 receive their ARVs through publicly-funded programs. These 240,000 people are in serious trouble, as the government is restricting treatment to some areas of the population based on a new policy to ration the ARVs. The Ministry of Health came up with 'Option B,' which establishes the need to treat populations that are 'drivers of HIV,' including pregnant women, adolescents, sex workers, and gay men.²²⁷ Civil society has spoken out in opposition to Option B, because it is not scientifically sound, and discriminatory.

Medical and dental practitioners must preserve patients' rights to non-discrimination and privacy, except in cases where the patient (or their caregiver) gives consent, or when disclosure is necessary to protect the public. The Code of Professional Ethics, published by Uganda Medical and Dental Practitioners Council (UMDPC) in 2013, enshrines these rights, and strives to improve the quality of healthcare delivery in Uganda.

²²⁶ Lewis, Katie. "More Counterfeit Drugs Enter Uganda." July 10, 2006. <https://ugandaradionetwork.com/story/more-counterfeit-drugs-enter-uganda>.

²²⁷ Athumani, Halima. "Lack of HIV Drugs Forces Uganda to Limit Treatment." Anadolu Agency. January 20, 2016

Management of patients based on gender, race, religion, disability, HIV status or any other indication of vulnerability [and protection of privacy, in which] practitioner shall observe the patient's confidentiality and privacy and shall not disclose any information regarding the patient except- (a) With the express consent of the patient; or in the case of a minor with the consent of a patient or guardian; or in the case of a mentally disadvantaged or unconscious or deceased patient, with the consent of his or her authorized next of kin; (b) To the extent that it is necessary to do so in order to protect the public or advance greater good of the community.²²⁸

The non-discriminatory and confidentiality clauses are particularly relevant because it holds doctors accountable to not share health information with employers, and not discriminate based on HIV/AIDS status. Though not all doctors adhere to these standards, it is important to note that such standards do exist.

Uganda is also facing a drastic shortage of doctors due to "brain drain" to the Middle East. In September of 2017, The Guardian reported that one hospital in Libya recruited at least 1,963 healthcare professionals from Uganda to fill vacancies. Between March and June of 2017, over 3,000 medics left the country, and in 2014, 263 health workers left Uganda for Trinidad and Tobago. The exodus includes nurses, laboratory technicians, and doctors from public health facilities, private hospitals, and PFPN hospitals. Healthcare professionals face little incentives to stay in Uganda as they often go months without pay, lack basic medical supplies, and are not deployed to hard-to-reach areas. Every year at least 320 medical students graduate from medical schools in Uganda, but in 2015 just 69 percent of healthcare positions were filled. The WHO recommends one doctor per 1,000 persons,

²²⁸ Uganda Medical and Dental Practitioners Council. "Code of Professional Ethics", 2013.

but in 2013 the doctor-to-patient ratio was 1:24,725 and the nurse-to-patient ratio was 1:11,000. The Institute of Public Policy Research Uganda sued the government in 2014 for not doing more to stop the mass emigration, but the health ministry has defended that they cannot stop workers from moving. Furthermore many recruitment agencies require HIV testing and will only hire HIV-negative people, which is a clear human rights violation.²²⁹

National Medical Stores

National medical stores (NMS) were established by the Ugandan Parliament in 1993 to be the central supplier of medicine and medical supplies to all public health facilities. They have since expanded to include vaccinations, and delivery to the police, army, and prisons. All supplies and medicines provided by the NMS are marked with a seal “UG NOT FOR SALE” to discourage black market and counterfeit growth. Their “Last Mile Delivery System” is an initiative aimed to see the medicine and supplies reach the end user everywhere in the country promptly. To do this, the NMS publish delivery schedules so that recipients can plan when they will receive their shipments.²³⁰

There are many problems associated with NMS. Despite their goals to provide adequate medicine and supplies to public health facilities, the deliveries are infrequent and unreliable. Doctors do not know when they will receive their shipments, and hospitals will often go months without medications they need. When the medicines do arrive, they are often expired due to delivery delay. These problems have a compounding effect: if HIV-positive persons do not receive their ARVs, then they can develop drug-resistance due to adherence. People

may seek treatment at NGO or FBO-run clinics or private hospitals if they have the money because of the unreliability of public facilities.²³¹

NGO or FBO-run Clinics

Pop-up clinics run by NGOs and FBOs often fill the gap of inadequate healthcare from hospitals, mismanaged public health institutions, and pricey private healthcare. Pop-up clinics in Uganda range from day-long to months-long, and these clinics provide testing, health counseling, and ARVs. Some clinics are permanent, while some operate for a finite period of time in a temporary location.²³² In the hard-to-reach rural communities, many rely solely on pop-up clinics for their primary healthcare needs.²³³ People may have their medical records in books that they bring with them to these clinics to show the medical staff. Our team observed a mobile clinic run by the FBO Fuel Uganda during the site visit to Fort Portal. We heard first-hand that clinic attendees primarily receive their medical care through mobile clinics. Members of Fuel Uganda told the research team that some days they’d have upwards of 500 people attending a clinic.²³⁴ Many clinics also have youth corners to encourage youth to come with their parents (usually mothers). These ‘youth corners’ host games, drawing activities, and support staff to educate the children on their disease and break down barriers based on stigma.²³⁵

231 Ibid.

232 Conley, Mikaela. “How Pop-Up Clinics in Uganda Are Filling the Gap in Sexual Healthcare.” *Global Citizen*. September 15, 2016. <https://www.globalcitizen.org/en/content/pop-up-clinics-in-uganda-fill-the-gap-in-sexual-he/>

233 “On the Road with Uganda’s Mobile Sexual Health Clinics – in Pictures.” *The Guardian*. December 02, 2016. Accessed April 16, 2018. <https://www.theguardian.com/global-development/gallery/2016/dec/02/reproductive-health-uganda-mobile-sexual-health-clinics-in-pictures>.

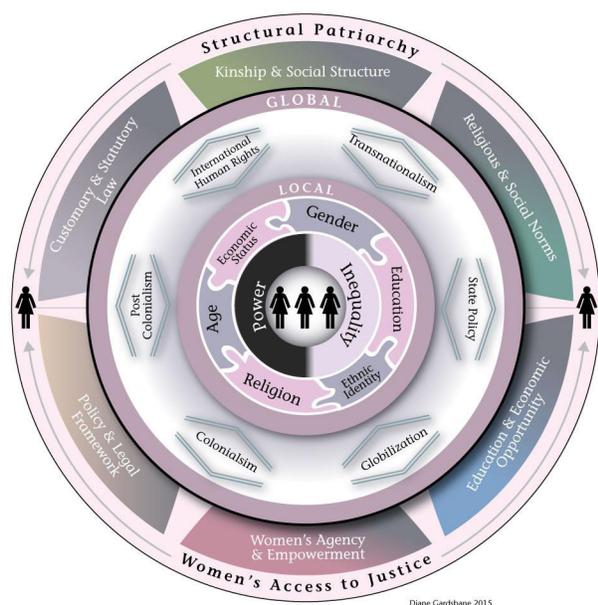
234 Meeting with Fuel Uganda, January 23, 2018 in Fort Portal, Uganda.

235 Meeting with Susan Ajok, Executive Director of Straight Talk Foundation, on January 25, 2018, in Kampala,

229 Okiror, Samuel. “Hospitals in Crisis in Uganda as Middle Eastern Countries Poach Medical Staff.” *The Guardian*. September 25, 2017.

230 “National Medical Stores.” *Devex*. <https://www.devex.com/organizations/national-medical-stores-29821>.

following figure portrays how patriarchy blankets over women's access to justice.²⁴⁴



When looking at the domestic level, the men hold power in a household. It was fairly common to hear the words, “the wives have to ask permission to leave the house.”²⁴⁵ The power dynamics in the rural areas seem to be more extreme than in urban areas, as the women have few opportunities of employment. The patriarchal society dictates the lives of many women and obstructs their access to justice and equality.

Domestic Relations

Marriage customs and practices in Uganda promote trends that have a possibility to increase HIV transmission. As stated previously, many of these factors are intertwined. Though considered controversial, risky sexual behavior within marriages and infidelity lead to an increase in HIV prevalence.²⁴⁶

Station on January 23, 2018 in Kalisizo, Rakai District, Uganda.

244 Gardsbane, “Violence Against Women Policy and Practice in Uganda.”

245 Meeting with Robert, Regional Manager from RHSP, on January 22, 2018, in Rakai District, Uganda

246 Gardsbane, “Violence Against Women Policy and

Polygamous relationships or having multiple sexual relationships were mentioned quite often during the team's visit to Uganda. In addressing this issue, religious institutions stepped forward and began to promote abstinence and to be faithful to their partners²⁴⁷. President Museveni, in the late 1990s, was globally recognized for his new approach that was known as the ABC Campaign.” Though he is against polygamous relationships, Museveni's statements on polygamy factored in patriarchy.²⁴⁸

“If you marry many wives, they will not have the same focus and spirit. They will not work together.”²⁴⁹

Moreover, it was observed that a majority of the marriages do not qualify as legal, making it all the more difficult to advocate for women and protect them. Marriage, in Uganda, is marked by the “bride price” that the family of the man pays the family of the bride. In Uganda, three types of marriage (that all require registration) are legally recognized: customary, religious, and civil. Though registration is requirement, not many abide by the rule and continue with the “process of marriage”, thus perpetuating polygamy. After the man pays the “bride price,” the marriage is official. The entire process abides by customs and has no legal backing (if it has not been registered). Consequently, issues arise when women bring up incidences of domestic violence, land rights, and infidelity.²⁵⁰

Practice in Uganda?”

247 Edward Green et al., “Uganda's HIV Prevention Success: The Role of Sexual Behavior Change and the National Response,” *AIDS and Behavior*, July 2006, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1544373/>.

248 “Museveni Cautions on Polygamy,” *Daily Monitor*, 25 August, 2014, <http://www.monitor.co.ug/News/National/Museveni-cautions-on-polygamy/688334-2429462-33kxpoz/index.html>.

249 Ibid.

250 Gardsbane, “Violence Against Women Policy and Practice in Uganda.”

When it came to infidelity, patriarchal norms made it more “acceptable” and common for men to have sexual relationships outside of marriage, without being questioned by their wives.²⁵¹ However, not many chose to speak of infidelity. In Kasensero, the team came to know that marriages are not official in the town and this led to a higher number of partners each person had.²⁵² Consequently there was a higher risk of HIV Transmission.

Polygamy and domestic relations, however, is only one of the several commonly found customs and practices that contribute to HIV prevalence in Uganda. In the following section, the role of religion is examined.

Religion

According to the 2014 Census of Uganda, 39 percent of the population identified as Catholics, 32 percent were Anglicans, 14 percent were Muslims, and 11 percent were Pentecostal/Born Again/ Evangelical.²⁵³ The rest of the population were Traditional, Baptist, Orthodox, Others, and Non-Religious. HIV prevention, treatment, and care have been largely influenced by religion. “Miracle Healing” or faith healing became a significant issue that the government had to address. A representative of the YWCA stated that though many churches claim that praying can cure HIV, they also urge the people to take medication and get tested regularly.²⁵⁴ The former health minister, Christine Ondua Dradidi, affirmed that she knew of three people whose results turned negative after prayers.

*“I am sure and I have evidence that someone who was positive turned negative after prayers.”*²⁵⁵

251 Ibid.

252 Meeting with Kasensero Police Force Officer Bategiriza Apollo on January 23, 2018 in Kasensero, Rakai District, Uganda.

253 “National Population and Housing Census 2014 – Main Report,” Uganda Bureau of Statistics, 2016.

254 Meeting with representatives of YWCA, on January 18, 2018, in Kampala, Uganda.

255 Shifa Mwesigye, “Prayer Can Heal AIDS, Says health Minister,” The Observer, 1 August 2011, [http://](http://observer.ug/component/content/article?id=14486:prayer-can-heal-aids-says-health-minister)

This statement came as a shock to not only Ugandans, but also the international community. Richard Ochai, the head of TASO, commented on Christine’s statements and such comments (especially from Born-Again Churches) continuously curb TASO’s efforts to fight against HIV.²⁵⁶ During a conference on HIV Treatment Adherence and Faith Healing in Africa, religious leaders and governmental organization representatives from across Africa met in Uganda to address this issue. They held discussions on the dichotomy between science and faith, the strengths of organizing a large community and finding common ground to combat HIV.²⁵⁷

Religious institutions are not only involved in treatment of HIV, but also preventive measure of HIV. During several meetings, the research team learned that churches do not prefer to promote the use of condom.²⁵⁸ Religious institutions tend to avoid talking about use of condoms due to the stigma around it. However, contrary to popular belief of the Christian community in Uganda, the representative from YWCA stated that they promoted the use of condoms and safe sex practices.²⁵⁹ Religious institutions emphasize on promoting abstinence and being faithful, which can also be seen by the programs implemented by Museveni.²⁶⁰

observer.ug/component/content/article?id=14486:prayer-can-heal-aids-says-health-minister.

256 Flavia Lanyero, “Minister’s Comment on HIV/ Aids Careless, Say Experts,” Daily Monitor, August 2, 2011,

257 Albin Hillert, “Four Voices, One Concern – Addressing “Faith Healing Only” In Context of HIV,” World Council of Churches, 7 September 2017, <https://www.oikoumene.org/en/press-centre/news/four-voices-one-concern-2013-addressing-201cfaithealing-only201d-in-context-of-hiv>.

258 Meeting with Dr. Sakor Mose, District Health Officer of Rakai, on January 23, 2018, in Rakai, Uganda.

259 Meeting with representatives of YWCA, on January 18, 2018, in Kampala, Uganda.

260 Edward Green et al., “Uganda’s HIV Prevention Success: The Role of Sexual Behavior Change and the National Response,” AIDS and Behavior, July 2006, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1544373/>.



Part II:

Intersection of Women's Rights and HIV/AIDS

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This section highlights the most salient challenges women face within the context of HIV/AIDS in Uganda. The first three sections identify challenges that result from deeply ingrained social norms and patriarchal structures, such as stigma, violence against women, and gendered differences in health seeking behavior. These same challenges present themselves in women's economic marginalization, the subject of the fourth section. This section addresses women's inequality in land ownership and property rights. Following a discussion of the lack of employment opportunities for women, this section highlights a case study on the prevalence of commercial sex work in the fishing village of Kasesero. Finally, this section concludes with an assessment of the human rights abuses committed by foreign companies investing in Uganda.

Stigma in Society

The stigma associated with HIV is vast. From testing to prevention, and treatment, HIV-positive status has opened doors to other taboos and challenges that women face daily. The ILO initiated the “World of Work” program in 2005 as a response to incidences of employee termination because of positive HIV status.²⁶¹ Since men hold higher positions in the workplace than women, firing women is considered easier than firing men. The situation for women is not worse due to their HIV status, but rather due to their gender.²⁶² Most companies must provide health care support to their employees, which consequently lead them to become concerned about covering the costs of HIV treatment and care. Employers do not fire employees with other chronic illness with the same frequency as those with HIV, revealing that the stigma associated with HIV causes employers to take these actions.²⁶³

While these are just some of the difficulties women deal with in the workplace, the challenges in the household are far more widespread. These challenges include GBV, child marriage, intergenerational sex, and limited access to justice. Women living in rural areas experience worse conditions than women residing in urban areas. The men of the household usually do not allow their wives to get tested for HIV. They believe that the HIV status would “brand” their entire household. They wish to evade the negative reputational costs by avoiding knowing their HIV status.²⁶⁴ If a woman does get tested and realizes she is HIV-positive, she may

hesitate to tell her husband or anyone else, because it may lead to domestic violence. The taboo is so strong and embedded in society that women sometimes travel to another village to seek testing and treatment such that nobody would recognize them. Out of fear of having their status “exposed women spend more time and money to travel farther out to retrieve their medication.”²⁶⁵

Although stigma against HIV/AIDS pervades Uganda, these negative views are not as present in Kasensero. Due to its demography, Kasensero has become highly sensitized to HIV, and women freely get tested and treated. The people of Kasensero, for the most part, are also open about their HIV status and are not afraid to disclose it.²⁶⁶ Kasensero is a town that is largely known for sex workers and fishermen. The nature of their profession creates fewer stigmas when discussing their HIV status. Kasensero will be further discussed under Part II: Economic Marginalization.

Gender-Based Violence/ Intimate Partner Violence

Colodina Namuleme, at seven months pregnant, arrived at the Kawempe General hospital with her intestines spilling out after being stabbed 10 times in the neck, arms, and stomach. She returned home tired from selling charcoal in February 2017, and after refusing to have sex with her husband he brutally stabbed her and accused her of sleep-

261 Meeting with David Maweje Muddu, National Coordinator for HIV/AIDS from ILO, on January 17, 2018, in Kampala, Uganda.

262 Ibid.

263 Ibid.

264 Meeting with the Kalisizo Hospital’s HIV/AIDS

Care Employee, Joseph Mureekowa, on January 23, 2018.

265 Meeting with Robert, Regional Manager from RHSP, on January 22, 2018, in Rakai District, Uganda

266 Meeting with Francis Kato from Kasensero Clinic In-charge, on January 23, 2018 in Kasensero, Rakai District, Uganda.

ing with other men. He fled the house with a bag of clothing when she started screaming, and the neighbors took her to Bukomero hospital. She was then referred to Kawempe and later to Mulago in Kampala. Namuleme said that her husband severely beats her whenever she refuses him sex or is menstruating.²⁶⁷ In the team's meeting with the Kalisizo Police Station, representatives indicated that education and sensitization efforts have taught women about seeking legal redress for these cases, but most women turn to friends, cultural or religious leaders for advice who encourage them to figure it out within the marriage.²⁶⁸ The socially-acceptable nature of GBV and IPV in society restricts women's rights, and has not been adequately addressed by policy makers.

The CEDAW Committee defines GBV as “violence that is directed against a woman because she is a woman or that affects women disproportionately.”²⁶⁹ GBV includes rape, sexual harassment, physical violence, sex trafficking, coercive or exploitative sex, female genital mutilation, early marriage, forced abortions, and widow inheritance.²⁷⁰ The WHO defines intimate partner violence (IPV) as “behavior by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors. [IPV] covers violence by both current and former spouses and other intimate partners.”²⁷¹ GBV is a structural problem that is embedded in the social expectations of gender roles and is used to enforce

gender inequality. It has direct consequences on women's rights to health, employment, and social interaction.²⁷² GBV is one of the most prevalent human rights abuses in the world, and estimates show that between 8-70 percent of women in the world experience assault by a male partner at least once in their lifetime.²⁷³ GBV results in a variety of negative health outcomes including gynecological disorders, HIV/AIDS, unwanted pregnancy, abortion, stillbirth, gastrointestinal disorders, chronic pain syndromes, and mental health disorders.²⁷⁴ The risk factors for perpetrators of GBV include alcohol use, drug use, and having multiple sexual partners. The risk factors for the woman include HIV-positive status, lack of education, low socioeconomic status, pregnancy, and being in a cohabitating relationship.²⁷⁵ The underlying factors that compound these risks include beliefs about gender and the roles of men and women in family life and society. Additionally, inter-generational sex is common in Uganda, and this increased power disparity exacerbates the risk factors for GBV and IPV. Furthermore, women face barriers in reporting or gaining redress because of stigma, shame, and other social and cultural factors.²⁷⁶

According to UN Women, 50 percent of Ugandan women aged 15-49 years have faced ei-

267 Nakabugo, Zurah. “Husband Stabs Pregnant Wife 10 times.” *The Observer - Uganda*. February 10, 2017. <http://observer.ug/news/headlines/51239-husband-stabs-pregnant-wife-10-times.html>.

268 Meeting with representatives of Kalisizo Police Station on January 23, 2018 in Kalisizo, Rakai District, Uganda.

269 “Gender-based Violence in Uganda Could Be Cultural, Not Poverty.” *Daily Monitor*. November 16, 2017.

270 Ibid.

271 United Nations Population Fund, “Strengthening Health System Responses to Gender-based Violence

in Eastern Europe and Central Asia,” *Health and Gender Violence*, July 30, 2014.

272 Ibid.

273 Heise L, Elesberg M and Gottemoeller M. Ending Violence Against Women. *Population Report*. 1999; 11:1-43.

274 Romito P, Turan JM and De Marchi M. The impact of current and past interpersonal violence on women's mental health. *Social science & medicine*. 2005; 60(8):1717-27.

275 Osinde, Michael O., Dan K. Kaye, and Othman Kakaire. 2011. Intimate partner violence among women with HIV infection in rural Uganda: Critical implications for policy and practice. *BMC Women's Health* 11: 50.

276 Achenef A. Muche, Adeyemi O. Adekunle, and Ayodele O. Arowojolu, “Gender-Based Violence among Married Women in Debre Tabor Town, Northwest Ethiopia: A Qualitative Study,” *African Journal of Reproductive Health* 21, no. 4 (2017): , doi:10.29063/ajrh2017/v21i4.11.

ther physical or sexual IPV in their lifetime, and 30 percent of Ugandan women have experienced it in 2016.²⁷⁷ A qualitative study of perceptions of GBV in East Africa revealed that many people think that GBV within marriage is not considered a crime, as the inner workings of marriage, are a private matter between a husband and wife. Some regard beatings by a husband to his wife as his expression of love to her, because the husband is the decision-maker for the household. The same study revealed that many people do not believe that there is such a thing as marital rape; society dictates that a husband has the right to have sex with his wife anytime and that she must accept any sexual desires he has. Many women feel that IPV is the norm, which deprives them of the happiness they could derive from being in a relationship, but they view it as the way out of poverty, so they accept and tolerate the violence from partners.²⁷⁸ There is a link between IPV and high-risk sexual behaviors such as multiple sexual partners, lack or inconsistent use of condoms, sexual coercion, and sexually transmitted infections. The reasons for this link lie in the structure of society; women and men are socialized differently, which influences the character of their sexual relationships and the power dynamics involved. In patriarchal societies, society teaches men to idealize toughness and sexual prowess, while it teaches women to be submissive and attend to the needs of men. Women's sexuality could pose a threat to a man's masculinity and the social order.²⁷⁹

GBV and IPV present challenges for women in the context of HIV/AIDS because IPV increases women's risk of contracting the virus due to sexual violence and lack of bargaining power to negotiate safe sex. Men who are more likely to engage in IPV

with their females spouses are also more at-risk for alcohol abuse, drug use, STIs, multiple sex partners, and concurrent sexual partnerships.²⁸⁰ Women facing IPV are at a greater risk of contracting HIV based on a higher likelihood that their spouse has HIV, and increase the risk of HIV transmission within the abusive relationship.²⁸¹ In fact, a study conducted in Rakai found a link between alcohol consumption before sex and an increased risk of HIV transmission in women aged 15-24 years in Uganda.²⁸² When the research team visited a "pop-up" health clinic in Fort Portal and observed the HIV-education station, a community member asked the question "how would you advise a family when a husband comes to find out that he is HIV-positive and forces his HIV-negative wife to have sex with him?"

Not only does IPV increase the risk of HIV contraction for women, but an HIV-positive status can encourage IPV.²⁸³ Many women come to know their status when they become pregnant, as they are tested to prevent mother-to-child HIV transmission. However, as covered in Part II: Genderized Differences in Health Seeking Behavior, men have much lower health-seeking behavior, so they often do not know their HIV status. When a woman comes home and tells her husband that she is HIV-positive, the man may blame her for bringing the disease into the house and commit acts of physical or sexual violence against her in retaliation. Additionally, when women come to know their positive HIV status and

277 "Uganda." Global Database on Violence Against Women. July 30, 2017. <http://evaw-global-database.un-women.org/fr/countries/africa/uganda?formofviolence=fac-5fe48636e4d3882bbd2ebbf29bd60>.

278 Muche, Adekunle, and Arowojolu.

279 Osinde, Kaye, and Kakaire.

280 Zablotska IB, Gray RH, Koenig MA, Serwadda D, Nalugoda F, Kigozi G, et al: Alcohol use, intimate partner violence, sexual coercion and HIV among women aged 15-24 in Rakai, Uganda. *AIDS and Behavior* 2009, 13(2):225-33.

281 Gaillard P, Melis R, Mwanyumba F, Claeys P, Muigai E, Mandaliya K, et al: Vulnerability of women in an African setting: lessons for mother-to-child HIV transmission prevention programmes. *AIDS* 2002, 16(6):937-9.

282 Zablotska, Gray, Koenig, Serwadda, Nalugoda, Kigozi, et al.

283 Gaillard, Melis, Mwanyumba, Claeys, Muigai, Mandaliya, et al.

ask the man to wear condoms or get tested, male partners will often retaliate. For this reason, many women fear discrimination, violence, and rejection by their partner, family, or in-laws. On average men have a higher number of sexual partners in Uganda than women, and the chance of the men bringing the HIV into the relationship due to infidelity is higher than women, as sexual promiscuity is more socially acceptable for men than women.²⁸⁴

Early marriage is another form of GBV that is prevalent in Uganda. According to UN Women, 40 percent of women aged 20-24 in Uganda were first married or in a union before age 18.²⁸⁵ Although the minimum age for marriage in Uganda has been 18 since 1995, many children still get married in unregistered unions.²⁸⁶ Early marriage in girls has adverse effects on educational attainment, literacy, labor force participation, voice, agency, IPV, and higher fertility. This reduction in agency, or the ability to define one's goals and act on them, associated with child marriage has ramifications for a woman's ability to negotiate or demand safe sex, confront a husband about possible infidelity, or ensure proper treatment for herself or her husband. A power disparity between men and women already exists in Uganda, but the age gap exacerbates this disparity. Child brides are less likely to have high educational attainment, which reduces their income-generating opportunities and makes them more dependent on their male partner. Low educational attainment also means that child brides are less-educated on issues

of public health, sexual education, and HIV-prevention and care.²⁸⁷ Reduction in child marriage and the empowerment of women and girls is an area that must be addressed to reduce the prevalence of HIV/AIDS.

Gender Differences in Health-Seeking Behavior

Gender plays an integral role in all aspects of Ugandan culture, and health-seeking behavior is no exception. Patriarchy is so ingrained in the culture that it permeates aspects of seeking medical attention, such as testing and treatment of diseases. During their field visit, the delegation was surprised by the trends that were brought up by health workers and clinic staff regarding health-seeking behaviors in the community. These trends remain the same in both rural and urban areas and irrespective of the economic status of the population in question. In Uganda, it is common for the males of the family to refuse to get tested.²⁸⁸ They may also refuse to let their wives get tested because the women are either doubting the male partner's faithfulness or are getting tested because the women themselves have been unfaithful.²⁸⁹ In other scenarios, the men

284 "Gender-Based Violence Increases Risk of HIV/AIDS for Women in Sub-Saharan Africa," Population Reference Bureau, April 12, 2011, <https://www.prb.org/gender-based-violence-hiv/>

285 "Uganda." Global Database on Violence Against Women. July 30, 2017. <http://evaw-global-database.unwomen.org/fr/countries/africa/uganda?formofviolence=fac5fe48636e4d3882bbd2ebbf29bd60>.

286 Secorun, Laura. "Uganda Fights Child Marriage With Job Courses and Kids' Clubs." News Deeply. May 26, 2017. <https://www.newsdeeply.com/womenandgirls/articles/2017/05/26/uganda-fights-child-marriage-with-job-courses-and-kids-clubs>.

287 Wodon, Quentin, Minh Cong Nguyen, and Clarence Tsimpo. "Child Marriage, Education, and Agency in Uganda." *Feminist Economics* 22, no. 1 (January 2016): 54-79.

288 Carol S. Camlin, Emmanuel Ssemmondo, Gabriel Chamie, Alison M. El Ayadi, Dalsone Kwarisiima, Norton Sang, Jane Kabami, Edwin Charlebois, Maya Petersen, Tamara D. Clark, Elizabeth A. Bukusi, Craig R. Cohen, Moses R. Kanya, Diane Havlir & the SEARCH Collaboration (2016) Men "missing" from population-based HIV testing: insights from qualitative research, *AIDS Care*, 28:sup3, 67-73. DOI: 10.1080/09540121.2016.1164806

289 Meeting with Dr. James from RHSP Clinic, on January 22, 2018 in Rakai District, Uganda.

of the house may encourage their wives or partners to get tested as a way to prove their fidelity. If the woman tests positive, the man may then subject her to GBV or abandon her.²⁹⁰ Even if a woman manages to get tested with or without the partner's knowledge, women are often put in a position within society and the family's hierarchy never to reveal if they tested positive. This situation then prevents them from obtaining the right medical treatment.²⁹¹

In other cases, men refuse to seek treatment due to masculine norms that dictate that positive health-seeking behavior is a sign of weakness. Instead, they may force their wives to stand in long lines at the nearest health center to obtain medication. Then the husband would force the wife to share the drugs that were prescribed only to her. The repercussions are that neither party intakes a full dosage of the drug, and so do not receive its full effect.²⁹² In some instances, men also steal the medication the women procure, leaving them in a position of helplessness.²⁹³ Physical access to treatment is also a barrier. Some people must travel over 12 miles to acquire necessary testing, medication, and treatment.²⁹⁴

Economic Marginalization

The Centre on Housing Rights and Evictions states that “one of the greatest obstacles HIV/AIDS

290 Ibid.

291 Siu GE, et al. 2018. “Dividuality, Masculine Respectability And Reputation: How Masculinity Affects Men's Uptake Of HIV Treatment In Rural Eastern Uganda. - Pubmed - NCBI”. Ncbi.Nlm.Nih.Gov. <https://www.ncbi.nlm.nih.gov/pubmed/23726215>.

292 Ibid.

293 Ibid.

294 Meeting with Dr. James from RHSP Clinic, on January 22, 2018 in Rakai District, Uganda.

infected women confront is their inability to secure property. Women's inability to possess and manage property may result in their impoverishment, particularly in cultures which have a propensity to humiliate or shun HIV/AIDS infected women and girls.”²⁹⁵ Land entitlement creates opportunities for socio-economic development, but a lack of property rights for a vulnerable group, such as HIV/AIDS positive women, forces them into an even weaker position. In Uganda, property rights issues are inter-related with gender inequalities and social stigma.

Land and Property Rights

Lack of Economic Independence

In Uganda, like other Sub-Saharan African states, customary law predominates property and land rights. The Constitution, which recognizes customary, freehold, Mailo (a colonial form of tenure),²⁹⁶ and leasehold tenure systems, allows individuals' rights to land by occupation. Customary tenure system, which refers to former unregistered public land, regulates 75 percent of the total land and is the most common form of tenure in the country.²⁹⁷ Kinship-oriented customary entitlement of property has created a barrier for clearly defin-

295 The Centre on Housing Rights and Evictions (COHRE) Women and Housing Rights Programme, “Women's Housing Rights in the Context of HIV/AIDS” *Women and Housing Rights Issue Brief Eight*, 2017, https://issuu.com/cohre/docs/cohre_housingrightshivaidis_issuebri

296 Cheryl Walker, “Land Reform in Southern and Eastern Africa: Key Issues for Strengthening Women's Access to and Rights in Land.” Food and Agricultural Organization Study Report, March 2002,

297 Food and Agriculture Organization of the United Nations (FAO), “Gender and Land Rights Database”, accessed April 3, 2018 http://www.fao.org/gender-landrights-database/country-profiles/countries-list/land-tenure-and-related-institutions/prevaling-systems-of-land-tenure/en/?country_iso3=UGA

ing formal rights of ownership,²⁹⁸ which scholars argue is a precondition for economic efficiency.²⁹⁹ UGANET confirmed that local clan leaders govern clan property decisions and are mostly composed of men and only expandable through them. Clans often think that women cannot typically own property, but especially not if they have HIV.³⁰⁰ Customary law, traditionally derived as a method for men in traditional societies to reclaim independence from colonization, is considered sufficient rules of society. As such, owners do not value registering their land through formal governmental channels. Such customary tenure provides power to decision makers, who can pursue their private interests, which can marginalize women even further. “Authority in land whether vested in chiefs, or in the government officials and political leaders, can, in turn, lead directly to private economic benefits for these actors, derived from land accumulation, patronage and land transactions.”³⁰¹ Studies show that in Uganda, statutory law conflicts with customary and religious law, which undermines the statutory law illegally.³⁰²

Women have secondary rights to land access, which bestows the right to farm a particular area only because the woman is married to a man who is of a specific kinship group. Such right implies that women are “not recognized as having autonomous

membership in a particular group and therefore have only the right to till land owned by a group.”³⁰³ Some women remain in relationships with a violent husband and endure rape and beating in fear of being thrown out of the property.³⁰⁴

There is gender inequality in both customary and statutory law that discriminates against women. For example, in customary law, if a husband discovers his wife’s unfaithfulness, he can divorce her without providing means of support for her and even for their children. Whereas in the opposite case, the wife, seen as property, would have no right to protest.³⁰⁵ Much of this is related to socially accepted practices of polygamy. 12.1 percent of Uganda’s population is Muslim, and Islamic law mandates their daily lives. Not only is polygamy accepted, but there also underlies gender inequality in inheritance,³⁰⁶ placing women at an economic disadvantage even when left with inheritance. The paramount conflict originates from insufficient enforcement of the Ugandan Constitution itself, allowing customary practices that conflict with international standards of human rights to supersede the law, especially in less developed regions of the country. If statutory law were to have a stronghold in implementation, monitoring, and prosecution, then traditional practices that violate women’s rights would be exterminated. Human Rights Watch criticized Uganda for not adopting legislation that would outlaw harmful traditional practices and improve women’s property rights. Furthermore, some even state that article 32 (b) of the Constitution has “never been activated.”³⁰⁷ This article prohibits customs and traditions that are against women and

298 S.F. Joireman, “The Mystery of Capital Formation in Sub-Saharan Africa: Women, Property Rights and Customary Law,” *World Development* 36, no. 7 (2008): 1233-1246

299 Omotunde E. G. Johnson, “Economic analysis, the legal framework and land tenure systems,” *Journal of Law and Economics* 15, no.1 (1972): 259-276, accessed April 3, 2018, <https://www.jstor.org/stable/725023>

300 Meeting with representatives of UGANET on January 18, 2018 in Kampala, Uganda.

301 Camilla Toulmin and Julian Quan, *Evolving land rights, policy and tenure in Africa*, (Great Britain, 2000), 1-30.

302 Rachel C. Loftspring, “Comment: Inheritance Rights in Uganda: How Equal Inheritance Would Reduce Poverty and decrease the spread of HIV/AIDS in Uganda,” *University of Pennsylvania Journal of Labor and Employment Law*, 29 (2007): 3.

303 Joireman, “The Mystery of Capital Formation”, 1233-1246

304 Human Rights Watch, *Just Die Quietly: Domestic Violence and Women’s Vulnerability to HIV in Uganda*, (New York: Human Rights Watch, 2003) 37.

305 Loftspring, “Comment: Inheritance Rights in Uganda,” 4.

306 Ibid, 8.

307 Sarah Kibisi Achen and Wendy Glauser, *Wom-*

undermines their status. Furthermore, many have criticized the government for failing to enact the promises it makes in international human rights conventions. For example, Uganda is a State party to CEDAW and the ICCPR, both of which abolish discrimination. Yet, according to the International Women’s Human Rights Clinic at the Georgetown Law Center, “the government’s continued failure to enact and enforce equal succession laws in compliance with international human rights law deprives women of the economic means to sustain themselves and their families and prevents them from reaching their full capacity as contributing members of the Ugandan society.”³⁰⁸

Property Grabbing

UNAIDS, UNFP, and the former United Nations Development Fund for Women have observed that “the abuse of human rights that women deal with on a daily basis can become nearly insurmountable obstacles when HIV/AIDS is involved. One of the most serious effects of HIV for women has been the loss of property.”³⁰⁹ Even more than formal land entitlements themselves, land inheritance issues critically marginalize women living with HIV and push them into abusive environments. UGANET stated that when HIV is an issue, it exacerbates restrictions for women to hold property and pointed out land-grabbing from widows as a major problem.³¹⁰ Other studies confirm this anecdote. The Federation of Women Lawyers (FIDA), reported

in 1995 that 40 percent of the cases handled were related to harassment of widows and property grabbing by their husbands’ relatives.³¹¹ Evidence from a study suggests that following the death of their husbands for 29 percent of 204 widows in the Luwero and Tororo areas in Uganda, the relatives of the husband took the widows’ property.³¹² The consequences of property grabbing put women at risk of HIV infection. According to a 2003 study by Human Rights Watch, “nearly all of the women who had lost property after their husband’s death had been forcibly evicted from their homes by their husbands’ relatives.”³¹³ In Uganda, women provide 80 percent of all agricultural labor and 90 percent of all labor involving food production, such that depriving them of land takes away a major source of economic activity.³¹⁴ In addition to the loss of food security, HIV positive women exhaust resources for medical necessities and experience marginalization due to stigma.

Lack of Employment Opportunities

The National Employment Policy for Uganda revealed that women constitute only 37 percent of the total public sector and identified women as the “backbone of agricultural production, accounting for 58 percent of the agricultural labor force.”³¹⁵ While these numbers in itself, independently do not

en’s Emancipation: The Struggle Continues, The Monitor (Uganda), Nov. 26, 2005.

308 Valerie Bennett et al., “Inheritance Law in Uganda: The Plight of Widows and Children,” *Georgetown Journal of Gender and the Law* 7, no. Special Issue (2006): 455.

309 Open Society Fund, “Securing Women’s Land and Property Rights: A Critical Step to Address HIV, Violence, and Food Security,” 2014.

310 Meeting with representatives of UGANET on January 18, 2018 in Kampala, Uganda.

311 Winnie Bikaako and John Ssenkumba, “Gender land and rights: Contemporary contestations in law, policy and practice in Uganda,” *Women and Land in Africa*, (New York, 2003): 250.

312 Laelia Zoe Gilborn et al., *Making a Difference for Children for Children Affected by AIDS: Baseline Findings from Operations in Uganda*, (The Population Council, 2001): 1.

313 Human Rights Watch, *Just Die Quietly*, 38.

314 Evelyn Nyakoojo, *Women Land Rights in Uganda in Kampala, Uganda: Eastern African Sub-regional Support Initiative for the Advancement of Women*, (2002): 48.

315 Republic of Uganda, *National Employment Policy of Uganda*, (2011): 9-10.

illustrate the lack of employment opportunities for women, when coupled with the various accounts, from different sources, it is apparent that women are placed in less advantageous economic position in the labor market. Uganda has the legal framework for non-discrimination at the hiring and termination stages of work and ensures equal treatment and fair pay: article 6 in the Employment Act promotes equal opportunity and eliminating any discrimination in employment, identified as “distinction, exclusion or preference made on the basis of race, color, sex, religion, political opinion, national extraction or social origin, the HIV status or disability”³¹⁶; the Constitution also defines in its article 40 “the right to equal pay for equal work without discrimination”.³¹⁷ Like many other developing and developed countries, therefore, the reason for lack of economic opportunities for women are not due to an absence of legal language. For Uganda, social constructs such as gender norms are discriminatory and constrain females because they are prevalent in different fields that end up contributing to disempowering women. One could argue the starting point as early marriage and domestic violence, two social constructs prevalent in Uganda,³¹⁸ that undercut girls from pursuing their education, and puts them at a disadvantage to earn the required skills for professional positions. Another study shows that at all levels of income, women do the majority of housework and care, constraining them from economic activities. In addition, women living in poverty carried heavier workloads than men for unpaid work, which makes women less likely to engage in paid work or subsistence agriculture.³¹⁹

Therefore, it is not a surprise that majority of farmers and unpaid workers are women.³²⁰ Agri-

culture is fundamental for the Ugandan economic wellbeing. As high as 79 percent of the labor force is self-employed or employed as unpaid family workers in the agricultural sector.³²¹ Also, the highest employment in the private sector is in the agriculture and fishing industry that constitutes 69.4 percent.³²² However, women managers cultivate plots that are on averages 0.23 hectares smaller than those managed by males, with restricted access to market, machinery, and agricultural technology.³²³ As these factors are coupled with unequal land rights, where women do not have the ownership, women are less likely to grow cash crops and decide to generate earnings.³²⁴ Instead, they are likely to develop high dependency on their husbands or the male head of the household. This increases women’s vulnerability in the household to the extent where in the case of a deceased husband, there is no alternative to sustain oneself economically without relying on others or engaging in dangerous and unhealthy ways of life.

In the labor market, only 12 percent of all women are in wage employment in comparison to 25 percent of all men. The same research also notes that male participation rate in wage sectors is more than three times that of women.³²⁵ About 50 percent of employed women work in the lowest paying three sectors, namely agriculture, household and mining and quarrying.³²⁶ “Men are still in the higher top management level,” stated the National Coordinator at the ILO meeting.³²⁷ Women experience

opment, *National Employment Policy for Uganda* (April 2011): 16

321 Ibid.

322 Ibid.

323 UN Women et al., *The Cost of the Gender Gap in Agricultural Productivity in Malawi, Tanzania, and Uganda*, (2015): 2.

324 Ibid. 15.

325 Ministry of Gender, Labour, and Social Development, *National Employment Policy for Uganda*. 16.

326 Ibid.

327 Meeting with David Maweje Muddu, National Coordinator for HIV/AIDS from ILO, on January 17, 2018,

316 Republic of Uganda, *Employment Act*, 2006.

317 Constitution of the Republic of Uganda, 1995.

318 OECD, *Uganda Social Institutions and Gender Index Report*, (2015): 15.

319 UNDP, *Country Gender Assessment*, (2016): 6.

320 Ministry of Gender, Labour, and Social Devel-

still prevalent in the country, particularly in the fishing village of Kasensero, the site of Uganda's first recorded case of HIV in 1982.³³⁴ Located approximately 250 kilometers southwest of Kampala on the shores of Lake Victoria, Kasensero is one of the most remote areas in Uganda. The community is largely mobile, composed of fishermen, boat owners, and other workers whose livelihoods center on fishing, as well as young women who earn income through commercial sex.³³⁵ Some workers come from far-away towns and cities, and even from neighboring countries bordering Lake Victoria. Women, too, come from afar, drawn from Kampala and elsewhere by the promise of earning income through sex work. The fishermen have a rather steady daily routine here. They leave for fishing on the crocodile-infested Lake Victoria early in the morning. After fishing, they come back to the shores around noon and begin to drink at the local bars. The sex workers wait for them in the evening. The life of a sex worker, however, is different. Since the fishermen risk their lives going into the crocodile infested lakes everyday, they wish to do as they please for the rest of the day. The women there are present to fulfill the men's wishes. Most of the day for the sex workers goes into negotiating prices and providing services. They are found loitering around local bars and restaurants to meet clients³³⁶. Francis Kato, in-charge of the Rakai Health Sciences Program-supported health clinic in Kasensero, described the life of a sex worker in Kasensero. When

a woman arrives from either a neighboring town or Kampala, her "rate" is high. After two or three weeks, her "rate" gradually decreases, as the men are not willing to pay as much for her services, or a newer woman has arrived in Kasensero.³³⁷ Either the woman chooses to stay on at Kasensero, or she moves back to where she was before. Francis Kato pointed out that in most of the cases the women carry HIV to the other cities, either knowingly or unknowingly.

According to data collected in 2014, approximately 44 percent of Kasensero's population was infected with HIV, including 74 percent of female sex workers (FSW).³³⁸ The incidence rate stood at 4.3 per 100 person-years (an estimate of the actual time at risk in years, months, or days) in women and 3.1 per 100 person-years in men.³³⁹ While these high rates can be explained, in part, by the norms and social behaviors predominant in Kasensero, the fact that the prevalence rate was almost double that of other fishing communities around Lake Victoria suggests that there are explanatory variables unique to Kasensero.³⁴⁰ The pervasiveness of sex work and HIV has stigmatized Kasensero, deterring healthcare workers and other service providers who fear being associated with the illicit business, or are assumed to be infected.³⁴¹ The resulting lack of personnel exacerbates problems created by a serious lack of infrastructure. With limited health services, one small primary school, and no proper roads connecting the village to the nearest town, Kasensero's population remains marginalized.

Two health centers serve Kasensero, providing

334 "Kasensero: Origin of the AIDS Epidemic," Deutsche Welle, <http://www.dw.com/en/kasensero-origin-of-the-aids-epidemic/g-17800454>.

335 Muhamadi Lubega et al., "Understanding the Socio-Structural Context of High HIV Transmission in Kasensero Fishing Community, South Western Uganda," US National Library of Medicine, 8 October 2015 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4599692/pdf/12889_2015_Article_2371.pdf.

336 "Deadly Catch: Uganda's Fishermen Seeking Sex Workers Prompt HIV Surge," The Guardian, April 25, 2014, <https://www.theguardian.com/global-development/2014/apr/25/aids-and-hiv-uganda>

337 Meeting with Francis Kato from Kasensero Clinic In-charge, on January 23, 2018 in Kasensero, Rakai District, Uganda.

338 Lubega et al., "Understanding the Socio-Structural Context."

339 Ibid.

340 Ibid.

341 Meeting with Francis Kato from Kasensero Clinic In-charge, on January 23, 2018 in Kasensero, Rakai District, Uganda.

Kampala clinic and forcibly subjected her to an HIV test.³⁵¹ The enforced test came back positive, and Annet's manager asked her to leave the job without any compensation. Both plaintiffs also sued for infringement of their right to privacy, stating that the clinic disclosed their HIV status to their managers without informed consent. In the pleadings submitted to the High Court, CCCC denied all allegations and asserted that their workers were never coerced to receive medical checkups, and indeed the medical testing was for employees' health benefits.³⁵² However, the company refused to answer questions regarding reasons for the job dismissal.

This case is far from an exception. Olivia Kugonza, a former kitchen staffer at the Chinese company Sinohydro, was dismissed from work after being forcibly tested for HIV along with 13 other women. Fearful of exposing their status, Olivia was the only one who brought the case to court. She lost the case despite the fact that the Constitution protects citizens from HIV/AIDS-related discrimination, stigmatization, and denial at the workplace. There are increasing concerns on whether foreign companies comply with national regulations protecting PLHIV.³⁵³ Ugandan authorities seem to turn a blind eye to the blatant discrimination that is taking place. Against this backdrop, young women, like Olivia and Annet, are particularly vulnerable not only because the virus disproportionately affects them, but also because they are desperate for employment to support their children.³⁵⁴ According to ICWEA, foreign companies have HIV testing

as a precondition for employment.³⁵⁵ The management of foreign firms often lacks understanding of Uganda's AIDS epidemic.³⁵⁶ The severity of the problem depends on the nationality of the firm and the context of their home countries. For instance, as explained by the ILO national coordinator for HIV/AIDS David Mawejje, when it comes to HIV-related stigma in the workplace, significant differences could be observed between South African companies, which are familiar with the issue and set up anti-discrimination policies accordingly, as compared to Malaysian firms which are new to the operating environment.³⁵⁷

Recent discoveries of minerals, aggressive government push for FDI, and the presence of legal loopholes have attracted many foreign corporations to do business in Uganda. Activities of these businesses have occasioned a wide range of human rights abuses.³⁵⁸ The Panorama Report on corporate accountability in Uganda examines the operations of seven foreign companies (from the U.S., U.K., China, Egypt, India, Kuwait, and Saudi Arabia) in Uganda's resource-rich areas, and concludes that "almost all companies operating in the areas under study have been implicated in unfair or abusive labor practices."³⁵⁹ Examples of these practices include economic exploitation of employees, delayed or non-payment of wages, poor and unsafe working conditions, and denied

351 Annet Namuyoma Mukisa & George William Kato v. China Communication Company Limited, 195 The Republic of Uganda in the High Court of Uganda at Kampala. (2017).

352 Robert I. Rotberg, "Chinese Company Fires HIV-Positive Workers," China-US Focus, August 1, 2017, <https://www.chinausfocus.com/political-social-development/chinese-company-fires-hiv-positive-workers>.

353 Meeting with Nadia El Ouargui, Senior Advisor from the Embassy of Norway, on January 19, 2018, in Kampala, Uganda.

354 Ibid.

355 Meeting with Lillian Mworeko, Executive Director, from ICWEA, on January 25, 2018, in Kampala, Uganda.

356 Meeting with David Mawejje Muddu, National Coordinator for HIV/AIDS from ILO, on January 17, 2018, in Kampala, Uganda.

357 Ibid.

358 Ronald K.S. Wakyereza, "Impact of Foreign Direct Investment on Economic Growth, Employment and Poverty Reduction in Uganda" (master's thesis, Victory University, 2017).

359 Uganda Consortium on Corporate Accountability (UCCA), *The State of Corporate Accountability in Uganda: A Baseline Study Report for the Uganda Consortium on Corporate Accountability* (2016). The report examines nine major foreign companies from U.S., U.K.,

access to medical care.³⁶⁰ Local communities also complain about the increasing social discord that foreign companies cause, such as alcoholism, prostitution, increase in HIV infections, abuse of young girls, and family breakdown.³⁶¹ International law encourages multinational corporations to regulate themselves concerning human rights.³⁶² However, only a handful of foreign companies operating in Uganda has codified anti-discrimination policies or rights-based corporate social responsibility (CSR) principles into their organizational guidelines.³⁶³

At the heart of these violations is the state's lack of either capacity or willingness to regulate the activities of businesses to protect human rights. The government imposes a slack licensing requirement on foreign investment.³⁶⁴ The Investment Code Act only requires foreign investors to contribute positively to the local economy while minimizing the environmental impact.³⁶⁵ The Act has no explicit reference to employment practices or respect for human rights. Moreover, the Uganda Investment Authority (UIA), the agency in charge of overseeing the foreign companies, is also responsible for attracting foreign investment with substantial tax and financial benefits. This conflicting role further undermines the government's ability to hold these firms accountable.³⁶⁶ In some cases, the government

itself acts as a perpetrator of human rights abuses to win over the "much needed" investment. For instance, the GoU excused some Chinese firms for violating women's rights because their unconditional infrastructure projects are becoming the government's preferred investment.³⁶⁷

360 Ibid.

361 Ibid.

362 There are some non-binding soft laws, such as OCED Guidelines and ILO Tripartite Declaration of Principles concerning Multinational Enterprises and Social Policy.

363 Meeting with David Mawejje Muddu, National Coordinator for HIV/AIDS from ILO, on January 17, 2018, in Kampala, Uganda.

364 U.S. Department of Commerce, US Commercial Service, *Doing Business in Uganda: 2016 Country Commercial Guide for U.S. Companies*, (Washington, D.C., 2016), <https://ug.usembassy.gov/wp-content/uploads/sites/42/2016/08/Uganda-CCG-2016.pdf>.

365 *The Investment Code Act 1992 (ACT)* ss 11-12, <https://ulii.org/ug/legislation/consolidated-act/92>.

366 UCCA, *The State of Corporate Accountability* (2016).

367 Meeting with Stephen Odong, Director of Programs from HURINET, on January 25, 2018, in Kampala, Uganda.



Part III:

Structural Impediments to the Realization of Rights

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This section discusses the structural barriers that women, WLHIV, or other similarly situated persons may face in attempting to realize their rights. It also serves as an entry point for policy-makers and foreign donors to reflect upon their current policies and make necessary improvements to address the rights of key populations. The section will first address access to justice issues concerning land and property rights, GBV, and labor rights. It will then proceed to discuss issues surrounding a variety of structural problems in the healthcare system, including governance failures, unsustainable funding, ineffective distribution of resources, and HIV-related discrimination. The section will end with a broader discussion on the recent wave of restrictive bills and its implications for the state's pledges to improving health services and human rights under international and regional treaties as well as the Ugandan Constitution.

but instead can be subject to disputes amongst extended family members. In rural areas where land is often the most valuable asset, a family's claims to ownership are even more antagonistic. Women already have a limited ability to hold property given their lowered status in Uganda's patriarchal society, but the restrictions become exacerbated when HIV is a factor. The difficulties exist not only if a woman herself has HIV, but also if her husband dies of HIV-related causes, which can lead to land-grabbing from the widow.³⁷³ Widows are often excluded from the inheritance process not only because they are women, but also because when a woman marries, she usually leaves her village behind to live in her husband's community. Because of this patrilocal residence, women are far away from the social support networks of their own families and are often considered outsiders by their husband's family.

Similarly, women whose husbands abandon or divorce them face obstacles. A husband may divorce or abandon his wife if he finds out that she is HIV positive, even if he is also HIV positive and was the one who infected her. In such cases, these men abandon their families and remarry, which may further spread the virus.³⁷⁴

Many of these cases never make it into the formal justice network. Women are not aware of their rights and are subject to Ugandan cultural norms. People give up on the justice system because it is archaic, corrupt, expensive, and slow.³⁷⁵ Formally reporting a violation and pursuing an investigation can involve high costs and take a long time, so people resort to handling situations among themselves. In instances of domestic violence, a man

might pay a woman who accuses him of abuse to silence her.³⁷⁶ Courts and lawyers are a far cry away from the access to justice of ordinary Ugandans. According to one study, "[l]ess than 5 percent of dispute resolution takes place in a court of law, and less than 1 percent of cases is a lawyer involved." Courts and lawyers are also among the least trusted institutions in Uganda.³⁷⁷

Most Ugandans seek first recourse through their families and social networks, or by confronting the offending party themselves. Another avenue towards accessing justice is through Local Council Courts (LCCs), community-level committees established in 1988 to "promote a more accessible justice system and to provide an efficient, popular system of justice and reconciliation."³⁷⁸ LCCs are currently the most widely used form of dispute resolution in Uganda.³⁷⁹ Although the GoU mandated that the LCCs were to include women representatives, for the most part, the GoU has not followed through on this goal. Moreover, the existing male-dominated power relations within communities often affect the outcome of disputes brought before the LCCs and continue to prevent women's access to justice.

To tackle some of these issues, some Ugandan organizations are working through the existing community legal frameworks to expand women's access to justice. They train women to understand and advocate for their right to own and inherit property, while also training men who, as leaders of the community, need to be educated about women's rights (See Part IV: Current Programs and Interventions).³⁸⁰

373 Meeting with representatives of UGANET, on January 18, 2018, in Kampala, Uganda.

374 Meeting with Stephen Odong, Director of Programs from HURINET, on January 25, 2018, in Kampala, Uganda

375 Meeting with representatives of UGANET, on January 18, 2018, in Kampala, Uganda.

376 Meeting with Christine Munduru, Public Health Expert and Consultant on January 24, 2018 in Kampala, Uganda.

377 HiiL Innovating Justice, 2016.

378 "Strategies for success: Access to Justice for Women," ActionAid, accessed on 27 April 2018 from: http://www.actionaid.org/sites/files/actionaid/strategies_for_success_-_access_to_justice_for_women.pdf.

379 HiiL Innovating Justice, 6.

380 Meeting with Human Rights Network-Uganda

Violence against Women

The path towards accessing justice takes a toll on Ugandans, especially those living in rural areas far removed from formal justice institutions. Men and women, however, experience the personal and financial costs of seeking justice differently. Women experience stress more often (57 percent), problems with relationships (31 percent), violence (18 percent) and personal injuries (15 percent). Men, on the other hand, report a loss of income (57 percent) and a loss of time (46 percent) more often.³⁸¹ Women are more vulnerable to retaliation for seeking legal services or reporting crimes, which often comes in the form of domestic violence or GBV. Women in Uganda are almost four times more likely to be victims of domestic violence than men.³⁸² Stigma presents a severe barrier towards women's ability to report and seek redress for abuse. Even if a woman does report violence and wins her case, she then must return to her community with the status of victim and accuser. She may be treated as a pariah or social outcast by her community, especially if the perpetrator of the abuse had some social standing. These reputational costs discourage women from reporting abuse to either law enforcement, legal, or medical professionals. The same barriers that block women's access to justice also block their access to medical treatment, which can delay or prevent them from taking measures to prevent becoming infected with or treated for HIV when contracted through sexual assault or rape.³⁸³

Rather than reporting to law enforcement or justice institutions, most Ugandans seek information and advice from family members and friends to resolve family disputes, whether involving violence

(HURINET) on January 25, 2018 in Kampala, Uganda.

381 HiiL Innovating Justice.

382 Ibid, 47.

383 Meeting with Christine Munduru, Public Health Expert and Consultant on January 24, 2018 in Kampala, Uganda.

or otherwise.³⁸⁴ ActionAid International Uganda is working to build greater community awareness on government-protected rights and mechanisms for accessing justice through “social theatre for change.” Organizers used theater and drama outreach to increase awareness of violence and educate women and girls about the available support mechanisms to access justice. Clan and community leaders were also involved and counseled on their role in mediating these crimes.³⁸⁵

Marginalized Groups

As discussed, there are many taboos in Uganda. The criminalization of sex work coupled with the stigma of being a sex worker invariably makes it difficult to report abuses that may occur in the course of the profession, such as rape or sexual assault by clients and non-payment for services. The LGBTI community is also notoriously marginalized and harassed in Uganda.³⁸⁶ Same-sex sexual conduct is criminalized,³⁸⁷ further forcing people into the shadows. The transgender community may fare even worse, given the extreme social isolation and intersection with sex work.³⁸⁸ These marginalized groups overlap with key populations at higher risk of contracting HIV or suffering from its impacts. Furthermore, HIV/AIDS adds an additional layer of barriers for these groups to come forward in the pursuit of justice.

384 HiiL Innovating Justice, 114.

385 ActionAid, 14-15.

386 Onyulo, Tonny. “Uganda’s Other Refugee Crisis: Discrimination Forces Many LGBT Ugandans to Seek Asylum.” USA Today. July 14, 2017. <https://www.usatoday.com/story/news/world/2017/07/13/uganda-other-refugee-crisis-lgbt-ugandans/475353001/>.

387 Uganda Penal Code (1950), arts. 145 - 146, 148, <http://www.wipo.int/edocs/lexdocs/laws/en/ug/ug008en.pdf> (as amended by the Penal Code Amendment (Gender References) Act (2000)).

388 See Dickerman.

Gender-Based Violence Court

Uganda’s national avenues towards accessing justice in GBV cases is currently limited to three institutions: the UHRC’s child and family court, a police unit responsible for children, and a tribunal that accepts cases related to GBV.³⁸⁹ This is not enough, however, given how deeply ingrained VAW is in patriarchal societies, as well as the barriers to reporting. Moreover, police and other actors in the justice system are neither trained, nor given the resources and financial support to pursue and handle VAW cases. Critical facilities are also lacking, such as “[s]helters where VAW victims can be accommodated and receive counseling and other support before returning home.” Four of Uganda’s thirteen shelters are donor funded, underlying the dire need for greater support for victims and survivors of GBV.³⁹⁰ Specialized GBV courts are one solution under consideration (See Part V: Policy Recommendations). In fact, given the widespread and normalized nature of VAW in Uganda, many have called for the creation of GBV courts. Members of the Uganda Women Parliamentary Association (UWOPA) have submitted a proposal to the Ugandan parliament calling for a specialized court with staff trained in gender sensitivity in order to reduce the backlog of GBV cases and deliver justice in a timely manner. Local NGOs, such as the Center for Domestic Violence Prevention, support this cause, noting that on average rape cases last for over ten years.³⁹¹ The Hon. Justice Dr. Yorokamu

Bamwine, a Ugandan Principal Judge, has championed this cause, placing it high on his agenda. He is set to retire soon, however, leaving the future of Ugandan GBV courts in the balance.³⁹²

Rights in the Workplace

HIV positive workers experience discrimination in multiple levels at the workplace; the hiring stage, non-consented testing and disclosure, and termination of employment. Women who are already susceptible to weaker social protection struggle to receive the adequate support for their rights (See Part II: Economic Marginalization). In addition, weak local infrastructure poses additional challenges for individuals to access legal and formal recourse, especially in the rural areas.

HIV status in the workplace hinders employment opportunities in Uganda. According to a 2013 study by the National Forum of People Living with HIV in Uganda (NAFOPHANU), 23 percent of the respondents reported losing jobs or income in 2012, and 27 percent of the respondents attributed the reason to HIV status.³⁹³ The starting point of discrimination is the hiring process, where forced HIV status testing remains despite regulations and policies against it. The Uganda National Policy Guidelines for HIV Counselling and Testing specify that “some employers, foreign governments and institutions have policies that require knowing the HIV status of certain persons before they are allowed to apply for particular privileges or ser-

389 Meeting with Ruth Ssekindi, Director of Complaints, Investigations, and Legal Services from the Uganda Human Rights Commission, on January 24, 2018 in Kampala, Uganda.

390 Stephen Ssenkaaba, “Uganda: Violence against Women Unabated despite Laws and Policies | Africa Renewal Online,” *United Nations*, (December 20, 2017). <http://www.un.org/africarenewal/news/uganda-violence-against-women-unabated-despite-laws-and-policies>.

391 Paul Kiwuuwa and Christopher Bendana, “MPs

want specialized courts for gender based violence cases,” *New Vision*, (November 23, 2016), https://www.newvision.co.ug/new_vision/news/1440681/women-mps-specialized-courts-gender-violence.

392 Meeting with representatives of the United Nations Development Programme (UNDP) on January 19, 2018 in Kampala, Uganda.

393 NAFOPHANU, *Stigma Index*, 20.

vices.”³⁹⁴ Despite its national employment policy in conditions of free, equal, secure conditions and that of human dignity, there is a gap in governance over foreign governments and institutions (See Part II: Economic Marginalization).³⁹⁵

Hiring discrimination occurs both in the formal sector and the informal sector for PLHIV. Police force in Uganda, for example, requires new recruits to take HIV testing due to high intensity in training and special accommodation for HIV positive officers to access ARVs.³⁹⁶ According to Dr. Moses Byaruhanga, Police Director of Medical Services, the policy is not meant to discriminate but rather to “protect them.” Police candidates are deemed unqualified if they are HIV positive before employment and during their nine-month training.³⁹⁷ However, HIV prevalence in the police sector is significantly higher than the national HIV prevalence (6.4 percent), which Dr. Walimbwa attributed to high mobility of the force and low rate of HIV testing.³⁹⁸ Such statistics questions the purpose and the effectiveness of the initial HIV screening. Rather this discriminatory practice seems to have added stigma within the field. According to a 2013 report by Makerere University Joint AIDS Programme (MJAP), police officers fear to reveal their status due to high levels of stigma, which marks them as one of the groups at higher risk of contracting HIV.³⁹⁹ The initial screening of eliminating qualified

candidates due to HIV status creates a social construct of vulnerability that understandably silences those who are HIV positive. It confines an HIV positive individual into a helpless state, shunned at their workplace and socially discriminated.

Nonetheless, even in the private sector, forced testing is not uncommon. Food processing companies and hotels also have HIV screening for safety and sanitation issues.⁴⁰⁰ Salome Atim, a project officer at NAFOPHANU, said there have been “cases of the hotel industry [and] catering services sacking or forcing [employees] to test” for HIV.⁴⁰¹ Nonetheless, health authorities around the world agree that HIV transmission through food and beverages is not a known risk. The U.S. CDC released a statement clarifying that HIV status should not restrict food-service workers from working.⁴⁰² Since misunderstandings about the risk of HIV transmission prevail in these sectors, more robust sensitization programs should be conducted (See Part V: Policy Recommendations).

To address workplace discriminatory practices and seek redress, the Employment Act defines in Section 6 (1) that “it shall be the duty of all parties including the minister, labor officers and the Industrial Court to seek to promote equality of opportunity with a view to eliminating any discrimination in employment.”⁴⁰³ However, as ILO identifies as problematic, due to the lack of labor officers and resources, especially in rural districts,

394 Ministry of Health, *Uganda National Policy Guidelines for HIV Counselling and Testing*, 2005, page 3.

395 Ministry of Gender, Labour, and Social Development, *National Employment Policy*, April 2011

396 Meeting with George Tamale and Opio Daniel from Federation of Uganda Employers, on January 2018, in Kampala, Uganda.

397 “Police policy sidelines people living with HIV”, *Daily Monitor*, December 3 2017, <http://www.monitor.co.ug/News/National/Police-HIV-policy-sidelines-people-living-with-HIV/688334-4212720-3276jp/index.html>.

398 Frederick Womakuyu, “HIV Silently Eating Up Police Force,” *New Vision*, Kampala, August 15 2011

399 “Police policy sidelines people living with HIV”, *Daily Monitor*, December 3 2017, <http://www.monitor.co.ug/News/National/Police-HIV-policy-sidelines-people-living-with-HIV/688334-4212720-3276jp/index.html>.

living-with-HIV/688334-4212720-3276jp/index.html.

400 Meeting with National Coordinator for HIV/AIDS, David Mawejje Muddu from ILO, on January 17, 2018, in Kampala, Uganda.

401 Amy Fallon, “Fired After Forced HIV Tests,” *Ugandan Women Head to Court*, *Newsdeply*, August 2017, <https://www.newsdeply.com/womenandgirls/articles/2017/08/14/fired-after-forced-hiv-tests-ugandan-women-head-to-court>>

402 “HIV/AIDS and the food Handler,” *Institute of Food Science Technology*, December 2017, <https://www.ifst.org/knowledge-centre/information-statements/hivaids-and-food-handler>.

403 Republic of Uganda, *Employment Act*, 2006

workers have not been able to use it effectively.⁴⁰⁴ The workplace inspection team is significantly understaffed, with only 45 labor officers covering the whole country.⁴⁰⁵ In addition, many articles report on the underfunding of the Industrial Court and its insufficient legal capacity. Therefore, even if there were to be a labor case addressed in Court, professionals do not find this form of remedy as efficient as it should be. One lawyer illustrated his or her experience of delayed justice; a labor officer could not resolve the matter for almost a year and a half and referred the case to the Industrial Court.⁴⁰⁶ These inefficient and underfunded legal structures make it difficult for workers to seek justice.

These gaps in government intervention led much of the decision-making regarding HIV dependent on varying independent workplace rules. Unfortunately, as UGANET notes, only a few employers have put strategies to tackle the issue in the workplace, and some employers force those who are positive, into early retirement and retrenchment.⁴⁰⁷ In the perspective of employers, employees living with HIV/AIDS increase the costs of health insurance. The issue with high insurance costs was a recurring argument observed both at the ILO and the Federation of United Employers in Uganda (FUE) meetings.⁴⁰⁸ Both organizations identified higher

health insurance fees for HIV positive employees as the leading factor for employers' discriminatory behavior. Without plans that subsidize companies with insurance packages, companies bear all the burden of high insurance costs. Study shows that 2.2 percent of the population have private health insurance through full corporate coverage.⁴⁰⁹ These employer-based insurances have limited HIV coverage; only a few reimburse HIV services and ARV.⁴¹⁰

Healthcare Challenges

An inadequate national healthcare infrastructure, governance failures, and an archaic justice system inhibit the realization of both Uganda's goal to eradicate HIV and the rights of WLHIV. While these systemic factors affect the entire population, they can have unique implications for women, who already suffer from their marginalized status.

Weak Domestic Healthcare System



Financing Access to Health

Uganda's heavy reliance on foreign aid to fund its health system puts it in a precarious position. Donor countries may choose to reduce or terminate foreign assistance at any time in response to shifting national priorities. Despite a proliferation of platforms for international cooperation around health – from the SDGs to the multilateral Global Fund – the reality is that country commitments

404 ILO, "Uganda: Labour Inspection Structure and Organization," ILO, http://www.ilo.org/labadmin/info/WCMS_209370/lang--en/index.htm.

405 Meeting with George Tamale and Opio Daniel from Federation of Uganda Employers, on January 2018, in Kampala, Uganda.

406 Sulaiman Kakaire, "Why a strategic rethink is needed to reinvigorate the Industrial court," *The Observer*, January 2 2017, <http://observer.ug/news/headlines/50565-why-a-strategic-rethink-is-needed-to-reinvigorate-the-industrial-court>.

407 Ministry of Gender, Labour, and Social Development, *National Employment Policy for Uganda*, 16

408 Meeting with George Tamale and Opio Daniel from Federation of Uganda Employers, on January 2018, in Kampala, Uganda. // Meeting with National Coordinator for HIV/AIDS, David Mawejje Muddu from ILO, on January 17, 2018, in Kampala, Uganda.

409 Koseki, S., T. Fagan, and V. Menon, *Sustainable HIV Financing in Uganda*, Futures Group, Health Policy Project, (Washington, D.C., 2015): 15

410 Ibid. p. 23

made through these initiatives are neither binding nor enforceable.

While international pressure and reputational concerns can encourage compliance in these settings, they hold less sway over bilateral agreements, which are often more politicized and unpredictable. Indeed, as rhetoric and policy among western leaders increasingly reflect a turn inwards, the risk of aid cuts has become far more credible. The “America First” policy of American President Donald Trump is one of the starkest examples, as manifested in the reductions to PEPFAR’s budget. While Uganda has thus far been spared from direct cuts and remains a priority country for PEPFAR, the situation demonstrates the high variability in foreign aid.⁴¹¹ When asked what impact it would have if President Trump follows through on threats to cut foreign aid, one medical officer at the Rakai Health Sciences Program (RHSP) warned of a “death sentence.”⁴¹²

A further example of the precariousness of foreign aid comes from the World Bank’s periodic decisions to suspend funding to Uganda. From August 2016 to May 2017, delays in disbursements and implementation, as well as evidence of weak safeguards in monitoring, led the World Bank to withhold new lending from its International Development Association (IDA) to the GoU. Member states can use World Bank lending and financing as leverage over recipients, withholding investments in the face of performance issues that signify deeper problems of governance and state capacity. The impact of these suspensions is not trivial; the World Bank currently has 5 active health-related projects in Uganda totaling US \$353.15 million.⁴¹³ Thus, international financial institutions such as the World Bank are yet another crutch for the GoU, increasing

the vulnerability resulting from dependence on external financing.

The GoU does, in fact, recognize the risk of its dependence on foreign aid, not only for the health sector but the economy more broadly.⁴¹⁴ As stated in the NDP II, “The high dependence on financing [health services] by the households reduces access and utilization of health services and while dependence on donor funding affects the sustainability of health financing in Uganda.”⁴¹⁵ In response, the GoU committed to domestic resource mobilization (DRM) by joining the multilateral Addis Tax Initiative (ATI) in 2015 and securing IMF assistance in instituting a tax reform package that same year.⁴¹⁶ As concerns financing its HIV/AIDS response, specifically, the GoU took a positive step in July 2014 by creating a National HIV Trust Fund to be financed, in part, by a two percent tax on alcohol and soft drinks. Still, this tax was estimated to contribute just USD \$2 million per year – far short of the US \$3,647 million needed to implement the current National HIV and AIDS Strategic Plan for the period 2015/16-2019/20.⁴¹⁷ More significantly, almost four years after passage of the HIV and AIDS Prevention and Control Act that set up the Fund, it has yet to be operationalized; debates over rules for the Fund’s

Bank Group, Accessed March 5, 2018, http://projects.worldbank.org/search?lang=en&searchTerm=&country_code_exact=UG.

414 “Second National Development Plan (NDPII), 2015/16-2019/20,” National Planning Authority, Republic of Uganda, June 2015, p. 33. <http://npa.ug/wp-content/uploads/NDPII-Final.pdf>.

415 Ibid.

416 “Uganda: Staff Report for the 2015 Article IV Consultation and Fourth Review Under the Policy Support Instrument – Press Release; Staff Report; and Statement by the Executive Director for Uganda,” International Monetary Fund, IMF Country Report No. 15/175, Washington, D.C., July 2015.

417 “HIV and AIDS in Uganda,” Avert: Global Information and Education on HIV and AIDS, Accessed February 28, 2018, https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/uganda#footnoteref60_bxpbuqy.

411 U.S. Department of State. *PEPFAR: Strategy for Accelerating HIV/AIDS Epidemic Control*.

412 Meeting with representatives of Rakai Health Sciences Program (RHSP) on January 22, 2018 at RHSP in Kalisizo, Rakai District, Uganda.

413 “Uganda: Projects & Operations,” The World

management – including calls by ICWEA for an independent agency to be given responsibility – have delayed parliamentary approval.⁴¹⁸

Even if levels of foreign aid were guaranteed to remain constant, an assessment by the WHO African Health Observatory (AHO) points out that “most donor aid is not harmonized [nor] aligned to the sector plan and [is] managed off-budget.”⁴¹⁹ The multiplicity of active donors in Uganda’s health sector – including China, Ireland, Japan, Korea, Norway, Sweden, and United States – in addition to the United Nations and multilateral initiatives like The Global Fund and IFIs – makes coordination essential. Donor efforts must not only complement one another, but also those of the GoU. Without systematic communication, extensive information sharing, and regular consultation, the various interventions are bound to result in competition, duplication, or other inefficiencies that undermine the GoU’s goals. Unfortunately, the reality on the ground illustrates this scenario. The United States dominates among foreign donors; of the nearly US\$500 million that PEPFAR contributes to Uganda’s health sector,⁴²⁰ the US\$371 million dedicated to the HIV/AIDS response accounts for over 85 percent of the national HIV response.⁴²¹ Invariably, this financial weight gives USAID a great deal of leverage in negotiations with the MoH, with which

it engages closely. The risk, however, is if USAID sets the agenda without sufficient coordination with other donors. Some countries, because of the lower levels of funding they provide, prefer to work through the UN, where pooled funds maximize the impact of individual contributions by consolidating activity and funding streams. The U.S. also contributes to these multilateral efforts even as it pursues its own initiatives bilaterally, as is common among donors. The scale of its engagement, however, makes it imperative that the two tracks communicate with and reinforce each other, rather than simply run in parallel.

In addition, weak coordination between government providers of official development assistance (ODA)⁴²², non-governmental, and private sector actors can undermine effective health financing. This reality motivated the creation of the Uganda HIV/AIDS Partnership Mechanism under the Uganda AIDS Commission (UAC) in 2002.⁴²³ The Mechanism names the Commission as the sole national coordinating authority and is supported by a Partnership Fund, largely financed by the Danish International Development Agency (Danida), Irish Aid, and the UK Department for International Development (DfID).⁴²⁴ It consists of twelve Self-Coordinating Entities (SCE) – clusters

org/10.1186/s12889-016-3573-0.

418 Meeting with representatives of the International Community of Women Living with HIV Eastern Africa (ICWEA) on January 25, 2018 in Kampala, Uganda.

419 “Analytical Summary – Health Financing System,” *Comprehensive Analytical Profile: Uganda*, World Health Organization (WHO) African Health Observatory, Accessed March 1, 2018, http://aho.afro.who.int/profiles_information/index.php/Uganda:Analytical_summary_-_Health_financing_system.

420 U.S. Department of State. *PEPFAR: Strategy for Accelerating HIV/AIDS Epidemic Control*.

421 Tom Kakaire, Walter Schlech, Alex Coutinho, Richard Brough, and Rosalind Parkes-Ratanshi, “The future of financing for HIV services in Uganda and the wider sub-Saharan Africa region: should we ask patients to contribute to the cost of their care?” *BMC Public Health*, 27 August 2016, Accessed 12 March 2018, <https://doi>.

422 As per the Organisation for Economic Co-operation and Development (OECD), “Official development assistance (ODA) is defined as government aid designed to promote the economic development and welfare of developing countries. Loans and credits for military purposes are excluded. Aid may be provided bilaterally, from donor to recipient, or channelled through a multilateral development agency such as the United Nations or the World Bank. Aid includes grants, “soft” loans (where the grant element is at least 25 percent of the total) and the provision of technical assistance.” Source: “Net ODA,” *OECD Data, Organisation for Economic Co-operation and Development*, Accessed March 5, 2018, <https://data.oecd.org/oda/net-oda.htm>.

423 “Partnership Coordination,” *Uganda AIDS Commission*, <http://www.aidsuganda.org/partnerships/partnerships>.

424 Ibid.

of similar types of stakeholders – and a Partnership Committee composed of representatives from each SCE and select government agencies.⁴²⁵ UAC Director of Partnerships, Enid Wamani asserted that the UAC’s approach to working with SCEs and partnership committees allows it to reach various groups – including government ministries and CSOs – as well discrete categories of PLHIV to give voice to their needs and develop a shared agenda.⁴²⁶ Notably, however, other stakeholders with which the research team met, did not explicitly mention the Mechanism. When subsequently asked, HEPS-Uganda Program Manager for Health Policy Advocacy, Kenneth Mwehonge, explained that the Mechanism is more of a descriptor for the coordinating role that the UAC plays.⁴²⁷ Within it, CSOs are represented by the Uganda Network of AIDS Services Organisations (UNASO). However, governance challenges at the UAC have discouraged CSOs from participating in this arrangement, rendering it nonfunctional for the last five years.⁴²⁸ The effectiveness of the Mechanism is further undermined by the autonomy granted to the SCEs. While this affords each entity greater flexibility in developing a bespoke agenda, it complicates the UAC’s ability to enforce compliance with reporting and other operational requirements.⁴²⁹ Indeed, a 2009 report in *African Health Sciences* asserted that, despite its creation, “Overall, harmonization of the funding mechanisms [for HIV/AIDS programs] is still difficult.”⁴³⁰ Ultimately, then, though the influx of resources for improving health is welcome

in this low-income economy, the proliferation of actors in the increasingly-crowded space of health funding creates additional complexity and risk of inefficiencies.

Adding the GoU’s track record of corruption to this picture of donor disarray, reports of public misuse of funding for HIV/AIDS are unsurprising. In 2005, The Global Fund temporarily suspended its five grants to Uganda – including two for HIV/AIDS response – citing gross mismanagement by the implementing partner in the Ministry of Health.⁴³¹ An *Aide Memoire* signed in November 2005 that lifted the suspension called for the Ministry of Finance, as Principal Recipient (PR), to assume responsibility for the management of Global Fund grants and work with the Country Coordinating Mechanism (CCM) to restructure implementation processes.⁴³² Despite these reform efforts, a 2016 audit again found serious problems, including “pervasive stock-outs of key medicines, unexplained stock differences, funds unaccounted for, lapses in services provided to patients and poor grant oversight by the Ministry of Health.”⁴³³ Following an investigation by the Office of the Inspector General (OIG), a statement was issued in May 2016 clarifying that “the bulk of” discrepancies between received and disbursed funds, and between actual and expected inventories of medical supplies in National Medical Stores (NMS) found in the audit could, in fact, be explained by

425 Ibid.

426 Meeting with Enid Wamani, Uganda AIDS Commission Director of Partnerships, on January 25, 2018 in Kampala, Uganda.

427 Kenneth Mwehonge, HEPS-Uganda Program Manager for Health Policy Advocacy, email message to co-author Daphne Panayotatos, April 29, 2018.

428 Ibid.

429 Ibid.

430 E. Agaba, “Funding the Promise: Monitoring Uganda’s Health Sector Financing from an HIV/AIDS Perspective.” *African Health Sciences*, Suppl 2 (2009): S81–S85.

431 “Global Fund Suspends Grants in Uganda,” *The Global Fund to Fight AIDS, Tuberculosis, and Malaria*, August 24, 2005, Accessed March 5, 2018, <https://www.theglobalfund.org/en/news/2005-08-24-global-fund-suspends-grants-in-uganda/>.

432 “Global Fund Lifts Suspension of Uganda Grants,” *The Global Fund to Fight AIDS, Tuberculosis, and Malaria*, November 10, 2005, Accessed March 5, 2018, <https://www.theglobalfund.org/en/news/2005-11-10-global-fund-lifts-suspension-of-uganda-grants/>.

433 “Audit of Global Fund Grants in Uganda,” *The Global Fund to Fight AIDS, Tuberculosis, and Malaria*, February 26, 2016, Accessed March 5, 2018, <https://www.theglobalfund.org/en/oig/updates/2016-02-26-audit-of-global-fund-grants-in-uganda/>.

incomplete data rather than fraud.⁴³⁴ Auditors had originally found a variance of US\$21.4 million and stock-outs of essential medicines, especially HIV medicines, in 70 percent of the 50 health facilities they visited, as well as stores of expired medicines in 54 percent of the facilities.⁴³⁵ While figures cited in the updated audit were significantly lower, the statement still noted that US\$4 million could not be accounted for and that at least US\$210,212 was spent on “unsupported expenses.”⁴³⁶ It also acknowledges that the administrative cause of the audit’s findings is, nevertheless, the reason for concern: “Poor documentation at the time of an audit that requires further review is a symptom of weaknesses in controls, compliance, and assurance.”⁴³⁷

Discrepancies in data and accounts from different stakeholders make it difficult to assess the extent of the current problem. While sporadic stock-outs have long afflicted Uganda, some reports indicate that they have become more frequent, more prolonged, and more severe since July 2017.⁴³⁸ According to HEPS-Uganda, some districts went four months without ARVs, and there are also shortages of second-line drugs and condoms.⁴³⁹ In early 2017, the majority of central ARV stocks in the public sector fell below the minimum-required three-month supply due to funding gaps, delayed shipments, in failures in the order and distribution system.⁴⁴⁰ The GoU responded with mitigating measures including front-loading procurements and securing expedited

delivery and additional funding from the Global Fund and PEPFAR. A February 2018 Stock Status Report by the MOH indicates that the public sector is now stocked with 55.5 percent of commodities at more than a three-month supply.⁴⁴¹

Still, any progress reflected in aggregate statistics belies the suffering of some individuals’ experiences. For women who live far away from ARV dispensaries, the costs of sacrificing a day’s wages to travel by foot to clinics, only to find the medicine unavailable, are enormous. The problem is particularly acute for those who develop drug resistance or increased viral loads due to treatment failure, and must thus switch to second-line treatment. In a tragic irony, second-line drugs are typically more expensive and in shorter supply; thus, prolonged outages can render individuals dependent on drugs that themselves are unavailable. The inability to access medicine also increases the risk of complications in immunosuppressed PLHIV. Media outlets drew attention to this issue in covering the death of a fourteen-year-old boy who developed AIDS-related Kaposi sarcoma, a type of skin cancer, when a stock-out forced him off of his ARVs.⁴⁴² Reporting from *The Observer* as recently as April 2018 shows the continued devastating consequences of stock-outs for many individuals.⁴⁴³

Indeed, the problem exists throughout the country, as the District Health Officer in Kalisizo also cited ARV stock-outs and unavailability of second-line treatment as major current challenges.⁴⁴⁴

434 “Update from the Executive Director – Uganda,” *The Global Fund to Fight AIDS, Tuberculosis, and Malaria*, May 15, 2017, Accessed March 5, 2018, <https://www.theglobalfund.org/en/oig/updates/2017-05-15-update-from-the-executive-director-uganda/>.

435 Ibid.

436 Ibid.

437 Ibid.

438 Meeting with HEPS-Uganda Program Manager for Health Policy Advocacy, Kenneth Mwehonge, on January 25, 2018 in Kampala, Uganda.

439 Ibid.

440 “Summary of ARV Situation, Calendar Year 2017-2018,” Submission for PEPFAR Fiscal Year 2018 Country Operational Plan (COP).

441 Ministry of Health Uganda Pharmacy Division, *Stock Status Report As At 1st*, February 2018, Kampala, Uganda.

442 Zahra Namuli, “Stock out of ARVs takes toll on HIV patients,” *NilePost*, November 29, 2017, <http://nilepost.co.ug/2017/11/29/stock-out-of-arvs-takes-toll-on-hiv-patients/>.

443 Zurah Nakabugo, “ARV stock-outs kill more Ugandans,” *The Observer*, April 11, 2018, <http://observer.ug/news/headlines/57433-arv-stock-outs-kill-more-ugandans.html>. Accessed April 24, 2018.

444 Meeting with Kalisizo District Health Officer,

Individuals at both HEPS-Uganda and UNAIDS attributed the stock-outs to funding issues. While the latter repeated its call for the GoU to increase its health budget, HEPS-Uganda pointed to the misuse of existing funds. The risks are high given that money from PEPFAR and The Global Fund, which finance about 90 percent of ARV provision, is channeled through the GoU, whose own 10 percent contribution “has not come through over the years.”⁴⁴⁵ Meanwhile, a medical officer at Rakai Health Sciences Program charged that supply-chain distortions have led to the stock-outs, particularly since the adoption of the Test and Treat policy.⁴⁴⁶ The frequency with which stakeholders mentioned this problem suggests the extent of its impact.

Importantly, securing access to adequate, sustainable funding and protecting it from mismanagement are only two of the challenges at hand. Ensuring that this funding is allocated to interventions that target the needs of all vulnerable and affected populations is equally critical. The Presidential Fast-Track Initiative appears to take an inclusive approach by explicitly calling for engaging men in prevention plans and reaching high-risk populations, such as youth and pregnant women. By specifically targeting these groups, the initiative has the potential to decrease new infections in years to come. The plan also identifies parents and community leaders as potential change agents who can help in the fight against HIV/AIDS by discouraging high-risk behaviors among youth, such as drug and alcohol use and early and unprotected sex.

However, one of the Initiative’s major flaws

is that it fails to include other key populations, such as MSM and commercial sex workers.⁴⁴⁷ The omission is unsurprising given social attitudes towards homosexuality and illegality of sex work.⁴⁴⁸ In fact, the National HIV and AIDS Strategic Plan for 2015/16-2019/20 acknowledges that “there are fewer interventions addressing vulnerable and key populations (sex workers, fisher folk, truckers, uniformed services, prisoners and men who have sex with men -MSM).”⁴⁴⁹ In that report’s analysis of resource estimates for the plan term, prevention efforts for FSW and their clients account for just USD 1.3 million of the USD 851.7 million budget, averaging just USD 0.25 million per year.⁴⁵⁰ Total funding for MSM over the five-year term is USD 0.2 million, while for women and girls it amounts to USD 24.3 million, or around 0.03 percent of the budget.⁴⁵¹

However, HIV prevalence is particularly high among these two populations.⁴⁵² An estimated 18 percent of new infections in 2015/2016 are attributed to sex workers and their clients.⁴⁵³ If women’s social and economic marginalization continues, more may find themselves resorting to sex work to obtain an income, incurring greater risks even as they fall outside of government-led responses. Thus, failing to invest in targeted outreach for these populations will certainly prevent the GoU from achieving its

Dr. Sakor Moses on January 23, 2018, in Kalisizo, Rakai District, Uganda.

445 Meeting with HEPS-Uganda Program Manager for Health Policy Advocacy, Kenneth Mwehonge, on January 25, 2018 in Kampala, Uganda.

446 Meeting with Dr. James Batte, Manager of TB, Care & Treatment at Rakai Health Sciences Program (RHSP) on January 22, 2018 at RHSP in Kalisizo, Rakai District, Uganda.

447 Samuel Okiror, “Uganda Fails to Target Gay Men and Sex Workers in Fast-Track HIV Initiative; Campaigners say President Museveni’s Plan to End HIV by 2030 will not Work if it Ignores Whole Communities where the Disease is Rife,” *The Guardian*, June 15, 2017.

448 Neela Ghoshal and Maria Burnett, “Is it Now Legal to Be Gay in Uganda,” *Human Rights Watch*, April 7, 2014.

449 National HIV and AIDS Strategic Plan 2015/2016-2019/2020, p. 10

450 Ibid. Annex 3, p. 57.

451 Ibid.

452 National HIV and AIDS Strategic Plan 2015/2016-2019/2020

453 “HIV and AIDS in Uganda,” Avert, Accessed May 4, 2018, <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/uganda>.

targets. Further, this neglect reifies the alienation of marginalized groups, sending the message that they cannot rely on the government to address their needs. While NGOs and foreign donors may try to fill this gap, the recent crackdown on civil society and unpredictability of foreign aid mean that these groups remain at a high risk of further exclusion. Without a shift in policy to allow citizens to monitor government's efforts in health care delivery, the national plans and goals will remain on paper.

Inadequate Healthcare Infrastructure

These failures in sourcing, allocating, and using funds are evident in Uganda's underdeveloped health system. In its assessment, WHO AHO notes that while "Uganda has the basic infrastructure required for leadership and governance of the health sector [...] the structures are weak and under-resourced."⁴⁵⁴ Poor donor coordination, as discussed above, as well as weak district-level leadership contribute to these weaknesses. In fact, discussion with a district health officer (DHO) in Kalisizo revealed gaps between the national and district levels.⁴⁵⁵ The Second National Development Plan (NDP II) outlines four objectives within the health sector and sets policy to inform implementation of the strategic plan at the district level. The district health management team (DHMT) then develops plans with local implementing partners, community representatives, and other key local players, including religious leaders and the district HIV/AIDS Committee. While national-level consultations

provide direction, the DHO acknowledged that the multiplicity of actors creates coordination challenges, including duplication and conflict among the various implementing partners (IPs) and NGOs. The oversight of the DHMT may help reduce the prevalence of coordination challenges at the local level, as in Kalisizo, but gaps with the national level remain, particularly concerning funding decisions. Without adequate alignment and regulation from the top, the weak district-level leadership cited by the WHO AHO is unlikely to be overcome.

The WHO AHO also warns that the "poor quality of health care [is] compounded by an inefficient delivery system."⁴⁵⁶ As concerns the stockouts discussed above, one independent public health expert attributes the problem, in part, to inefficiencies in the NMS system.⁴⁵⁷ In a report this expert conducted for Human Resources for Health, health workers cite several factors that contribute to stockouts: procurement of soon-to-be expired drugs that end up wasted; non-delivery of requested drugs reportedly due to drug shortages in the market; and the "push" or "kit-based" supply system used in lower-level health facilities.⁴⁵⁸ By this system, each facility (HC II and HC III) receives the same bundle of essential medicines, irrespective of the disease burden in the area it serves; this can mean certain facilities receive drugs that they do not need even as their credit lines are depleted.⁴⁵⁹ Moreover, an investigation by the Parliamentary Committee

454 "Analytical Summary – Leadership and governance," *Comprehensive Analytical Profile: Uganda*, World Health Organization (WHO) African Health Observatory, Accessed 1 March 2018, http://aho.afro.who.int/profiles_information/index.php/Uganda:Analytical_summary_-_Leadership_and_governance.

455 Meeting with Kalisizo District Health Officer, Dr. Sakor Moses on January 23, 2018, in Kalisizo, Rakai District, Uganda.

456 "Analytical Summary – Health System Outcomes," *Comprehensive Analytical Profile: Uganda*, World Health Organization (WHO) African Health Observatory, Accessed 1 March 2018, http://aho.afro.who.int/profiles_information/index.php/Uganda:Analytical_summary_-_Health_system_outcomes.

457 Meeting with Christine Munduru, Public Health Expert and Consultant on January 24, 2018 in Kampala, Uganda.

458 Christine Munduru, *Health Worker Migration and Its Effect on Service Delivery in Uganda*. With research team. Center for Health, Human Rights and Development; Amref Health Africa; Health System Advocacy Project, November 2017.

459 Ibid.

on HIV/AIDS found significant discrepancies in supplies in Kampala versus rural areas.⁴⁶⁰

The NMS website provides a December 2013 statement from NMS General Manager Moses Kamabare as its “Foreword.” It acknowledges that “the health sector is not as robust as we would want it” and cites major problems, such as under-trained health workers, theft of medical supplies, and insufficient storage capacity.⁴⁶¹ Persistent problems with supplies of drugs and medical supplies suggest that these challenges remain, despite conflicting information about the extent of stock-outs. In a recent positive development, MOH Permanent Secretary Dr. Diana Atwine issued a statement in February 2018 that the MOH would lead an effort by the NMS, Joint Medical Stores, and National Drug Authority to collect and dispose of expired and unwanted medicines from over 6,000 state-owned and public not-for-profit health facilities.⁴⁶² The statement asserts that “It is *naturally* expected that about five percent of pharmaceuticals in the distribution chain is bound to end up as obsolete or expired” (emphasis added) and estimates the current quantities of expired drugs to be about 1,200 to 1,500 tons nationally.⁴⁶³ Certainly, the aim must be to reduce this purportedly “natural” waste; however, the statement indicates only how the MOH will eliminate existing expired drugs, and not how it will improve the supply system to prevent future waste.

In addition to the inaccessibility of drugs, the

460 Jusus Lyatuu, “MPs want govt to break Medical Stores monopoly,” *The Observer*, 17 April 2017, <http://observer.ug/news/headlines/52378-mps-want-govt-to-break-medical-stores-monopoly.html>. Accessed 27 March 2018.

461 “About NMS: Foreword,” *National Medical Stores*, December 2013, Accessed 5 March 2018, <https://www.nms.go.ug/index.php/about-nms/foreword>.

462 “Press Statement: Government to Collect and Dispose Off [sic] Expired and Unwanted Medicines From Health Facilities Around the Country,” Dr. Diana Atwine, Republic of Uganda Ministry of Health, 7 February 2018, http://www.nms.go.ug/jdownloads/Press/Press_Statement_NMS.pdf.

463 Ibid.

lack of adequate medical supplies in health facilities hinders the delivery of care. Beyond the obvious implication that medical workers cannot perform procedures without the necessary equipment, this problem is closely related to that of health worker recruitment and retention. Lack of access to proper information and basic supplies, such as safe water and gloves, deters medical workers from doing their jobs, fearful of the consequences of not taking adequate precautions when treating patients.⁴⁶⁴ As one public health expert points out, the underutilization of health workers posted to non-functioning facilities leaves a great deal of potential productivity unmet.⁴⁶⁵ Health workers are further discouraged by the low salaries they receive.⁴⁶⁶ These factors, the expert says, can lead health workers to neglect their duties, take on additional work for supplemental income, or resort to corrupt practices, such as the theft of medicines that contributes to supply shortages. However, as government employees subject to the Code of Conduct and Ethics for Uganda Public Service, health workers in public health facilities and hospitals cannot speak openly about the challenges they face to the public media; as a result, the problems go unaddressed.⁴⁶⁷

Discrimination in Healthcare Settings

Related to the above is the failure to provide adequate training for healthcare workers, especially concerning human rights. The implications are

464 Meeting with Joint United Nations Programme on HIV and AIDS (UNAIDS), Country Community Mobilisation and Networking Adviser, Sarah Nakku on January 18, 2018 in Kampala, Uganda.

465 Meeting with Christine Munduru, Public Health Expert and Consultant on January 24, 2018 in Kampala, Uganda.

466 Christine Munduru, *Health Worker Migration*.

467 Meeting with Christine Munduru, Public Health Expert and Consultant on January 24, 2018 in Kampala, Uganda.

particularly harmful to WLHIV. Misconceptions about HIV/AIDS that exist among untrained health workers can lead to the unnecessary – and sometimes forced – administration of certain procedures. Certainly, the requirement that all pregnant women be tested for HIV may have been a well-intentioned effort to increase the number of individuals on treatment and reduce new infections through mother-to-child transmission (MTC) of HIV. Nevertheless, as a 2014 statement by Human Rights Watch notes, “Mandatory HIV testing [is] contrary to international best practices and violate[s] fundamental human rights.”⁴⁶⁸ Indeed, the WHO and UNAIDS have repeatedly issued their opposition to mandatory or coerced HIV testing, which “is never appropriate” including for “members of key populations at higher risk of HIV infection and other vulnerable populations, including pregnant women [...]”.⁴⁶⁹ Mandatory testing undermines a woman’s right to privacy, bodily integrity, and non-discrimination; it increases her vulnerability by generating sensitive information that could be used to discriminate against her. Instead, individuals should have the freedom to make their own, fully-informed decisions about their health. Health workers should thus be trained to educate patients about the risks of HIV/AIDS and the procedure for testing and to make a recommendation for testing.

Similarly, forced sterilization of WLHIV is medically unnecessary and a gross violation of women’s rights. While there is disagreement over its prevalence in Uganda, many acknowledge that it continues to occur; a clinician at Rakai Health Sciences Program (RHSP), for example, said that the

frequency of forced sterilization has declined in rural areas but occasionally occurs in urban centers.⁴⁷⁰ In fact, HESP-Uganda and ICWEA have uncovered evidence of forced sterilizations, in which health workers provide women with misinformation about their health and medical options or intimidate or coerce them into undergoing sterilizations, usually after giving birth.⁴⁷¹ ICWEA is currently working with UGANET to litigate a case that the organizations hope will end this practice.⁴⁷²

Finally, a failure to incorporate considerations of human rights into health programs and services, as well as to properly sensitize health workers, deteriorates the quality of care provided. Due to insufficient oversight and resources, even well-designed policies can unravel during actual implementation. For example, while the GoU’s “test and treat” policy requires that HIV counseling be provided before and after an HIV test is conducted, as per WHO recommendations, recent reports reveal that this often does not take place.⁴⁷³ Rather than training dedicated HIV counsellors, the MoH has relied on public health workers to provide counseling services; however, the overwhelming case-loads these workers manage, as well as inadequate training, often mean that they neglect their counseling responsibilities.⁴⁷⁴ These findings reinforce the importance of providing training and education about human

468 “Uganda: Deeply Flawed HIV Bill Approved,” *Human Rights Watch*, 13 May 2014, Accessed 5 March 2018, <https://www.hrw.org/news/2014/05/13/uganda-deeply-flawed-hiv-bill-approved>.

469 “Statement on HIV testing and counseling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing,” *World Health Organization*, 28 November 2012, Accessed 5 March 2018, http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/.

470 Meeting with Manager of Health Clinic at Rakai Health Sciences Program (RHSP), Dr. Andrew Luwangula, on January 22, 2018 at RHSP in Kalisizo, Rakai District, Uganda.

471 Amy Fallon “HIV-Positive Women in Uganda Are Being Sterilized Without Their Consent,” *Think Progress*, 3 May 2016, Accessed 5 March 2018, <https://thinkprogress.org/hiv-positive-women-in-uganda-are-being-sterilized-without-their-consent-662190f99ffa/>.

472 “News: Case Challenging Coerced Sterilization Continues on March 6,” International Community of Women Living with HIV Eastern Africa (March 2018), Accessed May 6, 2018, <http://www.icwea.org/case-challenging-coerced-sterilization-continues-on-march-6/>.

473 Gillian Nantume, “New govt policy on HIV hits a brick wall,” *Daily Monitor*, 20 February 2018.

474 Ibid.

As discussed above, corruption and weak institutions also undermine the provision of health care and protection of human rights in Uganda (See Part I: Uganda's Legal Framework). Corruption is not unique to the health sector; it is pervasive, affecting all sectors and all levels of government. While President Museveni has routinely promised to crack down on corruption, the reality of the deeply entrenched culture of corruption lends his pronouncements little credibility.⁴⁸²

Disregard for Human Rights

Despite constitutional provisions, official pronouncements, and international commitments, Uganda does not broadly protect human rights. Women constitute just one group that faces threats to their fundamental rights. The LGBTI community and MSM are at especially high risk – a colonial-era law makes homosexuality illegal in Uganda. The Anti-Homosexuality Bill approved by the parliament in December 2013 and signed by President Museveni in February 2014 further institutionalized their vulnerability. Uganda's Constitutional Court subsequently annulled the law on procedural grounds. The law would have expanded the list of criminal acts and strengthened penalties for committing them.⁴⁸³ The decision not to re-introduce

the likely bill stems from the severe backlash that came from the international community – including major donors – but a hostile environment remains. In August 2017, for example, the government shut down scheduled gay pride events for the second year in a row.⁴⁸⁴

Human Rights Watch's World Report 2018 identifies additional ongoing threats to Ugandans' rights.⁴⁸⁵ The 2013 POMA restricts freedom of assembly, thereby suppressing opposition voices among civil society and potential political challengers. The 2016 NGO Act, too, stifles civic participation and debate by restricting freedom of association. Threats to freedom of expression and media have a similar effect, as government regulatory bodies control content, and journalists face attacks on their profession and physical security.

Notably, Freedom House states in its 2017 Freedom in the World report that "Uganda's civil society and media sectors remain vibrant, despite suffering sporadic legal and extralegal harassment and state violence."⁴⁸⁶ Indeed, it attributes the slight improvement in Uganda's status in 2018 – from a score of 35/100 and a status of "not free," to a score of 37/100 and a status of "partly free" – to the resilience of these actors.⁴⁸⁷ However, meetings with civil society representatives reveal that the situation remains precarious; state repression and legal constraints have had significant implications for organizations' ability to operate. The

es budget allocation to hospitals," *Daily Monitor*, 29 December 2017, <http://www.monitor.co.ug/News/National/Government-slashes-budget-allocation-hospitals/688334-4244444-g8422r/index.html>. Accessed 31 March 2018.

482 The State House of Uganda, Press Release, "President Museveni vows on corruption, 'its an open war,'" 13 April 2017, <http://www.statehouse.go.ug/media/news/2017/04/13/president-museveni-vows-corruption-%E2%80%9Cits-open-war%E2%80%9D>. Accessed 31 March 2018.

483 David Smith "Uganda anti-gay law declared 'null and void' by constitutional court," *The Guardian*, 1 August 2014, <https://www.theguardian.com/world/2014/aug/01/uganda-anti-gay-law-null-and-void>. Accessed 1 April 2018.

484 Okiror, "No gay promotion can be allowed": Uganda cancels pride events," *The Guardian*, 21 August 2017, <https://www.theguardian.com/global-development/2017/aug/21/no-gay-promotion-can-be-allowed-uganda-cancels-pride-events-lgbt>. Accessed 1 April 2018.

485 World Report 2018, "Uganda: Events of 2017," *Human Rights Watch*, <https://www.hrw.org/world-report/2018/country-chapters/uganda>. Accessed 1 April 2018.

486 Freedom in the World 2017, "Uganda Profile," *Freedom House*, <https://freedomhouse.org/report/freedom-world/2017/uganda>. Accessed 3 April 2018.

487 Freedom in the World 2018, "Uganda Profile," *Freedom House*, <https://freedomhouse.org/report/freedom-world/2018/uganda>. Accessed 3 April 2018.

recent backlash has “muzzled” NGOs and activists, particularly those engaged in advocacy around sensitive political questions. In addition to limiting access to funding from foreign sources, the POMA has barred organizations’ use of some traditional advocacy tools; for example, NGOs can no longer organize demonstrations to voice public grievances nor access and mobilize communities due to the restrictions on assembly.⁴⁸⁸

For some NGOs, the crackdown has been more severe: police raided the offices of ActionAid Uganda and the Great Lakes Institute for Strategic Studies (GLISS). The Bank of Uganda then froze those groups’ accounts under the pretense of investigating money laundering and funding illegal activities.⁴⁸⁹ Both organizations monitor and promote human rights and were actively protesting the proposed constitutional amendment to abolish the presidential age limit at the time of the raids. ActionAid’s accounts were unfrozen after three months, without any explanations, even as the organization pledged to pursue its court challenge to the freeze.⁴⁹⁰ In a statement posted on its website, GLISS charges: “It is very absurd that the state bears not the slightest degree of shame in its disrespect to human rights, the rule of law and constitutionalism.”⁴⁹¹

Given the negative attention that such brash

actions can draw, the GoU may instead rely increasingly on administrative means of suppressing civil society. For example, the Ministry of Internal Affairs’ NGO Bureau implements burdensome bureaucratic processes which require multiple levels of registration through a complex application process, target organizations with requests for financial records, and otherwise create barriers to operations. Indeed, the staff at UGANET said that the government is “going on the defensive” by tightening restrictions on NGO activity, using bureaucratic red tape to create barriers and narrow the space for civil society.⁴⁹² Even organizations not been directly targeted by the GoU have tended towards self-censorship in response to the intimidation that the NGO Act creates.

Presumably, the GoU’s stated commitment to improving health care and services – and its strong reliance on NGOs to do so – would make health-focused organizations less susceptible to the effects of the laws. However, sources reported that the health sector had not been immune; multiple sources stated that the NGO Act and POMA presented major threats by undermining NGOs’ activities, such as public demonstrations, and instilling fear and intimidation in their staff. When asked, however, a health clinic manager at Rakai Health Sciences Program (RHSP) said that he had not seen NGOs in the district be much affected.⁴⁹³ Dr. Luwangula agreed that organizations in the health sector might be shielded “as long as the Ministry of Health un-

488 Meeting with representatives of UGANET, on January 18, 2018, in Kampala, Uganda. // Meeting with representatives of the International Community of Women Living with HIV Eastern Africa (ICWEA) on January 25, 2018 in Kampala, Uganda. // Meeting with Human Rights Network-Uganda (HURINET) Director of Programs, Stephen Odong, on January 25, 2018 in Kampala, Uganda.

489 “Bank of Uganda freezes ActionAid accounts,” *Daily Monitor*, 14 October 2017, <http://www.monitor.co.ug/News/National/Bank-of-Uganda-freezes-Action-Aid-accounts/688334-4139336-whadng/index.html>. Accessed 3 April 2018.

490 Statement by Management, “ActionAid Uganda Accounts Finally Unfrozen!” 25 December 2017, <http://www.actionaid.org/uganda/news/actionaid-uganda-accounts-finally-unfrozen>. Accessed 3 April 2018.

491 “Civil Society Position On The Current Threats, Intimidation And Arrests By The State And Its Agencies

On The Citizens Including Political Leaders, Civil Society Leaders And Pro-Democracy Activists In The Face Of The Constitutional Amendment Crisis,” *Great Lakes Institute for Strategic Studies*, 26 September 2018, <http://gliss.org/blog/post/civil-society-position-current-threats-intimidation-and-arrests-state-and-its-agencies-citizens-including-political-leaders-civil-society-leaders-and-pro-democracy-activists-face-constitutional-amendment-crisis>. Accessed 3 April 2018.

492 Meeting with representatives of UGANET, on January 18, 2018, in Kampala, Uganda.

493 Meeting with Dr. Andrew Luwangula from RHSP, on January 22, 2018, in Kalisizo, Rakai District, Uganda.

derstands what they do.” Similarly, a representative of UNAIDS contended that the NGO Act was not meant to harm NGOs “doing good work on health”; however, she conceded that the law’s “political bent” meant some such organizations had gotten “caught up in” it.⁴⁹⁴ This suggests that whether or not an organization is affected depends not on the MOH’s understanding of its mission and activities, but on whether the GoU deems those to be controversial or subversive. Presumably, pure service provision is acceptable, but discussion of human rights is not. Indeed, multiple sources spoke of the need to take care in addressing human rights issues; strategic use of language and planning is essential in an environment where the state is very sensitive to certain issues.⁴⁹⁵

Human Rights Watch also cites reports of torture, illegal detention, and extrajudicial killings carried out by the police and military with impunity.⁴⁹⁶ Freedom House points to the flawed 2016 elections, voter intimidation, and Museveni’s consolidation of power as violations of Ugandans’ political rights, while gender discrimination, unenforced labor laws, and a lack of judicial independence add to the list of civil liberties under threat.⁴⁹⁷ Indigenous groups, which are not recognized by the government, have also long suffered from social, economic, and political marginalization.⁴⁹⁸

Finally, human rights defenders themselves

face risks. For example, in May 2016, unidentified assailants broke into the offices of the Human Rights Awareness and Promotion Forum (HRAPF), beat a guard to death, and stole the organization’s paper files.⁴⁹⁹ Less than two years later, in February 2018, a similar attack was waged, in which eight attackers broke into the HRAPF offices and attacked two guards with machetes.⁵⁰⁰ The GoU’s failure to investigate and bring justice to bear in these cases raises the probability that more attacks will occur and, more disturbingly, suggests the GoU’s complicity. As another example, in Karamoja, where large mineral deposits are attracting investments that the government wants to encourage, those who call for regulation that will protect human rights as business grows are accused of being against development and the state. This stance forces some rights-based groups, like HURINET, to “tread carefully.”⁵⁰¹

Concerning efforts to improve the government’s response to failures in the rights of WLHIV, this widespread disregard for human rights makes tenuous an appeal to Uganda’s obligations under UN and regional charters to which it is a signatory.

494 Meeting with Sarah Nakku, Country Community Mobilization and Networking Advisor from the UNAIDS, on January 18, 2018 in Kampala, Uganda. .

495 Meeting with Christine Munduru, Public Health Expert and Consultant on January 24, 2018 in Kampala, Uganda.

496 World Report 2018, “Uganda: Events of 2017,” *Human Rights Watch*, <https://www.hrw.org/world-report/2018/country-chapters/uganda>. Accessed 1 April 2018.

497 Freedom in the World 2017, “Uganda Profile,” *Freedom House*, <https://freedomhouse.org/report/freedom-world/2017/uganda>. Accessed 3 April 2018.

498 “Indigenous Peoples in Uganda,” *International Work Group for Indigenous Affairs*, <https://www.iwgia.org/en/uganda/723-indigenous-peoples-in-uganda>.

499 “Hivos: Uganda must investigate HRAPF raid and bring the perpetrators to justice,” *Hivos*, 30 May 2016, <https://www.hivos.org/news/hivos-uganda-must-investigate-hrapf-raid-and-bring-perpetrators-justice>. Accessed 3 April 2018.

500 “Hivos: The Ugandan government must guarantee safety and security for human rights actors,” *Hivos*, 19 February 2018, <https://east-africa.hivos.org/news/hivos-ugandan-government-must-guarantee-safety-and-security-human-rights-actors>. Accessed 3 April 2018.

501 Meeting with Stephen Odong, Director of Programs from HURINET, on January 25, 2018, in Kampala, Uganda. .



Part IV:

Current Programs and Interventions

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This section examines strategies and approaches stakeholders have undertaken both to combat HIV/AIDS and to promote women's rights. As discussed, women face considerable stigma associated with HIV/AIDS, threats to their human rights, structural barriers to accessing quality health care services, and socio-economic challenges in making and following through on their healthcare decisions. To tackle these issues, stakeholders seek to influence policy development and legal reform at the national level. NGOs and CBOs have spearheaded advocacy campaigns to change harmful laws, policies, and practices affecting women and girls that have the potential to exacerbate their vulnerability to HIV. Such efforts include reviewing current laws and policies and their impact on the HIV response, raising the salience of policy issues among the public, encouraging full implementation of settled

law, connecting activists working on the same issues, and diffusing international human rights norms to local contexts. Meanwhile, international organizations and foreign governments have taken up auxiliary roles, in the form of funding, research, technical assistance, and capacity building to support the design and implementation of advocacy campaigns.

In addition to efforts to improve the legal and policy environments, stakeholders deploy community-driven approaches to reach key populations and mitigate the effects of HIV. Community engagement takes three main forms: participation, mobilization, and empowerment. Community participation refers to sensitization and education activities that engage communities as the target audience for information or service provision. Community mobilization seeks to encourage community members to talk about HIV-related problems and provide feedback on existing HIV/AIDS interventions. Such efforts include advocacy, as well as education and support programs that value the role and participation of PLHIV. Finally, community empowerment centers on a rights-based approach to empower individuals and communities to take greater control of their health and rights. This approach is extremely important in the context of Uganda, where discriminatory customary practices prevail over statutory laws, and women are often not aware of their legal rights. In recent years, local NGOs, foreign governments, and international organizations have shifted their community engagement strategy from participation to mobilization and empowerment.

Government of Uganda

The NSP is the second such Plan developed by the GoU to provide “the overall strategic direction” for the national, multi-sectoral response to

HIV/AIDS.⁵⁰² It is aligned with the NDP and seeks to address recognized failures in the implementation of the first National Strategic Plan 2011/12-2014/15, as well as new priorities and challenges in the fight against HIV/AIDS. Specifically, the NSP emphasizes the need to scale up evidence-based interventions that use the “combination HIV prevention approach.”⁵⁰³ This approach relies on the simultaneous use of biomedical, behavioral, and structural interventions, with the “scale, quality, and intensity” of implementation tailored to what has proven effective in each locale. Through such bespoke, holistic interventions, the government aims to reduce the rate of new infections by making more people aware of their status, lowering the risk of HIV transmission from PLHIV, and reducing incidence among high-risk populations. Interestingly, the NSP recognizes PEPFAR recommendations to prioritize “high impact interventions,” including targeting Most at Risk Populations (MARPS).⁵⁰⁴ As noted above, however, the inferior level of resources allocated for prevention among certain key populations, such as sex workers and MSM, makes the GoU’s commitment to this last point questionable.

The GoU’s policies also reflect calls within the public health field for strategies of treatment as prevention (TasP). Based on evidence that ART can reduce an individual’s viral load enough that she cannot then transmit the virus, the WHO recommends the “test and treat” policy (also known as “test and start” or the “treat-all approach”).⁵⁰⁵ This policy calls for immediately beginning ART

502 “National HIV AND AIDS Strategic Plan 2015/2016 - 2019/2020 | Knowledge Management Portal”. 2018. Library.Health.Go.Ug. <http://library.health.go.ug/publications/service-delivery-diseases-control-prevention-communicable-diseases/hivaids/national-h-1>.

503 Ibid., p. 9.

504 Ibid.

505 “Treatment as Prevention (TasP) for HIV,” AVERT, <https://www.avert.org/professionals/hiv-programming/prevention/treatment-as-prevention>.

for any individual who tests positive for HIV, rather than basing eligibility for treatment on a patient's CD4 cell count.⁵⁰⁶ Through this strategy, increasing ART coverage among the infected population reduces both the treatment gap and the incidence rate.⁵⁰⁷ The GoU adopted the WHO's guidelines in 2016.⁵⁰⁸ Evidently, however, its effectiveness depends on widespread testing which, in turn, requires increasing access to reliable testing services and eliminating the stigma that often deters individuals from seeking those out. The fourth edition of the MoH's National HIV Testing Services Policy and Implementation Guidelines, published in October 2016, aims to accomplish this. It asserts that HIV testing services (HTS) "are offered within a legal and human rights framework ensuring quality counselling, confidentiality, informed consent, giving of correct results, and connecting those tested to further care and treatment," or the "5Cs."⁵⁰⁹

The GoU's policy on testing has evolved since 2002, when it centered on Voluntary Counselling and Testing (VCT), which entails individuals consciously seeking out testing. Its second edition reflected a position that testing should be integrated into routine medical service provision (RTC) in or-

der to increase coverage and lessen stigma.⁵¹⁰ While both VCT and RTC require the patient's consent, the policy also identified situations in which consent was not necessary, as when testing minors and prior to administration of post-exposure prophylaxis (PEP), including in cases of rape. However, the Center for Disease Control notes that there is a "window period" between the time an individual was exposed to HIV and the time when a test can give a definitive result, while PEP should be taken within 72 hours of suspected exposure.⁵¹¹ Thus, while testing would certainly be recommended for anyone suspecting that they have been exposed to HIV, it is not clear that such testing should be mandatory. Nevertheless, the 2016 HTS Policy is an ambitious effort to develop a comprehensive testing strategy that responds to the changing nature of the HIV epidemic in Uganda as well as the social factors that shape it. In addition to describing the medical services to be provided, such as pre- and post-test counseling, the policy details approaches to reaching different priority populations, including pregnant and breastfeeding women.⁵¹² The policy also provides an HTS Protocol, commits to undertaking Social Behavior Change Communication (SBCC) to increasing take up of HTS, and addresses both structural issues and ethical matters that will shape actual implementation.⁵¹³ Indeed, it will be critical to monitor whether the operationalization of this policy in practice matches its strong design.

The GoU is perhaps best known for the ABC

506 "Test and Start; Optimizing Antiretroviral Therapy Services to Save Lives," *United States Agency for International Development (USAID)*, <https://www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/test-and-start>.

507 "Test And Treat Showing Results In Uganda And Zambia". 2018. Unaids.Org. <http://www.unaids.org/en/resources/presscentre/featurestories/2018/april/test-and-treat-showing-results-in-uganda-and-zambia>.

508 "Uganda launches HIV/AIDS test and treat guidelines at World AIDS Day commemoration," World Health Organization Uganda, News, <http://www.afro.who.int/news/uganda-launches-hiv-aids-test-and-treat-guidelines-world-aids-day-commemoration>.

509 Government of Uganda Ministry of Health, *National HIV Testing Services Policy And Implementation Guidelines Uganda* (October 2016) <http://health.go.ug/sites/default/files/UGANDA%20HTS%20POLICY%20AND%20IMPLEMENTATION%20GUIDELINES%202016%20%282%29.pdf>.

510 Government of Uganda Ministry of Health, *Uganda national policy guidelines for HIV counselling and testing* (February 2005).

511 Center for Disease Control and Prevention, "HIV/AIDS: Testing," <https://www.cdc.gov/hiv/basics/testing.html>.

512 Government of Uganda Ministry of Health, *National HIV Testing Services Policy And Implementation Guidelines Uganda* (October 2016) <http://health.go.ug/sites/default/files/UGANDA%20HTS%20POLICY%20AND%20IMPLEMENTATION%20GUIDELINES%202016%20%282%29.pdf>.

513 Ibid.

model launched by President Museveni in the late 1990s. PEPFAR and other actors have credited the approach with the dramatic fall in the percentage of Ugandans living with HIV from 15 percent to about 6 percent over the decade beginning in 1992.⁵¹⁴ Some scholars point to the success of programs encouraging behavioral changes such as “zero grazing,” which urges individuals to remain faithful and take fewer sexual partners.⁵¹⁵ However, others question whether the strategy in practice matches the strategy in name; a 2005 report by Human Rights Watch charged that, “Uganda is redirecting its HIV prevention strategy for young people away from scientifically proven and effective strategies toward ideologically driven programs that focus primarily on promoting sexual abstinence until marriage” the effect of which is “to replace existing, sound public health strategies with unproven and potentially life-threatening messages, impeding the realization of the human right to information, to the highest attainable standard of health, and to life.”⁵¹⁶ Importantly, HRW researchers found that abstinence-only messages simply did not resonate with Ugandan youth, thus undermining the potential of such programs to help eradicate HIV. HRW’s claims are consistent with official statements made by Ugandan First Lady Janet Museveni, as mentioned in section III.C.i.3. Nevertheless, ABC continues to be cited as a “core intervention” in the Presidential Fast-Track Initiative instituted by the GoU in June 2017.⁵¹⁷ While the ambitious Initiative

demonstrates the GoU’s commitment in the fight against HIV/AIDS, this adds to other weaknesses discussed in section Part III: Healthcare Challenges.

In addition to its monitoring and inspection role, the Uganda Human Rights Commission (UHRC) also leads sensitization and outreach programs around human rights. In addition to television and radio campaigns, UHRC provides civic education programs targeted at various subpopulations, such as women, youth, and community leaders. In these meetings, UHRC representatives discuss a range of issues, from gaps in the legal system to human rights matters, to domestic violence and the equitable sharing of childcare duties between parents.⁵¹⁸ Officials in the UHRC Fort Portal office go directly into communities to educate people about their rights and responsibilities and the services available to them. In one creative effort at civic education, they drive a van mounted with speakers around villages, broadcasting human rights messages. UHRC Fort Portal also runs radio talk shows that allow people to call in to ask questions or raise concerns about human rights issues in their communities, and formal workshops with local councils, police, and local leaders that focus on sensitization of human rights.⁵¹⁹ Each year, UHRC details its activities along with its recommendations to the GoU in its Annual Report to the Parliament of Uganda.⁵²⁰ Whether parliament heeds these recommendations, however, is questionable. Indeed, despite UHRC’s warnings about aspects of the NGO Act and the now-overturned Anti-Homosexuality Act that

514 Cohen, Jonathan and Tony Tate, “The Less They Know, the Better: Abstinence-Only HIV/AIDS Programs in Uganda,” *Human Rights Watch*, 17, no. 4(A) (March 2005) <https://www.hrw.org/report/2005/03/30/less-they-know-better/abstinence-only-hiv/aids-programs-uganda>.

515 Green, Edward C., Daniel T. Halperin, Vinand Nantulya, and Janice A. Hogle. “Uganda’s HIV Prevention Success: The Role of Sexual Behavior Change And The National Response”. *AIDS And Behavior* 10, no. 4 (2006): 335-346.

516 “The Less They Know, the Better: Abstinence-Only HIV/AIDS Programs in Uganda,” *Human Rights Watch*, (2005).

517 “Taking a Stand Against HIV and AIDS: A Pres-

idential Handbook,” Presidential Fast-Track Initiative on Ending HIV & AIDS in Uganda (June 2017).

518 Meeting with Ruth Ssekindi, Director of Complaints, Investigations, and Legal Services from the Uganda Human Rights Commission, on January 24, 2018 in Kampala, Uganda.

519 Meeting with Willy Agirembabazi, Uganda Human Rights Commission, Fort Portal Regional Office, 22 January 2018.

520 “The 19th Annual Report to the Parliament of the Republic of Uganda 2016,” Uganda Human Rights Commission, Accessed March 7, 2018, <http://uhrc.ug/reports>.

would infringe on human rights, those components remained in the Acts when passed. UHRC provides recommendations to specific ministries and follows up once a year. They further monitor the ministries' progress on implementing the recommendations by looking at the budget and returns of each ministry to confirm that they implemented the recommendations.⁵²¹ More frequent follow-up could help improve this system. While there may exist safeguards to ensure the budget returns UHRC receives are accurate, these were not discussed with the research team and may not be readily apparent, given the widespread perception of public sector corruption in Uganda (see general challenges in accessing justice in Part III: Access to Justice for more detail). Therefore, UHRC must ensure the validity of the numbers and information they review.

The GoU has also partnered with UN agencies and local NGOs to eliminate workplace HIV/AIDS-related stigma and discrimination, especially the rights of workers who are unfairly dismissed based on their HIV status. With the support of Ministry of Gender Labor and Social Development, the HIV/AIDS Parliamentary Committee is advocating for tougher sanctions on employers who violate the rights of workers living with HIV/AIDS.⁵²² The National Organization of Trade Unions (NOTU) is also pledging to pass an industrial court order to warrant foreign companies to respect freedom of association and trade union activities.⁵²³

Foreign Government Donors

Foreign governments also work with local implementing partners to increase access to prevention and treatment, reduce the stigma surrounding HIV/AIDS, and improve women's health more broadly. Their efforts include sensitization, policy advocacy, and capacity building. DREAMS, for example, continues as USAID's cornerstone partnership for empowering young women and improving gender equality. In addition, USAID supports the use of media and advertisements to help combat stigma and related problems, including GBV. Billboards and advertisements found throughout Uganda use personalized messages of empowerment, such as, "He got circumcised and we use condoms. That's our way of stopping HIV. What about you?" The Embassy of Sweden has partnered with UNFPA to support the sensitization programs of Straight Talk Foundation. One program in the under-served Karamoja region involves teaching adolescent boys and girls to make reusable sanitary pads. Involving adolescent boys in the process works to reduce stigma around menstruation as unclean and taboo, and instead frames women's menstrual health in a wider, social, public health context.⁵²⁴

In addition, in 2017, the Embassy of Sweden announced a four-year, USD 13 million Sexual and Reproductive Health and Rights (SRHR) Umbrella Fund in Uganda.⁵²⁵ It is led by the Community Health Alliance Uganda (CHAU) and Internation-

521 Meeting with Ruth Ssekindi, Director, Monitoring and Inspections, Uganda Human Rights Commission, Kampala Office, 24 January 2018.

522 "ILO Tripartite Constituents Promoting and Enforcing the Legal Policy Provisions on Employment and Labor Rights," *ILO*, June 13, 2017, http://www.ilo.org/addisababa/countries-covered/uganda/WCMS_561301/lang--en/index.htm

523 Ibid.

524 Meeting with representatives from Embassy of Sweden, on January 19, 2018, in Kampala, Uganda.

525 "Fund for Sexual & Reproductive Health & Rights Launches in Uganda," *International AIDS Alliance*, February, 2017, <https://www.aidsalliance.org/news/880-fund-for-sexual-reproductive-health-rights-launches-in-uganda>

al HIV/AIDS Alliance. The Fund aims to build NGO and CBO capacity to deliver quality, integrated HIV-SRHR services; advance peer education and community dialogue around SRHR; and empower communities and key populations to advocate for their rights and needs.



Indeed, foreign donors play an important role in both directly advocating for policy change at the GoU and in supporting advocacy by communities themselves. PEPFAR’s Country Operational Plans and Annual Reports, among others, assess Uganda’s progress towards achieving its HIV/AIDS epidemic control and identify priorities and recommendations. In 2014, USAID launched the Advocacy for Better Health project, a five-year, USD 20 million project that works to strengthen CSOs’ capacity to advocate for their communities’ right to health.⁵²⁶ The project is implemented by

PATH and Initiatives Inc. and partners with over 20 CSOs and hundreds of community groups across 35 districts. It advances a three-pronged strategy of “citizen mobilization and empowerment, social accountability, and policy advocacy,” by providing CSOs the necessary skills and resources to engage in government decision-making processes affecting their health.⁵²⁷

International Organizations

The international community, in conjunction with the GoU and local NGOs, are doing commendable work in addressing the human rights abuses of women living with or at-risk of HIV in Uganda. Since women face a heightened risk of stigma and discrimination due to socioeconomic challenges, many IOs recognize the need to equip them with essential livelihood skills. Income-generating and capacity-building interventions, designed to address poverty, unemployment, and lack of economic opportunities, have become a popular strategy to counter HIV-related stigma and increase access to treatment among WLHIV. These programs provide women with skills to cope with external stigma and confidence to overcome self-stigma. Moreover, being part of a wider network allows them to engage in collective resistance to discrimination and violence that would otherwise be difficult to achieve individually.

Many women, especially those living in rural areas or on the outskirts of urban areas, are excluded from the health service delivery system in Uganda. These women may not have the mobility to seek medical services or go to a clinic on their

526 “Advocacy for Better Health,” <https://www.advocacyforbetterhealth.com/>.

527 Ibid.

own, forcing them to rely on a male-figure such as a father, husband, or brother, to make their medical decisions. To this end, UN-Women seeks to bring women into existing health networks and better advocate for their own healthcare decisions. To promote health rights, UN Women trains women to act as leaders and mentors to other women. These mentors integrate dialogue and discussion about health into a woman's daily routine, such that women can build confidence to be more assertive in demanding their right to health. UN Women has found and celebrated outstanding women through their outreach, whom they refer to as "champions," and continues their training by providing space for their participation and advocacy on a national level. These "champions" lead gatherings and raise issues during meetings with government agencies like the Ministry of Health.⁵²⁸

With regard to women's economic rights, UN Women strives to increase women's "economic muscle" through access to resources, education, and enterprise development.⁵²⁹ For example, UN Women offers entrepreneurship and financial literacy trainings for WLHIV and provides "starter kits" to help them devise an enterprise development plan.⁵³⁰ One such program in the Karamoja district has reached 260 women who now own small stores selling grain, sorghum, and other goods. Beneficiaries of the project have reported improved financial and budgeting skills as well as greater confidence. This confidence has, in turn, empowered them in other ways, making them more comfortable disclosing their HIV status.⁵³¹ The trainings also educate women about their inheritance and property rights regarding the discriminatory laws that result in

women's exclusion from formal financial institutions. UN Women extends these educational and training programs to community elders and cultural leaders to illustrate the cross-cutting nature of property rights and GBV.⁵³² More information on increasing women's realization of property rights can be found in Part III, which discusses access to justice.

The ILO builds upon trainings on women's economic rights by applying them to the workplace. According to the ILO, some workers in Uganda have been forced to undergo HIV/AIDS testing and subsequently dismissed from work if they test positive. To help individuals seek legal redress, from 2014 to 2015, the ILO supported the training of legal magistrates. It also aimed to support legal aid projects, including training legal practitioners on HIV issues, but faced obstacles due to stigma and lack of resources. Still, the ILO encourages people to go to a legal officer to mediate situations rather than go through formal legal means, as this can be more accessible to them.⁵³³ Some companies in Uganda's private sector are receptive to the ILO's trainings and the HIV/AIDS and the World of Work standards. The Federation of Uganda Employers (FUE) provides in-house training for companies on HIV issues, discrimination in hiring, and violence and sexual harassment in the workplace. Every quarter the FUE runs an HIV course, advertised through its publicly available training calendar, in addition to other HIV-related events. FUE also started the Female Future Program (FFP) in 2011. This nine-month program trains women for leadership positions by developing their skills in communication, negotiation, planning, and business devel-

528 Meeting with Elizabeth Mushabe, National Consultant Gender & HIV/AIDS, UN Women, on January 22, 2018, Kampala, Uganda.

529 Ibid.

530 Ibid.

531 "Rural Ugandan women living with HIV break stigma and build businesses," *UN Women*, January 30, 2017, <http://www.unwomen.org/en/news/stories/2017/1/>

feature-rural-ugandan-women-living-with-hiv-break-stigma-and-build-businesses

532 Ibid.

533 Meeting with David Maweje Muddu, National Coordinator for HIV/AIDS from ILO, on January 17, 2018, in Kampala, Uganda.

opment.⁵³⁴ In addition, ILO collaborates with the Uganda Investment Authority to make HIV/AIDS an integral component of the compliance framework for foreign investors.⁵³⁵ ILO and UNAIDS also advocate at the Chinese Embassy for long-term solutions to the violation of workers' rights among Chinese construction companies in Uganda.⁵³⁶

Importantly, Uganda's health service delivery system is also strained by the effects of civil and regional conflict. In 2016, UNHCR estimated that there were approximately 441,392 South Sudanese refugees and asylum seekers in Uganda.⁵³⁷ These vast migratory flows create additional health needs that require a unique response. Conflict and displacement have left many refugees and forced migrants more vulnerable to rape, forced marriage, and sexual assault, through which they are at higher risk of exposure to HIV. This is the case, for example, for women who were abducted by the Lord's Resistance Army (LRA), whose captivity made them especially vulnerable to sexually transmitted diseases.⁵³⁸ To this end, the IOM has partnered with Makerere University School of Health Sciences, College of Humanities and Social Sciences to provide a training course on migration health. The course targets members of the government, districts, universities, UN agencies, and CSOs whose work pertains to migration, with the goal of strengthening the capacity of migration

health systems. In the long-term, these trainings aim for the "reduction of the burden of disease; enhanced integration and social stability; social and economic development in destination countries and communities; and poverty reduction in countries and communities of origin."⁵³⁹ The IOM has also provided training and sensitization activities for voluntary migrants and mobile populations, such as truck drivers, fishermen, and sex workers in fishing villages, including Kasensero. As of 2014, IOM trained 350 sex workers to serve as peer educators to promote behavior change, such as practicing and negotiating safe sex. The sensitization and training programs also address family planning, safe sex, counseling and HIV testing through informational brochures and and videos.⁵⁴⁰

Finally, UNDP works through governmental- and non-governmental partners to engage with communities. It works extensively to promote women's access to justice by partnering with organizations dedicated to this cause, including UGANET and CEHURD.⁵⁴¹ For example, the UNDP Rule of Law and Constitutional Democracy program supports CEHURD's efforts to advocate for less expensive HIV medication by addressing protective intellectual property rights.⁵⁴² Legal and policy reform is another area of focus for UNDP, which takes up specific laws that it thinks should be fast-tracked and makes recommendations to the GoU. Finally, one of UNDP's stated priorities in the near term is to improve access to justice by integrating HIV/

534 "Female Future Uganda," Federation of Uganda Employers Women Executive Chapter (FUEWEC), Accessed 7 March 2018, <http://fuemployers.org/wp-content/uploads/2018/01/brochure-FFP.pdf>.

535 Meeting with David Mawejje Muddu, National Coordinator for HIV/AIDS from ILO, on January 17, 2018, in Kampala, Uganda.

536 Ibid.

537 "IOM, Makerere University Launch Training Course in Migration Health," IOM, 21 October 2016, Accessed 26 March 2018, <https://www.iom.int/news/iom-makerere-university-launch-training-course-migration-health>.

538 *Uganda Human Development Report 2015 Unlocking the Development Potential of Northern Uganda*. (Kampala, Uganda: United Nations Development Programme (UNDP), 2015), 102.

539 "IOM, Makerere University Launch Training Course in Migration Health," IOM, 21 October 2016, Accessed 26 March 2018, <https://www.iom.int/news/iom-makerere-university-launch-training-course-migration-health>.

540 "'You and I can prevent HIV/AIDS'; Migrant Awareness Campaign in Uganda," IOM, 27 June 2014, Accessed 26 March 2018, <https://www.iom.int/news/you-and-i-can-prevent-hiv-aids-migrant-awareness-campaign-uganda>.

541 Meeting with James Muge, Officer for Institutional Effectiveness, from UNDP, on January 19, 2018 in Kampala, Uganda.

542 Ibid.

AIDS sensitization into training for the judiciary.⁵⁴³

Faith-Based Organizations

FBOs have a crucial role to play in promoting uptake of preventive behavior and services, as well as reducing HIV-related stigma in their communities.⁵⁴⁴ Their positions of influence and reach in rural and remote areas makes them important partners for HIV response. The church itself is an effective channel for sensitization, as many Ugandans structure their daily lives, activities, networks, and social groups around it.⁵⁴⁵ However, there is a risk that FBOs with insufficient health expertise will send messages that are in line with their religious positions but counter to the medical community's recommendations. The resulting mixed messages can prevent individuals from accessing accurate information, prevention methods, and treatment they need.

One Christian missionary organization, Fuel Uganda, exemplifies the role that an FBO can play in the fight against HIV/AIDS. Missionaries from Fuel Uganda set up temporary clinics in rural Ugandan villages where they provide basic healthcare services, education, and sensitization, in addition to worship activities. One of their efforts at reducing the stigma of HIV/AIDS is through a cube exercise. This demonstration uses a cube-shaped display with

images on the panels that can be folded to illustrate a set of scenarios. The various panels illustrate certain misconceptions about HIV/AIDS, including its cause and symptoms. For example, they explain that people cannot transmit HIV by sharing utensils or food, bathing in the same river, or being bitten by a mosquito that has bitten an HIV-positive person. At a portable clinic in Kamwenge, several members of the research team observed how the cube exercise enhances learning by inviting audience participation. In one case, the facilitator showed the audience a panel depicting people of varying age, race, and gender and asked, "of the people shown in this picture, who do you think is HIV-positive?" Most of the audience thought that a young boy with dark skin was HIV-positive; one or two people guessed that it was the white man. The point of this exercise is to encourage participants to confront their biases stemming from misinformation and recognize that anyone can be HIV-positive, irrespective of their physical appearance. It demonstrates to village community members that they cannot detect HIV/AIDS through features such as skin color or age, and should therefore endeavor to treat every member of the community with equal respect, regardless of their supposed HIV status.

It is important to note, however, that the cube demonstration was not given by a trained medical professional, but rather a church volunteer. As such, much of the information presented was rooted in moral and religious arguments, rather than public health. The facilitators also were not prepared to answer critical questions about systemic issues of domestic violence or provide proper referrals for survivors of GBV to seek the necessary support. For example, during the "question and answer" segment, one woman asked what she should do if her husband beats her when she tries to share the kind of information she learned at the clinic. The volunteer advised her to talk to her local community leaders and the pastor of her local church. While this may

⁵⁴³ Ibid.

⁵⁴⁴ Otolok-Tanga, Erasmus, Lynn Atuyambe, Collen Murphy, Karin Ringheim, and Sara Woldehanna, "Examining Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: A case study of Uganda," *African Health Studies* (Makerere Medical School) 7, no. 1 (March 2007): 55-60. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2366130/>.

⁵⁴⁵ Meeting with representatives from the YWCA. January 18, 2018 in Kampala, Uganda

be a positive first step, it is potentially problematic given the barriers to reporting and access to justice women face, noted in Part III. Moreover, the Fuel Uganda model is based on cultivating relationships with community churches; local pastors are designated to continue church, worship, and spiritual activities after the missionaries leave to ensure the longevity and dissemination of their message. However, it is difficult to determine in advance whether a pastor will take the mission seriously or is merely seeking the title and status for personal gain, as Fuel Uganda missionaries noted had happened before. Given the short-term nature of the missions and limited follow-up with the communities after Fuel Uganda departs, they acknowledged that it is difficult to mitigate against this circumstance.⁵⁴⁶

Another international FBO, World Vision International, incorporates sensitization into their timed and targeted counseling (ttC) approach to generating behavioral change among pregnant women and new mothers.⁵⁴⁷ Using a community-based framework, the program relies on Village Health Team (VHT) members who visit rural Ugandan households to promote preventive and care-seeking behaviors that, *inter alia*, help prevent MTCT. World Vision also participates in the SAGE-DREAMS program, which strives to keep Ugandan girls and adolescents in school to reduce their engagement in behaviors that raise the risk of HIV transmission. As part of the Early Warning System (EWS), World Vision trained teachers in positive discipline, as well as establishing and training members of a “Stay in School Committee” consisting of both students and adults. These programs have led to a reduction in school dropout rates, as well as the re-enrollment of former dropouts.⁵⁴⁸

546 Meeting with Fuel Uganda, January 23, 2018 in Fort Portal, Uganda.

547 “Timed and Targeted Counseling (ttC),” World Vision International, <https://www.wvi.org/health/timed-and-targeted-counseling-ttc>.

548 Meeting with World Vision, on January 25, 2018

NGOs and CBOs

Uganda’s robust civil society has played an integral role in addressing the interrelated issues of women’s rights and HIV. NGOs and CBOs employ a variety of approaches to improve access to HIV prevention and treatment services; empower communities to demand their rights; and promote legal and policy reform. The result is a multi-pronged, holistic strategy to combating the various drivers and effects of women’s vulnerability to HIV.

Through high-level advocacy and strategic litigation, NGOs have sought to change laws, policies and practices that discriminate against women and preserve obstacles to their access to health. Current efforts by OSIEA, ICWEA, HURINET, CEHURD, UGANET, and HEPS-Uganda have tackled laws that restrict women’s economic opportunities, deny women property and inheritance rights, perpetuate harmful gender norms, threaten sexual and reproductive health, and undermine NGOs’ capacity to address these issues. Importantly, several of these organizations go beyond direct advocacy to empower WLHIV to advocate for themselves. The mission of ICWEA, for example, is to ensure that WLHIV are directly involved in relevant decision-making platforms at local, national, and international levels.⁵⁴⁹ CEHURD also launched a community empowerment program to complement its litigation work, recognizing the importance of informing individuals of their rights and making their voices heard.⁵⁵⁰ This is particularly important

in Kampala, Uganda.

549 Meeting with representatives from ICWEA, on January 25, 2018 in Kampala, Uganda.

550 Meeting with representatives from CEHURD on January 23, 2018 in Kampala, Uganda.

for communities outside of Kampala, which are most severely affected but also most removed from decision-making channels. The Uganda Network on Law Ethics and HIV/AIDS (UGANET), also supports litigation and advocacy through its research, often in partnership with ICWEA and others.⁵⁵¹

NGOs also provide legal services programs, including community legal education and training of lawyers, paralegals, healthcare workers, and police. UGANET, for example, focuses on eliminating barriers to property rights for WLHIV. In addition to empowering women and educating communities to help change deeply ingrained cultural practices and social attitudes, UGANET works to improve women's access to justice by providing legal assistance and training paralegals. These community-based paralegals help marginalized individuals to navigate the legal process and secure their rights in the context of HIV/AIDS. The Slum Women's Initiative for Development (SWID) is another NGO that works to help women secure rights to land and housing, as well as economic opportunities.⁵⁵² Based in Jinja, SWID trains community paralegals to help women living with or affected by HIV to understand land laws and rights and seek legal recourse in land-related cases. Through its "Local to Local dialogue" method, SWID also empowers women to initiate and engage in on-going dialogue with local duty bearers and opinion leaders.⁵⁵³

These initiatives are, in fact, part of NGOs' efforts to directly engage affected communities in improving access to health and rights. Importantly, there has been a notable shift in community-based

engagement strategies from passive engagement, such as community sensitization and counselling services, to meaningful involvement of WLHIV and other key populations. This has included the use of peer support groups; grassroots dialogue involving entire communities and decision makers; and innovative approaches such as story-telling and dramatizations. Direct engagement enables women to ensure that policies and programs address factors known to influence their vulnerability to HIV, such as GBV, intimate partner violence, land grabbing, and inadequate access to quality healthcare. ICWEA, for example, describes itself as "an organization by and for women living with HIV/AIDS." By employing WLHIV, it affords the women economic opportunities they may not otherwise have.⁵⁵⁴ Moreover, these women serve as role models and trusted messengers for their peers, with whom they are better able to build the rapport that is crucial to their interventions' success.

Community engagement activities also offer a platform for key populations, such as WLHIV and survivors of GBV, to talk about their experiences and work together to develop feasible solutions. For example, Kapchorwa-Bukwo Human Rights Organization (KABHURO) adapted the REFLECT circles method in Kapchorwa, Kween, and Bukwo districts.⁵⁵⁵ Developed by ActionAid, REFLECT is "an innovative, participatory approach to adult learning and social change."⁵⁵⁶ In this context, REFLECT circles provided spaces for community members to discuss HIV and GBV issues and devise corresponding action points. WLHIV found both emotional support and means of taking action to improve their situations. Given that HIV-related

551 Meeting with representatives of UGANET, on January 18, 2018, in Kampala, Uganda.

552 "Our Work," Slum Women's Initiative for Development (SWID), <http://www.swidugandahelpawoman.org/initiatives/>.

553 Joyce Nangobi and Pamela Ransom, "The Role of Gender in Securing Land Rights for Equity, Sustainability, and Resilience: In Jinja District, Uganda," *Annual World Bank Conference on Land and Property*, (2017).

554 Meeting with representatives from ICWEA, on January 25, 2018, in Kampala, Uganda.

555 James Thomas et al., *Protecting the Land and Inheritance Rights of HIV-Affected Women in Kenya and Uganda*, MEASURE Evaluation, (2016), [https://www.icrw.org/wp-content/uploads/2016/10/sr-13-80-\(1\).pdf](https://www.icrw.org/wp-content/uploads/2016/10/sr-13-80-(1).pdf).

556 "What are REFLECT circles?" ActionAid. <http://www.actionaid.org/australia/REFLECT-circles>.

stigma is associated with greater violence against women, combatting GBV is, in fact, a priority for many NGOs and CSOs dedicated to supporting WLHIV. Recently, more activists have sought an integrated approach to address HIV-related stigma and GBV. Raising Voices, for example, is known for developing the SASA! approach for preventing violence against WLHIV through community mobilization efforts.⁵⁵⁷ SASA, a Swahili word meaning “now,” is an acronym for the four-stage change model: Start, Awareness, Support and Action.⁵⁵⁸ Guided by Activist Kits, community members are encouraged to speak out about stigma and violence and empowered to take action. The approach has been adopted by several other groups; in 2009, for example, UGANET entered into a partnership with the Center for Domestic Violence Prevention (CEDOVIP) to use the SASA! approach to prevent domestic violence in communities in Pallisa and Ntungamo districts.⁵⁵⁹ UGANET developed a community-based network of change agents who, with technical support and mentorship from UGANET, conducted grassroots advocacy initiatives. These included community dialogue, soap operas, and radio programs, to raise awareness about power asymmetry, GBV, and HIV/AIDS in ways that are accessible to local community members. A pair-matched cluster randomized controlled trial, conducted from 2007 to 2012 in eight communities in Kampala, confirmed that SASA! reduces incidences of IPV and fosters supportive community responses to victims.⁵⁶⁰

NGOs have worked to address failures in Uganda’s health delivery system. For example, the shortage and inadequate geographic distribution of

health workers with appropriate skills have continued to undermine efforts to combat HIV/AIDS and provide quality HIV services. Strikes by doctors frustrated by low salaries and job insecurity have exacerbated the problem. In 2015, a coalition of more than 50 CSOs sought to address these challenges by launching the Uganda Election 2016 Health Manifesto, which urged all political parties and candidates participating in the 2016 national election to prioritize lifesaving health services. The document took a rights-based approach to HIV treatment and called for the elimination of violence against women and promotion of access to SRHR. This campaign marked the first time that CSOs in Uganda joined together to leverage Uganda’s general election to prevent an imminent ARV stock-out. One of the organizations involved in this effort, Action Group for Health, Human Rights and HIV/AIDS (AGHA), continues to engage in advocacy campaigns on increasing domestic financing for HIV/AIDS commodities and improving recruitment, retention, and deployment of skilled health-care workers.⁵⁶¹ The Coalition for Health Promotion and Social Development (HEPS-Uganda) is also devoted to promoting health rights through advocacy and community empowerment.⁵⁶² Through citizen engagement, advocacy campaigns, and policy analysis, it works to demand greater availability of affordable essential medicines for the poor and vulnerable.

Finally, NGOs and CBOs have espoused the value of innovative approaches that are easily accessible and appealing to broad audiences. OSIEA, for example, supports groups that use theater, poet-

557 “SASA!” Raising Voices. <http://raisingvoices.org/sasa/>.

558 Cady Carlson, “SASA! Mobilizing Communities to Inspire Social Change,” Raising Voices, 2013.

559 “Preventing Gender Based Violence,” UGANET, accessed March 24, 2018. <http://uganet.org/index.php/preventing-gender-based-violence>

560 Tanya Abramsky et al., “Findings from the

SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda,” *BMC Med*, 12, (2014): 122.

561 “About Us,” Action Group for Health Human Rights and HIV/AIDS, <https://www.gha.or.ug/about-us>.

562 Meeting with Kenneth Mwehonge, Manager for Health Policy Advocacy from HEPS-Uganda Program on January 25, 2018 in Kampala, Uganda.

ry, and story-telling to disseminate messages about health and rights.⁵⁶³ Medical professionals and civil society representatives also emphasized the importance of using credible, trusted messengers, namely other PLHIV.⁵⁶⁴ This strategy is not only more effective, but serves to help reduce stigma. Indeed, it can be seen in an initiative launched by the Uganda Network of Young People Living with HIV&AIDS (UNYPA). One of their highly-publicized efforts to destigmatize HIV is the Y+ Beauty Pageant. This pageant features a group of “young positives” (Y+), all living with HIV, who compete for the title of Mr. Y+ and Ms. Y+. It highlights the contestants’ inner beauty and dispels stereotypes of PLHIV as weak or sickly by demonstrating that they can lead productive, full lives. Ultimately, the Y+ pageant highlights the achievements of these “young positives,” and positions them as “ambassadors” to help combat the stigma surrounding HIV/AIDS.⁵⁶⁵

Ultimately, the variety of activities undertaken by these organizations demonstrates the vibrancy of Uganda’s civil society and their critical role as partners and change makers in the fight against HIV/AIDS and for women’s rights.

563 Meeting with representatives from OSIEA, on January 25, 2018, in Kampala, Uganda.

564 Meeting with Dr. James Batte, Manager of TB, Care & Treatment at Rakai Health Sciences Program (RHSP) on January 22, 2018 at RHSP in Kalisizo, Rakai District, Uganda.

565 Aizenman, Nurith, “Uganda Crowns Mr. And Miss HIV Positive,” *NPR*, 29 September 2016, Accessed 7 March 2018, <https://www.npr.org/sections/goatsandso-da/2016/09/29/495904420/uganda-crowns-mr-and-miss-hiv-positive>.



Part V:

Policy Recommendations

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Based on the research team’s discussions with stakeholders and experience in the field, they have come up with the following recommendations. The recommendations cover a range of topics, such as education, funding, donor coordination, and access to justice. These recommendations are rooted in a rights-based framework and are directed towards the GoU, foreign government donors, NGOs, and the international community as a whole. While these recommendations are far from comprehensive, the team hopes they will serve as a starting point and will be of use to relevant stakeholders.

Increase Domestic Funding for HIV/AIDS Response

Government officials, UN and foreign donor representatives, health workers, and members of Uganda's diverse civil society all agree on one thing: domestic public funding is critical for the fight against HIV/AIDS. Increasing spending requires that the government enhance domestic revenue mobilization (DRM), invite critical examination of national budget allocations, and tackle corruption. These are the preconditions for reducing dependence on foreign aid and operationalizing the HIV Trust Fund that will, in turn, improve the financial stability and sustainability of HIV/AIDS interventions and help ensure more efficient resource allocation and disbursement to the areas of greatest need.

Recognizing the risk of over-reliance on foreign aid, the GoU has committed to DRM. Considered by USAID to be “a critical step on the path out of aid dependence,” DRM entails developing both revenue-raising policies and the institutions necessary to implement them.⁵⁶⁶ The GoU made a formal commitment to DRM for the sake of development in 2015 when it joined the ATI, a multi-stakeholder initiative through which it benefits from access to foreign technical assistance.⁵⁶⁷ Tax reform measures, undertaken with IMF assistance since 2012,

have consistently met the target of raising the revenue-to-GDP ratio by about ½ percent of GDP per year.⁵⁶⁸ Also, recently-discovered vast oil reserves promise to bring in additional tax revenue once production starts; the IMF predicts that infrastructure and oil sector investments can drive growth to 6-6.5 percent in the medium term.⁵⁶⁹

Despite these positive steps, revenue levels remain relatively low, at 14 percent of GDP in FY 2016/17, and the most recent IMF assessment warns that the government's efforts may not suffice to continue meeting its targets.⁵⁷⁰ The country earned a low grade of C+ on the indicator “Effectiveness in collection of tax payments” in the 2015 ATI Monitoring Report.⁵⁷¹ Moreover, though oil production is scheduled to begin in 2020, delays in building the necessary infrastructure are significant. Beyond technical capacity, this must include building in social and environmental safeguards and establishing a transparent revenue fund. This will ensure that oil companies do not exploit resources at the expense of Ugandans' human and economic rights. The IMF also advises that the GoU replace recently-introduced corporate tax exemptions with other measures that will be both more effective in raising revenue and more transparent. Indeed, an IMF Fiscal Transparency Evaluation completed in May 2016 concluded that “23 of the 36 dimensions [in the IMF's Fiscal Transparency Code] are scored as basic or not met, reflecting issues with the coverage, quality, and reliability of some information

566 “Domestic Resource Mobilization,” USAID, Updated 12 May 2017. <https://www.usaid.gov/what-we-do/economic-growth-and-trade/domestic-resource-mobilization>. Accessed 26 March 2018.

567 “Addis Tax Initiative,” Financing for Development Office, United Nations Department of Economic and Social Affairs, <http://www.un.org/esa/ffd/ffd3/commitments/commitment/addis-tax-initiative.html>. Accessed 26 March 2018.

568 “Uganda: 2017 Article IV Consultation and Eight Review Under the Policy Support Instrument – Press Release; Staff Report; and Statement by the Executive Director for Uganda,” International Monetary Fund, IMF Country Report No. 17/206, Washington, D.C., July 2017. <http://www.imf.org/~media/Files/Publications/CR/2017/cr17206.ashx>. p. 17.

569 Ibid. p. 22.

570 Ibid. p. 17.

571 “ATI Monitoring Report 2015,” Addis Tax Initiative, International Tax Compact. https://www.addistaxinitiative.net/documents/Addis-Tax-Initiative_Monitoring-Report_2015_EN.pdf. Accessed 26 March 2018.

[...].⁵⁷²

For DRM to be successful in Uganda, the government must strengthen the administrative capacity of the Uganda Revenue Authority (URA). Moreover, it must put in place strong, accountable institutions to ensure that increased revenue is efficiently collected and invested in the highest public priorities, including health. Ring-fenced funds, which restrict the use of assets for predetermined purposes, have built-in constraints that can reduce misappropriation and increase the public's trust in institutions. Such requirements are implied – but must be enforced – with respect to the proposed National HIV Trust Fund.

Indeed, operationalizing the HIV Trust Fund must be a top priority for the GoU. Members of parliament should act quickly to finalize regulations for the Fund in consultation with civil society representatives and other key stakeholders. These rules must include appointing an independent agency to host and manage the Fund, as called for by ICWEA and others.⁵⁷³ The GoU must also seek additional means of financing the Fund, beyond the proposed tax on alcohol and soft drinks. For example, it could allocate a portion of petroleum-related revenue to the HIV Trust Fund. Notably, the Public Financial Management Act of 2015 stipulates that oil-related revenue be deposited in the Petroleum Fund and withdrawn only for infrastructure and development spending, with parliamentary approval. Though the health system is not one of the four priority areas for infrastructure development identified in the NDP II, investment in this area is consistent with the 2008 National Oil and Gas Policy's guiding principles of “using finite resources to create lasting

benefits to society.”⁵⁷⁴ The positive spillover effects of HIV/AIDS interventions, particularly as a result of dual-use programs, underscore the value of such investments.⁵⁷⁵ In addition, the GoU's continued efforts to reform its tax structure should keep in mind these development goals and needs.

Of course, even well-designed policies and institutions will not be effective if not faithfully enforced. The pervasive corruption in Uganda makes greater budget transparency and formal mechanisms for civil society monitoring of budget allocations and disbursements essential. Indeed, the IMF notes that “improving fiscal transparency will [...] support effective fiscal and budget management [and] increase the ability of the legislature, media, and civil society to provide effective oversight and scrutiny, which should improve governance and reduce opportunities for fraud and corruption.”⁵⁷⁶ Perhaps surprisingly, there are promising signs of this possibility. For example, the IMF's 2017 Fiscal Transparency Evaluation was, in fact, conducted at the request of Uganda's Permanent Secretary/Secretary to the Treasury of the Ministry of Finance, Planning, and Economic Development (MoFPED). Moreover, the report cites the publication of budget allocations in the *Citizen's Budget* and the “*Know Your Budget*” website as concrete mechanisms that “support public participation in budget processes” and improve transparency.⁵⁷⁷ However, simply pro-

572 Flynn, Suzanne, Imran Aziz, Kubai Khasiani, Fa-zeer Sheik Rahim, Brooks Robinson, and Amitabh Tripathi, “Uganda: Fiscal Transparency Evaluation,” Technical Assistance Report, *International Monetary Fund*, May 2017, Accessed 26 March 2018.

573 Meeting with representatives from ICWEA, on January 25, 2018, in Kampala, Uganda.

574 “National Oil and Gas Policy for Uganda,” The Republic of Uganda, Ministry of Energy and Mineral Development, February 2008, <http://www.energyandminerals.go.ug/downloads/NATIONALOILANDGASPOLICYFORUGANDA.pdf>. Accessed 26 March 2018.

575 Meeting with Elizabeth Allen, Director from ACT Health, on January 18, 2018, in Kampala, Uganda. Meeting with Dr. Andrew Luwangula from RHSP, on January 22, 2018, in Kalisizo, Rakai District, Uganda.

576 Flynn, Suzanne, Imran Aziz, Kubai Khasiani, Fa-zeer Sheik Rahim, Brooks Robinson, and Amitabh Tripathi, “Uganda: Fiscal Transparency Evaluation,” Technical Assistance Report, *International Monetary Fund*, May 2017, Accessed 26 March 2018. pp. 8-9.

577 Ibid.

viding information is not equivalent to enabling citizens to engage with it; it will be essential to monitor whether the new restrictions on NGO activity hinder the work of organizations dedicated to empowering community budget monitoring. Furthermore, the IMF assessment acknowledges that the GoU's fiscal reporting is incomplete, only covering about 77 percent of public sector spending and omitting certain transactions among those reported.⁵⁷⁸ This failure directly undercuts the IMF's positive assessment of opportunities for public participation in the budget process and demands that more attention be given to strengthening this area.

Ultimately, the GoU has a duty and an opportunity to put in place policies and institutions that will generate greater domestic resources for HIV/AIDS response. By increasing stability, this will facilitate long-term planning and coordination between government, foreign, and non-governmental actors. Transparency, accountability, and citizen participation can reduce the risk of financial mismanagement and ensure that spending responds to the needs and interests of populations at risk. As mentioned above, one health expert noted that the effective provision of medicines by the National Medical Stores suffers significant obstacles, including inadequate financing, lack of transparency and accountability, and delivery failures.⁵⁷⁹ In April 2017, even members of Uganda's Parliamentary Health Committee called out the inefficiencies of the NMS. As reported by *The Observer*, Joy Atim, MP for Lira District, asserted that "it is high time the NMS monopoly is broken" and suggested "setting up small medical stores at districts so that district health officers (DHOs) can easily access them."⁵⁸⁰ At the same time, however, other MPs argued that

the solution lies in increasing the NMS budget to enable it to operate at the necessary capacity. Given the evidence of mismanagement within the NMS and the important role of DHOs, particularly for marginalized rural communities, the recommendation to reduce the power of NMS is sound. Even so, any opening to increase competition should be accompanied by coordination and oversight mechanisms to prevent duplication and ensure efficiency among providers.

Improving Strategic Coordination of Donor Funding

A significant challenge for the international response to the HIV/AIDS crisis in Uganda remains the lack of coordination between external donors and the Ugandan government. To ensure future coordination between all stakeholders, a more strategic national planning process is needed. International donors must reconfirm their commitment to supporting the Ugandan government in its national action plan to combat HIV/AIDS.⁵⁸¹ Irrespective of international aid structures, effective coordination arises when various donors have defined mandates, work efficiently together, and create policies founded in the national context in which they function.⁵⁸² While every external donor holds their own expectations and priorities related to the HIV/AIDS epidemic, coordination must refocus on supporting the needs of the Ugandan population and the favored approaches of the GoU. Donors should continue

578 Ibid.

579 Meeting with Christine Munduru, Public Health Expert and Consultant on January 24, 2018 in Kampala, Uganda.

580 Lyatuu, "MPs want govt to break Medical Stores monopoly."

581 "Joint Evaluation: Support to the National Response to HIV/AIDS in Uganda 2007-2012." Ministry of Foreign Affairs of Denmark. January 2014. <https://www.oecd.org/derec/denmark/Support-to-the-national-response-to-hiv-aids-in-uganda.pdf>

582 "The Future of AIDS Coordination." UN Development Program. March, 2013.

and intensify policy dialogue through the AIDS Partnership Forum, as a means of identifying standard procedures, and ensuring goals are aligned.⁵⁸³

Many actors in the international community have already rallied around Uganda's national action plan on combating HIV/AIDS. However, all donors must renew their commitments to the HIV/AIDS response, primarily by realigning their programs and policies in coordination with the GoU. An agreement between all stakeholders in the HIV/AIDS response must articulate not only the priorities and needs of the GoU but how international funding will be used to support those programs directly.⁵⁸⁴ All aid organizations must participate in an open and inclusive planning and financing process for Uganda's national AIDS strategy.⁵⁸⁵ However, in realigning priorities with the GoU, it is imperative that international donors continue to ensure that marginalized populations within Uganda are addressed. These populations, including sex workers and LGBTQI individuals may not be adequately acknowledged or helped due to societal stigma. In establishing future priorities with the GoU, the international community must continue to advocate for these populations.

In addition to realigning international donor's priorities to the mission of the GoU, information sharing between donors will also be an integral component to improving implementation of interventions. Effective coordination and management of resources at the national level will require spending money on interventions with a proven success rate. Overarching national coordinating bodies, such as the Uganda AIDS Commission have the mandate to better align international resources, to

ensure greater value for money in aid. Sharing information through this national agency would not only ensure that every international donor is best able to mobilize their resources in service of the HIV/AIDS response, but will additionally increase ownership of the issue by the GoU.⁵⁸⁶

Since the HIV/AIDS epidemic began, the Ugandan government has relied heavily on external financing.⁵⁸⁷ Given the vast sums of funds provided by donors – and the United States, in particular – it is important to recognize the tremendous leverage foreign donors hold in improving spending on the HIV/AIDS response in Uganda. This influence can be used to incentivize greater fiscal management, including through improving transparency and crackdowns on corruption. Donors that continue to provide funding even as evidence of mismanagement, corruption, and human rights violations alight, become complicit in these harms. Certainly, sudden suspensions of funding could be catastrophic to the individuals who rely on foreign donations to have access to medicine and other treatment. Thus, donors should engage closely with the GoU to monitor how it manages grants and domestic funds for HIV/AIDS response, before a need for extreme measures – such as suspensions – arises.

Additionally, given the Ugandan government's dependence on external financing, foreign donors must address the increasing vulnerability of the HIV/AIDS response to the unpredictability of international funding. Discussions between external donors and the GoU should continue to seek government commitment to increase its funding of the HIV/AIDS response, as well as adequately funding the Ministry of Health to bolster health sector services.⁵⁸⁸ As previously discussed, ensuring a long-

583 “Joint Evaluation: Support to the National Response to HIV/AIDS in Uganda 2007-2012.” Ministry of Foreign Affairs of Denmark. January 2014. <https://www.oecd.org/derec/denmark/Support-to-the-national-response-to-hiv-aids-in-uganda.pdf>

584 Ibid.

585 “The Future of AIDS Coordination.” UN Development Program. March, 2013.

586 “Joint Evaluation: Support to the National Response to HIV/AIDS in Uganda 2007-2012.” Ministry of Foreign Affairs of Denmark. January 2014. <https://www.oecd.org/derec/denmark/Support-to-the-national-response-to-hiv-aids-in-uganda.pdf>

587 Ibid.

588 “The Future of AIDS Coordination.” UN Devel-

term commitment by the Ugandan government is the foremost strategy for sustaining progress in the fight against the HIV/AIDS epidemic.

Further, an effective AIDS response requires a strong partnership between the national government and civil society, which remain at the forefront of prevention, care, and support programs, particularly among people living with HIV, women and key populations. As the service delivery arm of the state, both the GoU and international donors must ensure that the HIV/AIDS response is not only coordinated with community actors but also that these actors remain funded. Increasingly civil society organizations are feeling constrained by the GoU, as well as international donors.⁵⁸⁹ To cope with reduced amounts of funding by key external donors, many civil society organizations have scaled back on key programs, specifically human-rights based initiatives. To continue to provide effective services, civil society requires reliable, long-term grant funding. In an environment where short-term funding has come under fire from changing international priorities on foreign aid, fewer, larger grants, by external donors will enable sustained engagement in the HIV/AIDS response.⁵⁹⁰

Strengthen Women's Access to Justice

Uganda needs an adequate domestic violence law. The Penal code (Amendment) Act of 2007, Domestic Violence Act of 2010, the Sexual Offences Bill and the Marriage Bill do not give women adequate access to justice for gender-based violence. None of these criminalize marital rape or

address cohabiting partners. The 2004 amendment to the Land Act of 1998 requires spousal consent for sex, but does not recognize co-ownership of land between spouses.⁵⁹¹ The law criminalizes rape and defilement, which is beneficial, but it is not a deterrent if the women are not willing to report violations and go to court because of the burdens of providing evidence.

There are successes from the GoU, foreign governments, and the civil society. The GoU formed a National Gender-Based Violence policy, which details how each sector needs to respond to GBV in prevention and response. They launched the Ugandan Women Entrepreneurship Programme (UWEP) to give women more access to financial services and train them in entrepreneurship.⁵⁹² The Norwegian Embassy has a successful intervention against sexual violence in Busoga and Karamoja through the Joint Programme on GBV, in partnership with the UN, Irish Aid, and the Irish Government Programme for Overseas Development.⁵⁹³ Many CSOs, including CEHURD and UGANET, provide legal aid for women who wish to seek legal redress for a crime committed against them.

The Judiciary has a proposed GBV court, but they have not yet implemented it. In Uganda, there are specialized courts on corruption, environment, terrorism, and labor.⁵⁹⁴ The Ugandan Human Rights Commission investigates claims of GBV; however, this is currently the closest equivalent to a specialized court. In the proposal by Justice Dr. Yorokamu Bamwine in August of 2017, he indicated the need for such a court to deal with GBV cases in a timely and efficient manner in a specially trained court. A

opment Program. March, 2013.

589 Ibid.

590 Ibid.

591 Ssenkaaba, Stephen. "Uganda: Violence against Women Unabated despite Laws and Policies | Africa Renewal Online." United Nations. December 20, 2017.

<http://www.un.org/africarenewal/news/uganda-violence-against-women-unabated-despite-laws-and-policies>.

592 Ibid..

593 Ibid.

594 Ibid.

GBV court could be beneficial in theory; however, this judge and others commend the video and audio recording of witnesses and victims and emphasize rights of police officers. In setting up the GBV court, the GoU must utilize the civil society to set it up in a rights-based way. There must be provisions for anonymity, specially trained lawyers, and reforms to evidence collection.

The judiciary must revise the Penal Code in its requirements for evidence collection, anonymity, and requirements for conviction. Many women are discouraged from filing a complaint and going to court. In the colonial-era archaic legal system enshrined in the Penal Code, trials are public and televised. The trials are humiliating for rape victims. The requirements for physical evidence (samples of semen, wounds, etc.), the types of invasive questions a judge would ask the victim, and the costs (including bribes) will keep women away from seeking legal recourse.⁵⁹⁵ To prove rape, a woman must go to a health clinic (rather than police station) to get a doctor certificate that she's been raped. For a doctor to give this, she must be unbathed, there must be signs of a struggle in and around the vagina, and she has to pay for the examination and certificate. To prove marital rape in court, they ask highly humiliating questions such as 'did you enjoy it, were you aroused, how far did he penetrate.' Additionally, most women do not have the money for to acquire the certificates and proceed to the courts. As a result, women of all socio-economic statuses underreport GBV.

Decriminalizing Sex Work in Uganda

⁵⁹⁵ Meeting with representatives from CEHURD, on January 23, 2018, in Kampala, Uganda.

When it comes to sex work in Uganda, the laws are extremely stringent. The Ugandan Penal Code Act not only criminalizes sex work, but also certain activities that relate to sex work⁵⁹⁶. Acts 136-139 of the Penal Code Act regulate aspects sex work such as living on the earnings of prostitution, operating brothels and criminalizing prostitution. Furthermore, other laws such as The Anti-Pornography Act 2014 and The HIV Prevention and Control Act 2014 directly affect the sex workers in Uganda.⁵⁹⁷ Although sex work is illegal, it is still regularly practiced as a way of living for many Ugandans. The risks of GBV and HIV-transmission associated with sex workers work is the highest for any profession; with the laws against their favor, it becomes extremely difficult for both the sex workers and their advocates to fight for their rights. Not only is it difficult for sex workers to report cases relating to violence and abuse, but they also face discrimination at health clinics while being tested for STIs and HIV. They face the stigma of being a sex worker as well as an increased risk of being HIV Positive⁵⁹⁸.

Having seen the issues sex workers experience in Uganda, decriminalizing sex work is necessary to allow them to pursue their rights to health and rights to work. It would be easier for the sex workers to overcome difficulties—such as reporting cases related to violence or transmission and getting proper care in health clinics—and also help in reducing the stigma around HIV/AIDS. Although there are certain mechanisms such as security networks and community unions, which are already in place to protect sex workers, there is still a large gap in the system.⁵⁹⁹ In the team's discussion with Taitan, a

⁵⁹⁶ "Legal Regulation of Sex Work in Uganda: Exploring the Current Trends and their Impact on the Human Rights of Sex Workers," Human Rights Awareness and Promotion Forum, October 2016.

⁵⁹⁷ "The Penal Code Act," June 15, 1950, http://www.wipo.int/wipolex/en/text.jsp?file_id=170005.

⁵⁹⁸ Meeting with Taitan Rollis, Human Rights Activist, on January 22, 2018 in Kalisizo, Uganda.

⁵⁹⁹ Ibid.

Human Rights Activist in Rakai, it was very clear that decriminalizing sex work would have positive compounding effects on sex workers in Uganda.⁶⁰⁰

Coming to Kasensero, the town filled with a large number of sex workers and a high prevalence rate of HIV (at 36 percent), decriminalizing sex work would largely help their population. The stigma regarding HIV/AIDS in Kasensero is low compared to the rest of Uganda, and decriminalizing sex work would promote a healthier attitude towards the profession and health care. However, certain officials believe otherwise. The officer in charge at the Kasensero Police Station opposes the idea of decriminalizing sex work.⁶⁰¹ According to the officer, decriminalizing sex work would lead to younger women engaging in the activity (out of economic desperation) and also increase the rate of GBV.

Although decriminalizing sex work has its opposition, it would largely benefit sex workers. In addition to decriminalizing sex work, the Employment Act should be reviewed so as to incorporate and recognize sex work as a profession. This way, the workers would enjoy the rights, protection and privileges under this act and their human rights would not be violated. Civil society organizations and people should also continue to engage in promoting human rights, focusing on sex workers and other marginalized communities.

Improve Policies to Combat Discrimination in Employment

Workplace discrimination based on HIV/AIDS, gender, and sexual orientation is a persistent and growing concern in Uganda, especially amongst WLHIV. Discrimination against PLHIV takes many forms, including pre-employment testing, unfair employment termination, denial of health insurance benefits, and verbal and physical harassment. The results of discrimination include more profound levels of poverty, social exclusion, lack of social protection, and informal employment. For Uganda to achieve sustainable economic development and gender equality, ending discrimination at work is indispensable. Employment policies of both the public and private sector should ensure employees living with HIV/AIDS have the same rights and obligations as other employees.

The National Uganda Employment Policy envisions for a “productive and decent employment for all women and men in conditions of freedom, equity, security, and human dignity to create better livelihoods for all women and men seeking such work, in conditions of freedom, equity, security and human dignity.”⁶⁰² However, there are signs of poor implementation of the goal, which impact in further marginalizing women living with HIV/AIDS.

According to the Employment Act 2006, discrimination in employment due to HIV status is against the law, including using the HIV status as a reason for employment termination or disciplinary penalty⁶⁰³. Even though the Act does not include forced HIV testing, the National Policy on HIV/AIDS and the World of Work 2007 clearly highlights key principles of confidentiality, HIV testing, treatment, care and support, and gender concerns in the world of work.⁶⁰⁴ The National Policy is in

600 Ibid.

601 Meeting with representatives from Kasensero Police Station. January 23, 2018 in Kasensero, Uganda.

602 Ministry of Gender Labour and Social Development, National Uganda Employment Policy, April 2011

603 The Employment Act, 2006

604 National Policy on HIV/AIDS in the World of Work, 2007

accordance with ILO's Recommendation concerning HIV and AIDS and the World of Work 2010, which underlines voluntarism of HIV testing. Nevertheless, further efforts in enforcing the Act are required.

According to the section 13 of the Occupational Safety and Health Act of 2006, employers must ensure the health, safety, and welfare of persons at the workplace. These measures include providing adequate facilities and arrangements for the welfare of workers. The labor inspection system provides inspectors to perform various examinations to ensure the act.⁶⁰⁵ The system could be beneficial in ensuring basic needs of HIV/AIDS employees such as inspecting for appropriate means of access to medicine. Especially noting that the Ministry of Gender, Labour, and Social Development encourages for companies to develop their hiring policies,⁶⁰⁶ these national systems of inspection are necessary to scrutinize equitable business practices. Nonetheless, the current system is weak in carrying out its full requirement. Federation of United Employers stated that they do inspect all workplaces, and there are only 45 labor officers to cover a total of 121 districts in Uganda, with some places that have not been inspected for two years.⁶⁰⁷ The government must strengthen the gaps in their capacity in order to ensure basic health and safety of Ugandans, which is the sole responsibility of the government. Moreover, better inspection will allow for more information in terms of employment conditions in Uganda, including those of the most at risk. The government would then set policies that target them better.

The agriculture and fishing industry, which is also where women are mostly involved, has the highest private sector employment. Yet, this sec-

tor pays notoriously low wages, and since mostly it is informal sector of business, national social schemes are hard to reach. The World Bank report low wages in the agricultural sector derive from its predominant production in subsistence farming than the cultivation of high-value commercial crops.⁶⁰⁸ Empowering the agriculture sector, with the underlying gender and health discrimination in mind, would allow for a systemized structure within the biggest labor market in the country. There needs to be equitable growth that is nondiscriminatory in order for a sustainable workplace environment.

State and employers should ensure access to justice and remedy, both in judicial and non-judicial forms, to citizens and employees. The National Policy agrees there is a need for grievance procedures and disciplinary measures to deal with HIV-related complaints in the workplace. However, the current act and policies leave room for misconduct by foreign companies. Employers should make remedial plans should available irrespective of employers' origins: domestic and foreign. As such, there is a need to urgently pass bills and regulations on discrimination at work specific to HIV/AIDS to include multinational corporations.

Explore and Invest in Mobile Technology to Encourage Health- seeking Behavior

605 Occupational Safety and Health Act, 2006

606 Meeting with George Tamale and Opio Daniel from FUE, on January 2018, in Kampala, Uganda.

607 Ibid.

608 The World Bank, Jobs: Key to prosperity, Employment Opportunities Critical to Uganda's Economic Growth, August 2013 <<http://www.worldbank.org/en/country/uganda/publication/uganda-economic-update-jobs-key-to-prosperity>>

As researcher Dennis Bataringaya noted, “[i]nformation technology has surpassed culture in some ways.”⁶⁰⁹ More and more Ugandans, especially the youth, are turning to social media and mobile technology not only for communication and entertainment but also as sources of health information. Many organizations in Uganda have picked up on this trend and are utilizing mobile technology to carry out their mission. UN Women and UNFPA, for example, have developed an app where women, who are often unable to make their own healthcare decisions, can become part of a network with other women in similar situations. The mobile app gives them a space to share their story and their testimony, and connect with women who have shared experiences. They plan to scale up this effort to 40 districts, as well as link it to a “virtual clinic.”⁶¹⁰ Healthcare workers in Uganda also use apps to improve access to maternal care for adolescents. The app “GetIN” uses Google Maps and GPS to mark each pregnant adolescent’s location and the location of the nearest antenatal clinic. Healthcare workers can also record health information about the pregnant adolescent into the app, which then sends out automatic text reminders for appointments and offers pregnancy advice.⁶¹¹ Apps are also being used to prevent and treat non-communicable diseases. For example, sending text message alerts to remind diabetes patients to check their sugar level, or for cervical cancer screening and treatment services, among others.⁶¹² Uganda and other sub-Saharan

African countries have also integrated mobile technology into preventing and treating malaria. These innovations

In Tanzania, an innovation called “SMS For Life” uses text messages and electronic mapping technology to eliminate stock-outs and increase access to medicines. This technology, funded by Novartis, helps remote African medical clinics maintain a steady supply of antimalarial medications, and has reduced the wait times for malarial medications from 3 months to a few days.⁶¹³ SMS For Life can be used as a foundation to create a mobile technology that tracks the supply of ARVs in HIV/AIDS clinics in Uganda, and help to improve the impact of stock outs reported by many of the interviewed stakeholders. Rather than having to travel several hours to several days to reach the closest HIV/AIDS clinic, only to find there are no medications left, rural Ugandans can use this app to check the status of the medication supply before leaving their home. This information can also help the Ministry of Health record patterns of ARV stock-outs in the hopes of getting to the bottom of the reason for such stock outs, and work to ensure all clinics have an adequate supply of ARVs.

Another concern brought up by the stakeholders interviewed was a lack of accurate health information in Ugandan village communities. Ugandan culture, particularly in the rural areas, still relies primarily on traditional therapeutic practices administered by families or village elders. Misconceptions about how diseases are spread and should be treated exist as well. Youth can be especially vulnerable to receiving inaccurate, antiquated information regarding healthcare. To that end, mobile technology is being used to connect youth to

609 Meeting with Annet Nannungi and Dennis Bataringaya, 17 January 2018.

610 Meeting with Elizabeth Mushabe, National Consultant on Gender-HIV/AIDS from UN Women, on 22 January 2018, in Kampala, Uganda.

611 UNFPA, “A new mobile app brings the digital revolution to adolescent maternal care in Uganda,” 11 April 2016, Accessed 25 March 2018, <http://www.un.org/youthenvoy/2016/04/a-new-mobile-app-brings-the-digital-revolution-to-adolescent-maternal-care-in-uganda/#prettyPhoto>.

612 WHO Africa, “WHO and ITU to use digital technology to strengthen public health services in Africa,” 26 October 2017, Accessed 25 March 2018,

<http://www.afro.who.int/news/who-and-itu-use-digital-technology-strengthen-public-health-services-africa>.

613 Novartis, “Text messages in Africa help to fight malaria,” 17 February 2014, Accessed 25 March 2018, <https://www.novartis.com/stories/access-healthcare/text-messages-africa-help-fight-malaria>.

healthcare professionals. In South Africa, an interactive cellphone health platform called “B-Wise” connects adolescents to information on a variety of topics such as: sexual and reproductive health and rights; HIV/AIDS; tuberculosis; nutrition; alcohol and substance abuse; mental health; gender-based violence; chronic diseases; physical and mental disability; violence, trauma and injuries; and oral health. B-Wise also allocates hours where users can live-chat with experts such as psychologists, nutritionists, and general practitioners.⁶¹⁴ A mobile site like this could help educate Ugandans on HIV/AIDS, dispelling misconceptions that people transmit AIDS by sharing food or utensils with an HIV positive person or bathing in the same river as the individual. It can also provide Ugandans with information on how to prevent HIV transmission, especially in societies where talking openly about sex is taboo.

Current efforts to integrate mobile technology into healthcare platforms are sporadic, spread out over distances, and dependent on the resources of the organization creating and disseminating these innovations. Moreover, a significant challenge is the lack of connectivity and access to the internet and mobile technology for many Ugandans living in rural areas. The Ugandan government, in conjunction with the private sector, international organizations, civil society, and tech entrepreneurs, should work together to scale up these efforts and expand their reach. They have an opportunity to harness the technological growth and spillover that comes with foreign investment in Uganda, to make use of mobile technology integrated into the formal healthcare system. Youth are a prime audience at which to target mobile, health-based apps, as they are already receptive to new technologies and highly adaptive. Organizations that are already using apps

should lead the way, but also coordinate with one another through information and knowledge sharing such that work is not duplicated.⁶¹⁵ The Ugandan Ministry of Health, through implementing partners such as UNICEF, are promoting mobile technology services to deliver better quality health services, and to achieve social accountability to the intended beneficiaries. There are toll free phone numbers on public spaces, including health facility notice boards, TV, and radio spots. Registered subscribers also receive some SMS messages about the availability of health services such as ARTs and what to do to report if the health services are not available or run out. These interventions, however, face many challenges, namely a lack of phone sets, high cost for airtime, lack of battery charging systems and media networks, as well as illiteracy among most rural populations. Unless these issues are resolved, mobile technology will help only a few sections of society.⁶¹⁶

Improve Human Rights-Based Education

Uganda has put in place several policies and laws which are critical in advancing a rights-based approach to HIV/AIDS prevention, treatment, and care.⁶¹⁷ The Constitution spells out government obligations to ensure that all Ugandans enjoy access to health services. In particular, article 33 addresses the state’s duty to protect women and their right to health. The Second National Health

614 Mzekandaba, Simnikiwe, “B-Wise with health dept’s mobi-site,” *ITWeb*, 21 August 2015, Accessed 25 March 2018, <https://www.itweb.co.za/content/klLn-14MmpxV7J6Aa>.

615 Ibid.

616 Dennis Bataringaya feedback

617 Center for Health, Human Rights and Development (CEHURD). *The Status of Integration of Human Rights-Based Approach in Health Care Delivery in Uganda: A Case Study of Selected Northern and Central Regions’ Health Services Points*, Uganda National Commission for UNESCO, 2016.

Policy also explicitly identifies equity and human rights as key components guiding HIV responses.⁶¹⁸ The government has also set up structures which provide spaces for communities to engage at various levels of the health sector and demand quality treatment.⁶¹⁹ Despite the existence of these legal and institutional frameworks, women who are at risk of stigma and violence have limited awareness of their fundamental rights and ways to claim them.⁶²⁰ Legal protection alone will not contribute to a more conducive environment for WLHIV to access better treatment and care. The reduction of stigma and human rights violations depends on the willingness and ability for women themselves to seek out their right to health and other related socio-economic, civil, and political rights.

The GoU should strengthen the current Human Rights Education (HRE) framework in the school system so that the general public knows their rights and imparts the skills needed to promote and defend them. In accordance with the World Programme for Human Rights Education (WPHRE), the GoU laid down a three-phase HRE implementation plan in 2004 to incorporate HRE in its school curriculum and promote a common understanding of the basic principles of HRE.⁶²¹ The first phase (2005-2009) evolved around HRE in primary and secondary schools. The second phase (2010-2014) targeted

HRE at the higher education institutions. The third phase (2015-2019) designed to take stock of previous efforts and strengthen the implementation. However, the GoU has failed to fully incorporate HRE in their national curriculum at all school levels.⁶²² A 2011 report on the human rights awareness in Uganda indicates that majority of students cannot define human rights.⁶²³ According to a government situational analysis study, the HRE implementation faces some roadblocks as schools do not fully conceive the concept of HRE and their respective areas of responsibilities.⁶²⁴ Regarding content, the GoU shuns away from articulating specific human rights that the curriculum should encompass and what skills students are expected to acquire to demand these rights in daily life. The latest national action plan focuses exclusively on the right to education and neglects other dimensions of human rights that are critical within the context of HIV/AIDS and women's rights.⁶²⁵ The GoU should acknowledge the interdependence of socio-economic, political, and civil rights to set up a comprehensive HRE curriculum that would foster a culture of human rights and contribute to the prevention of stigma and violence. Adding to the ambiguity is the ban on comprehensive sexual education in schools on the grounds of promoting positive values within the wider Uganda society.⁶²⁶ Studies have demonstrated that sexual education programs are among the strongest means of curtailing the spread of HIV/AIDS.⁶²⁷

618 Uganda, Ministry of Health, *The Second National Health Policy*, July 2010. https://www.unicef.org/uganda/The_Second_National_Health_Policy.pdf

619 See CEHURD 2016.

620 Meeting with representatives of UGANET, on January 18, 2018, in Kampala, Uganda. // Meeting with Stephen Odong, Director of Programs from HURINET, on January 25, 2018, in Kampala, Uganda. // Meeting with representatives of Mana Rescue Home on January 23, 2018 in Fort Portal, Uganda. // Meeting with Nadia El Ouargui, Senior Advisor from the Embassy of Norway, on January 19, 2018, in Kampala, Uganda.

621 The Republic of Uganda, Ministry of Education and Sports, *National Action Plan for Formal Human Rights Education in Uganda (2016-2021)*, 2016. <http://www.unesco-uganda.ug/files/downloads/NAPHRE-UNESCO%20Insides.pdf>

622 Ibid.

623 Human Rights Awareness and Promotion Forum-Uganda, "The State of Human Right Awareness and Promotion in Uganda", Nebbi, Uganda: HRAPE, 2011.

624 Uganda National Commission for UNESCO, *Implementing the National Strategy on Human Rights Education in Uganda*, 2016.

625 The Republic of Uganda, Ministry of Education and Sports, *National Action Plan for Formal Human Rights Education in Uganda (2016-2021)*, 2016.

626 Amy Fallon, "NGOs turn to courts to unravel Uganda's ban on sexual education," Devex, 2017. <https://www.devex.com/news/ngos-turn-to-courts-to-unravel-uganda-s-ban-on-sexual-education-89979>

627 Jessica M. Sales and Ralph J. DiClemente, *Ad-*

These programs help young people, especially adolescent girls form healthy beliefs about sex and relationship, and equip them with knowledge and necessary skills to make informed decisions and act on those decisions to others.

A human rights-based approach to HIV/AIDS prevention, treatment, and care also entails the promotion of legal rights and legal capacity building from the ground up. These programs should focus on sensitizing communities on human rights issues, including the rights of PLHIV, land rights, GBV, and existing accountability mechanisms for ensuring the observance of human rights. The programs should also incorporate empowerment approaches that would allow women to use legal and political means to take greater control of their health, property, land and other rights. The *SASA! Activist Kit* is a great tool for NGOs and CBOs working in the realm of HIV/AIDS and gender-based violence.⁶²⁸ Moreover, peer-based networks are also important as they encourage participants to become role models for other HIV-positive women and show their communities that women's rights should be respected. In addition to enhancing HRE for the affected individuals, human rights training for healthcare workers, law enforcement, and security agencies is also critical to ensuring respect and protection of human rights.

The absence of knowledge about patients' own rights within clinical settings is astonishing. A 2012 qualitative and quantitative study concluded that at least 36.5 percent of patients surveyed faced a challenge regarding their rights whilst seeking health care and most never attempted to demand their rights when facing challenges.⁶²⁹ It is disturbing

that even at hospitals less than half of the patients struggle in demanding their rights. These statistics urge for better education and training of health care workers on human rights issues. Under the section of Rights of Health Workers in the 2008 Guidelines for Occupational Safety & Health, it mandates the prohibition of HIV-related discrimination towards patients and the training "of all health workers at all levels on HIV and AIDS in order to increase their understanding."⁶³⁰ The scope of understanding should expand to include human rights implications. Patients would learn about their HIV status at clinical settings, which makes health service workers important source for patients to depend and trust. Well informed and educated personnel should not only enhance the HIV treatment and care service but also appropriately follow internationally agreed standards of human rights that protects the vulnerable population. The national guidelines for all health providers who take care of HIV patients does not include human rights related content but instead guided to "promote the establishment of community support groups to which mothers [who are HIV positive] should be referred."⁶³¹ The more effective way to promote for human rights that empowers PLHIV is to require training to health professionals and build their understanding of human rights. There are NGOs and international organizations that provide relevant programs and manuals for health workers, for example the Action Group for Health Human Rights and HIV/AIDS (AGHA). The training should focus on privacy, informed consent, duty to treat, access to service, non-discrimination, non-violence, GBV, and other

olescent STI/HIV Prevention Programs: What Works for Teens, ACT for Youth Center of Excellence, 2014. https://www.researchgate.net/publication/242752165_Adolescent_STIHIV_Prevention_Programs_What_Works_for_Teens

628 Cady Carlson, "SASA! Mobilizing Communities to Inspire Social Change," Raising Voices, 2013.

629 Harriet Rachel Kagoya, et al., *Awareness of,*

responsiveness to and practice of patients' rights at Uganda's national referral hospital, African Journal of Primary Health Care & Family Medicine, V.5(1), 2013

630 Ministry of Health, Guidelines for Occupational Safety and Health, Including HIV in the Health Services Sector, February 2008

631 Ministry of Health, *The Integrated National Guidelines on Antiretroviral Therapy, Prevention of Mother to Child Transmission of HIV, Infant & Young Feeding,* 2012

issues addressing women's economic marginalization in the community. Government should partner with these organizations, conduct research and adapt its best practices to train professionals nationwide.

Confront Challenges in Monitoring and Evaluation

Routine monitoring and evaluation (M&E) is required to ensure that HIV/AIDS-related programs act responsibly and effectively to fulfill their objectives. Although government plans and projects often include M&E statements, their functions are not translated into program operations.⁶³² Major evaluations are driven by donor demands and conducted by NGOs who receive funding from international organizations and foreign governments. Adding to the fragmented M&E regime is the lack of a comprehensive database documenting all M&E carried out by various stakeholders and a standardized system to study the data collected. Instead of leaving the M&E burden to NGOs, the GoU should carry out a broader M&E strategy that facilitates quality-assured data collection to inform decision-making at all levels and shares findings among policymakers to constantly update national HIV responses. The GoU should also tackle the under-staffing problem and develop a multi-sectoral capacity building strategy to train HIV/AIDS-specific M&E personnel at both national and district levels.

The GoU has made some recognizable efforts in harmonizing M&E of HIV prevention, treatment

and care programs at the national level, including the publishing of the National HIV and AIDS Monitoring and Evaluation Plan.⁶³³ However, the plan has some gaps that might affect its implementation. First, there is a limited awareness of the national M&E plan and reporting system. Most of the NGOs that carry out M&E interventions either follow the tools provided by international organizations or pilot their own systems. Second, existing data is not reliable enough to inform learning due to lack of control at various governmental levels to ensure accountability. Third, the national plan does not provide an explicit guideline for data analysis and use. Last but not least, the plan fails to integrate sufficient gender analysis into the program design and implementation.

To address these issues, the GoU should strengthen the operationalization of the national plan and incorporate reporting tools for behavioral and structural community indicators to capture data from NGO implementers. The GoU should also promote stronger coordination on data management between local and central level as well as ministerial levels. With the support of local government, NGOs and health facilities, the GoU should disseminate findings of the key surveys and ensure that programs align with the newest information. Most importantly, a gender-sensitive M&E tool should be developed to incorporate GBV indicators and ensure that data are collected, analyzed, and reported separately for women, men, boys and girls. Since most of the M&E are conducted at the regional and district level, the GoU should establish training sessions to train local implementers on basic GBV concepts and procedures for responding to GBV.

Aside from the government, M&E has yet reached an acceptable level of operation within NGOs working on women's rights and HIV/AIDS. Most NGOs only carry out monitoring efforts right

632 Uganda. Ministry of Health. *National HIV and AIDS Monitoring and Evaluation Plan 2011-2014*, Ministry of Health, 2011.

633 Ibid.

after the intervention ends to fulfill M&E requirements set by donors. Few NGOs seek to engage in systematic M&E to test the sustainability of the program. NGOs working to reduce HIV-related stigma and harmful cultural practices should keep track of their program beneficiaries in a timely manner and document best practices taking place in the communities. Where possible, NGOs should hire professional personnel to develop M&E plans and questionnaires to better capture the impact of the program and identify key challenges.



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Conclusion

This report finds that the realization of women's rights is a crucial part of the fight against HIV/AIDS in Uganda. Given the disproportionate prevalence and impact of HIV on women, promoting gender equality, sexual and reproductive rights, and economic empowerment is necessary to mitigate the transmission and impact of the disease. More broadly, combatting the discrimination and stigma surrounding PLHIV in healthcare settings, employment, and daily life is critical to eliminating deterrents to HIV testing and easing the burden of living with the disease, thereby advancing both prevention and treatment efforts.

Certainly, women have benefited from the overall progress achieved through Uganda's HIV/AIDS response. Nevertheless, their continued marginalization – in both society and policy – create a real risk of their, indeed, being left behind. Although there are programs, information campaigns, and advocacy efforts underway, stakeholders need to enhance efforts to address underlying factors that make women particularly vulnerable to both contracting the disease and the impacts of living with it. One priority must be to combat GBV by shifting attitudes and norms and eliminating victims' stigmatization to prevent violence and promote access to justice for victims.

The state of Uganda's existing financial, development, political, and legal landscapes are of concern in this context. Current trends in donor funding could threaten future support for the HIV/AIDS response. As a result, Uganda should prioritize domestic funding for the HIV/AIDS response even as donors aim for improved coordination and efficiency. Moreover, the GoU cannot treat foreign investment and human rights as a zero-sum game – achieving middle-income status at the expense of individual dignity is no achievement at all. In fact, the patronage, corruption, and authoritarian tendencies of the Museveni regime undermine the potential advancement of democracy, women's rights, public health, and development. Finally, recently strengthened legal restrictions on freedom of speech, assembly, and association increase the risks and barriers for human rights defenders to conduct their work in advocating for responses to HIV/AIDS and women's rights.

HIV does not discriminate, and neither can the response. To eradicate HIV/AIDS, the intervention must be multi-pronged, multi-sectoral, and inclusive. It must fulfill the promise of the GoU and the international community that no one be left behind – not women, not drug users, and not sexual minorities. Neglecting, ignoring, or intimidating

certain segments of society, at best does nothing to help achieve Uganda's 2030 targets, and at worst is counterproductive to these efforts. Absent a universally acceptable, available, and affordable cure, the realization of human rights is the lynchpin to eliminating HIV/AIDS in Uganda. Rights-based approaches to public health and other development initiatives ensure that the country pursues a path of growth that lifts all members of society and honors existing natural and legal commitments of fundamental rights to the Ugandan people.

While foreign and non-governmental actors continue to play a critical role, this puts the onus on the government of Uganda to make both targeted interventions and structural changes that will facilitate an effective and sustained response to HIV/AIDS and enable women to access their rights. The government has a responsibility to do so, consistent with the commitments it has made in its national policies and under international law. As Uganda chases its ambitious development goals, these changes will ensure that women are not, in fact, left behind.

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Meeting with David Mawejje Muddu, National Coordinator for HIV/AIDS from ILO, on January 17, 2018, in Kampala, Uganda.

Meeting with Dr. Andrew Luwangula from RHSP, on January 22, 2018, in Kalisizo, Rakai District, Uganda.

Meeting with Dr. James Batte, Manager of TB, Care & Treatment at Rakai Health Sciences Program (RHSP) on January 22, 2018 at RHSP in Kalisizo, Rakai District, Uganda.

Meeting with District Health Officer of Rakai, Dr. Kasako, on January 23, 2018 in Rakai, Uganda.

Meeting with Eddy Migeero from the AIDS Information Network, on January 23, 2018, in Rakai, Uganda.

Meeting with Elizabeth Allen from ACT Health, on January 18, 2018, in Kampala, Uganda.

Meeting with Elizabeth Mushabe, National Consultant on Gender-HIV/AIDS from UN Women, on 22 January 2018, in Kampala, Uganda.

Meeting with Enid Wamani from Uganda AIDS Commission’s Director of Partnerships, on January 15, 2018, in Kampala, Uganda.

Meeting with Francis Kato from Kasensero Clinic In-charge, on January 23, 2018 in Kasensero, Rakai District, Uganda.

Meeting with Fuel Uganda, on January 23, 2018, in Fort Portal, Uganda.

Meeting with George Tamale and Opio Daniel from FUE, on January 2018, in Kampala, Uganda.

Meeting with Kenneth Mwehonge, Manager for Health Policy Advocacy from HEPS-Uganda Program on January 25, 2018 in Kampala, Uganda.

Meeting with Nadia El Ouargui from the Embassy of Norway, on January 19, 2018, in Kampala, Uganda.

Meeting with Rita Nalu Nalunkuuma from CEHURD, on January 23, 2018, in Kampala, Uganda.

Meeting with Stephen Odong from HURINET, on January 25, 2018, in Kampala, Uganda.

Meeting with representatives from Straight Talk Foundation, January 25, 2018 in Kampala, Uganda.

Meeting with officers from Kasensero police force, on January 23, 2018, in Kasensero, Rakai District, Uganda.

Meeting with representatives from ICWEA, on January 25, 2018, in Kampala, Uganda.

Meeting with representatives from Mana Rescue Home, on January 23, 2018, in Fort Portal, Uganda.

Meeting with representatives from RHSP, on January 22, 2018, in Kalisizo, Rakai District, Uganda.

Meeting with representatives from Embassy of Sweden, on January 19, 2018, in Kampala, Uganda.

Meeting with representatives from IOM, on January 24, 2018 in Kampala, Uganda.

Meeting with representatives from Kalisizo Police Station. January 23, 2018 in Kampala, Uganda

Meeting with representatives from Kasensero Police Station. January 23, 2018 in Kasensero, Uganda

Meeting with Lillian Mworeko, Executive Director, from ICWEA, on January 25, 2018, in Kampala, Uganda.

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