2015

POLICY PROPOSALS FOR YOUTH ENGAGEMENT IN HIV/AIDS PREVENTION

Konrad
Adenauer
Stiftung

POLICY PROPOSALS FOR YOUTH ENGAGEMENT IN HIV/AIDS PREVENTION

Submitted by: HIV Working group
2015

Konrad-Adenauer-Stiftung e.V.Uganda
Plot 51 A, Prince Charles Drive, Kololo,
P.O. Box 647 Kampala, Uganda
Tel: +256 - (0)393 - 262011/2
www.kas.de/Uganda/en

© Konrad-Adenauer-Stiftung 2015
All rights reserved. Reproduction of all or parts of this publication for educational or other noncommercial purposes is authorised without prior written permission from the copyright holder provided the source is fully acknowledged and any alterations to its integrity are indicated.
Reproduction of this publication for sale or other commercial purposes is prohibited without prior written consent of the copyright holder.
The opinions expressed in this publication do not necessarily reflect the views of the Konrad-Adenauer- Stiftung.

CHAPTER 1:
Background and Introduction

HIV/AIDS has been at the core of Uganda's health policy, services and reality for well over two decades. Since the early 1980s, Uganda has been affected by the HIV/AIDS epidemic. To-date, the HIV and AIDS epidemic is generalized in the country with the prevalence in the general population having increased from 6.4% in 2005 to 7.3% in 2011. The prevalence is also higher (a) among women (7.5%) than men (5%), (b) among the fishing communities (22%), (c) commercial sex workers (35%) and (d) men who have sex with men (13%). There is also regional variation with the highest level of prevalence in central region (10.4%) and lowest in West Nile region (4.3%).[1] It is important to remember that an increase in HIV prevalence is not necessarily a sign of ineffective HIV prevention programs; it could be a result of more people knowing their HIV status and taking antiretroviral (ARV) medication, resulting in more people with HIV living longer, the Uganda AIDS Indicator Survey 2011 continues to assert.

It is now three decades since the first case of acquired immune deficiency syndrome (AIDS) was reported in Uganda. Over the years, the country has experienced a big burden of AIDS. The National HIV (human immunodeficiency virus) Surveillance System established in the mid-1980s to track the epidemic has documented more than 2 million people in the country who have been infected with HIV. Furthermore, mathematical projection estimates have shown that approximately 130,000 new HIV infections occur annually in Uganda. To address this high burden, the National HIV Prevention Strategy 2011-2015 is being implemented with teh goal to reduce HIV Infections by 40% until 2015 and various approaches are used to monitor the progress of the national response.[2]

1 MoH (2011). Uganda AIDS Indicator Survey 2011. Ministry of Health. Kampala.
2 MoH (2011). Uganda AIDS Indicator Survey 2011. Ministry of Health. Kampala.

Uganda, in a bid to address the explicit and implicit factors around HIV/AIDS, employed a comprehensive, multi-pronged and multi-sectoral intervention intended to address the knowledge, behaviour and practices of the populace in order to arrest the epidemic and ultimately provide best treatment and management to alleviate the effects of HIV/AIDS. This so is the initiation and implementation of the ABC approach – Abstinence, Be Faithful and Use of Condoms – a campaign that sought to provide the citizens with the information and recommended behaviour and practices to arrest this scourge. This approach to HIV/AIDS prevention and management indeed garnered great results for Uganda in the fight against HIV/AIDS as there was dramatic decrease in infection and prevalence rates from 23% in 1988 to 6% in 2002[3]. This put Uganda on the global spotlight as a best practice and example in HIV/AIDS programming. One key driver behind this success was the political will by the Government of Uganda towards shaping this shift in behaviour and practice towards prevention primarily, but also to treatment and ultimate management of HIV/AIDS by those infected and affected.

Expenditure on HIV/AIDS interventions: More than 80% of spending comes from AIDS Development Partners (ADPs). Uganda's national HIV and AIDS response is heavily dependent on external support as USD 1.565 billion was contributed by international donors out of the total USD 1.747 billion used in the national response between 2007/08 and 2012/13. The National AIDS Spending Assessment (NASA) Report 2008-2010, that included on- and off-budget expenses known to government as well as private spending that is not usually captured by government indicated that between 2008/09 and 2009/10 funding from public sources contributed approximately 10.5% of expenditures on HIV and AIDS while private out-of-pocket sources contributed roughly 21%; the largest source of funding came from donors at 68%. Out-of-pocket spending by households on HIV and AIDS and related conditions not only accounts for more than one-fifth of annual AIDS expenditures in the country, but is also twice the amount contributed by the government[4].

3 Ploem R (2006) AIDS controversies in Ugandafurther analyzed. Report of the mission to Uganda from 5 until 16 December 2005. KIT, Share-Net, Wemos. p.6

4 National AIDS Spending Assessment (NASA) Report 2008-2010, Government of Uganda, on UNAIDS Website

It is clear from this finding that although the cost-sharing policy for health services was dropped by government many years ago and currently 24.5% of Ugandans live below the poverty level, Ugandan households do contribute substantially towards the national response at the individual, family and community levels[5]

One of the tools utilized to bring about this shift was information. Multi-media campaigns resulted in 99% of Ugandans aged 15-49 having heard of AIDS. Awareness of the modes of HIV transmission is high, with over 90% of adults knowing that having only one uninfected, faithful partner can reduce the chances of getting the AIDS virus. Rejection of misconceptions related to HIV is also widespread; 88% of women and 90% of men know that a healthy-looking person may be HIV positive, and almost four in five persons know that HIV cannot be transmitted by sharing food with someone, who has the virus. Comprehensive knowledge about HIV has increased somewhat from 28% in women 36% in men in 2004-05 to 36% and 43% respectively in 2011.[6]

Although HIV prevalence stands at 7.2%, the incidenc[e7] in the country has been declining since 2007. The rate has fallen from 0.90% to 0.77% between 2007 and 2012.[8] **.** This can be attributed to access to prevention knowledge and tools and the great EMTCT (Eliminating Mother To Child Transmission) care/interventions that are now part of the mainstream HIV interventions. Meanwhile, members of the Uganda AIDS Commission have argued that at this point complacency is the real driver behind the reemerging rise in new infections.[9] This complacency narrative is supported by the fact that even though the majority of the populace knows about HIV/AIDS – transmission and prevention, less than 14% of sexually active men who had more than one sexual partner said they used a condom in the past 12 months prior to the Uganda AIDS Indicator Survey 2011. This shows a presence of highly risky behavior that is behind the increasing prevalence rates.

5 The case for more strategic and increased HIV investment for Uganda 2015-2025, 2014
6 http://health.go.ug/docs/UAIS_2011_REPORT.pdf
7 Incidence rate is the number of new infections per 1,000 people in the population expressed as a percentage
8 The Case For More Strategic And Increased HIV Investment For Uganda 2015-2025)
9 http://thinkafricapress.com/uganda/hiv-rate-back-rise

A keen study of trends from the Uganda AIDS Indicator Survey 2011 shows that there has been a consistent increase in knowledge about HIV/AIDS among both men and women and most have an accepting and supportive attitude to people living with HIV/AIDS. Also, interestingly, over 94% of women and men aged 18-49 agree that children aged 12-14 should be taught to wait until marriage to have sex and two thirds of the same group of adults agree that children aged 12-14 should be taught about using a condom to avoid AIDS. This provides a strong indication that the majority of Ugandans have the knowledge for prevention and management of HIV/AIDS and also provide a good supportive environment for people affected and infected with HIV. This augurs well for HIV/AIDS interventions as it is apparent that the basics are covered – though there is clearly a gap, for example, between the knowledge about HIV/AIDS management and utilisation of the same, especially in prevention of new infections.

The Option B+ intervention under the Elimination of Mother To Child Transmission efforts guidelines by the WHO reduces the risk of mother to child transmission of HIV and fights malnutrition among babies at the same time as mothers/babies can be able to breastfeed for at least a year, while the mother is on medication. This has been bolstered by the involvement of traditional birth attendants in referral of these expectant mothers and also educating them about these safe birth options. This intervention has largely reduced the risk of HIV infection for babies from 32% in 2009 to 21% in 2011[10] thus giving them a chance at full healthy lives.

Situation of young people and HIV/AIDS in Uganda

According to the Uganda AIDS Indicator Survey 2011, Uganda continues to experience an increase in HIV/AIDS among men and women in the 15 – 49 age brackets. Since 2004/2005, the rate has risen from 6.4% to 7.3% for women and 5.0% to 6.1% for men. Overall, 3.7% of young women and men aged 15-24 are HIV-positive. Overall, HIV prevalence among young women is markedly higher than among young men, a gap that starts out minimal and the grows into a difference of 3.4% for the age group 23-24. Among

10 Countdown To Zero. Elimination of New HIV Infections Among Children by 2015 And Keeping Their Mothers Alive. Uganda draft. UNICEF 2012

young women aged 15-24 HIV prevalence is higher among those living in urban areas, while among young men aged 15-24 HIV prevalence is higher among those living in rural areas. There is no clear relationship between HIV prevalence and level of education or household wealth among youth. This is added to the fact that only 39% of young women and men aged 15-24 have comprehensive knowledge about HIV and AIDS . Knowledge increases slightly with age and is higher among never-married youth, who have had sex, than among those never-married youth, who never had sex. It is also higher among those who have never been married in comparison with those who have been married. Young people in urban areas are more likely than rural youth to have comprehensive knowledge about HIV and AIDS.[11] Research is still going on towards identifying the drivers behind these trends and the jury is still out on this, but what is clear is that on average, young people have the knowledge about HIV/AIDS and the gap could be in the behaviour and practices including, but not limited to, multiple sexual partners among other factors driving up the infection rates despite the knowledge on prevention and transmission.

Youth under the age of 30 in Uganda comprise 75% of the population with 58% being children aged 18 and below[12]. This should potentially translate into productivity and other development opportunities for Uganda. However, the trends around HIV/AIDS among young people have a direct and lasting negative impact on the future of the country's workforce as they are the most at risk and affected with HIV/AIDS.

A situational analysis of HIV/AIDS by the Uganda Aids Commission[13] also indicates that 570 Ugandan girls aged between 15 – 24 get infected every week.

The 2013 Millennium Development Goals Report for Uganda indicates a reversal on MDG Goal 6 target A on halting and reversing the spread of HIV by 2015. This can largely be attributed to the slow pace of reduction among

11 http://health.go.ug/docs/UAIS_2011_REPORT.pdf
12 The National Labour force Survey and Child activities survey, 2011/12
13 Report published June, 2014

young women and men as a key driver of the epidemic. With the previously registered successes in the fight against HIV/AIDS, the reality around an ever increasing number of youth and the perceived failure of the previously lauded interventions around reducing HIV/AIDS prevalence, all actors are faced with a reality that calls for urgent action towards arresting this trend and preserving the successes of previous efforts to combat HIV/AIDS.

According to the *Uganda* HIV/AIDS Sero-Behavioural Survey (UHSBS) 2004/5 and the Uganda AIDS Indicator Survey 2011, prevalence rates among 15-24 age group has been on the rise from approximately 2.9% in 2004/5 to 3.7% in 2011(UHSBS). Notable trends also show inconsistent condom use over the years with a sharp drop in the uptake for condoms use in 2006 (especially among female youth) and a subsequent recovery in 2011.

Table 1 below shows a consistent increase in knowledge of HIV among young people with minimal disparities among young women and men yet the prevalence continues to increase among this age group. This can be attributed to many factors including among others information and interventions that exclude or do not target young populations.

Table 1: Overview Indicators in MDG Target 6A

INDICATOR	2000/01	2004/05	2006	2011
6.1 HIV prevalence among populations aged 15-24	N/A	2.9%	N/A	3.7%
15-19 years, female	N/A	2.6%	N/A	3.0%
15-19 years, male	N/A	0.3%	N/A	1.7%
6.2 Condom use at last high risk sex, 15-24 years old	53.1%	54.0%	46.5%	56.1%
Female	44.2%	52.9%	38.4%	51.0%
Male	62.0%	55.1%	54.5%	61.1%

6.3 proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	34.5%	32.4%	35.1%	38.8%
Female	28.5%	29.5%	31.9%	38.1%
Male	40.4%	35.3%	38.2%	39.5%

Extracted from 2013 MDG Progress Report on Uganda

There is a growing recognition that although Uganda's HIV epidemic is generaliy affecting all population groups, there are key populations that are more susceptible to the underlying factors driving HIV – that operate at distal level to influence the proximate risk factors for HIV infection, including influencing uptake of HIV prevention services and sexual behaviour in Uganda. There is a general acknowledgement of the knowledge gap and therefore the need to research on demographics and dynamics of the epidemic to guide future programming. The National Prevention Strategy 2011/12 - 2014/5 identified key population groups with HIV prevalence exceeding that of the general population as: sex workers at 37% (Vandepitte et al., 2011) accounting for about 10% of new infections, fishing communities at 22% (Opio A. et al, 2011), partners of sex workers (18%),men with a history of having sex with men (13%) and men, who operate motorcycle transport known as "*Bodaboda*" at 8% (MUSPH & CDC, 2009). According to recent data, students in six universities had lower prevalence of HIV averages of 1.2% (EALP & IUCAE, 2010). By 2011, the majority of people infected had shifted from unmarried younger individuals as was the case in the 1980s and 1990s to older individuals aged 30-35 years more likely to be married or in long-term relationships. Analysis of the categories of key affected populations in Uganda, like sex workers and partners, fisher folk, uniformed services, men who operate motorcycle transport as well as injecting drug users show that these are predominantly young people below the age of 30.

Little is known on whether identifying youth as a target group in programs and policies has been truly responsive to the needs of young women and men in the HIV/AIDS response. For instance the youth has been identified as a priority target audience for prevention interventions (broken down into youth prior to sexual debut, youth engaged in cross-generational sex relationships and their partners and youth involved in multiple sexual partnerships) next to more generally men and women who engage in transactional sex and their clients, adults working away from home, uniformed services and residents of high prevalence areas and epidemic hotspots, such as urban slums, Northern Uganda, transportation corridors, border crossing points and fishing landing sites.

CHAPTER 2:
National Policy Framework on HIV /AIDS and Youth

In light of the background given above, this chapter will analyze and summarize the response the HIV/AIDS and Youth with the national policy framework in Uganda. The analysis specifically focused on the following policies and plans:

- National Health Policy,
- National Population Policy,
- National Gender Policy,
- National Youth Policy (current Draft),
- National Policy on HIV/AIDS and the World of Work,
- Adolescent Health Policy and
- National HIV Prevention Strategy.

1. National Development Plan

The National Development Plan explicitly recognises the impact of HIV on macro-economic development potential. The given prediction is that HIV/AIDS will lead to a fall in GDP of 6.5% per year in the future witch leads to the clear targets of the policy to:

- Reduce incidents by 40%,
- Increase access to prevention and ABC**+** promotion,
- Promote counselling, joint treatment and disclosure, and
- Support women empowerment in decision making and train them in specific care needs.

2. National Health Policy

The policy does not explicitly mention HIV, but includes targets on overall coverage of communicable diseases in the Minimum Health Care Package (made a priority and including a focus on prevention and behaviour change) that focuses on health financing, including increased budget allocations (to match international commitments). However, the policy continues to rely heavily on the private sector engagement and external donor promotion and coordination.

3. National Population Policy

The National Population Policy recognizes HIV in its demographic overview as a feature of the population and includes a target to promote improvement of health status of the population. However, no further mention of the topic of HIV/AIDS is made.

4. The National Adolescent Policy

This policy makes a clear mention of HIV with a specific and separate focus on adolescence with the following targets to Increase knowledge and the perception of risk and eliminate harmful traditional practices.

Strategies put forward:

- Advocacy to increase resource commitment by all and create a conducive legal, social and cultural environment
- Behavioural change and communication to increase awareness for positive change on attitude and practice

5. National Youth Policy

The National Youth Policy includes a full section on HIV, but is limited to situational analysis with targets on intervention areas defined as access to resources and services. Select strategies include to increase awareness, make services more available and accessible and promote campaigns for behaviour change.

6. National Policy on HIV/AIDS and the World of Work

This policy makes a clear mention of the topic with a focus on HIV/AIDS and its relation to the work place and includes targets on non-discrimination, integration, confidentiality and prohibition of compulsory testing.

Strategies:

- Promote information dissemination in the work place
- Workers Rights and Laws to support people living with HIV/AIDS (not prevention)

7. National HIV and AIDS Strategic Plan (NSP) (2007/8– 2011/12)

In 2000-2001, the Government of Uganda through the Uganda AIDS Commission formulated the National Strategic Framework (NSF) on HIV/AIDS to cover a period of five years. The Uganda Aids Commission then developed a National Strategic Plan (NSP) 2007/8 – 2011/12 to guide the national response to HIV/AIDS over the subsequent five years. While the NSP includes considerable guidance on legal and Human Rights responses to the epidemic, it is noteworthy for its silence on the lesbian, gay, bisexual and transgender (LGBT) community, placing this population outside the ambit of protection and bringing the NSP into conflict with the principle of non-discrimination on the basis of sexuality that is contained in the draft National AIDS Policy.

The NSP has three service thematic areas, namely, prevention, care and treatment and social support. The service thematic areas are supported by strengthened systems of delivery that include institutional arrangements and human resource requirements, research and development, resource mobilization and management, monitoring and evaluation and infrastructure requirements.

Among the highlights in the NSP that are important for promoting a Human Rights response to the issue of HIV/AIDS is the identification and targeting of vulnerable and most at risk populations. These are defined in the NSP to include commercial sex workers, fishing communities, uniformed services, internally displaced persons, persons with disability, orphaned and

vulnerable children (OVCs), and discordant couples (i.e. couples where one partner is HIV positive and the other is HIV-negative). It is noteworthy that criminalization of deliberate transmission of HIV and AIDS is among the strategic actions anticipated under the NSP 2011-14.

8. National Prevention Strategy 2011-2015

The Government of Uganda identified prevention as a priority in the National Development Plan 2010-15 (NDP) and set to reduce new HIV infections by 40% by 2015. To achieve this, the government conceived the need for a new HIV prevention strategy 2010. The strategy builds on previous efforts of the National HIV Strategic Plan NSP 2007/8-11/12, the 2006 roadmap towards accelerated HIV prevention and efforts of local and international stakeholders[14].

The strategy is focused on HIV with the stated targets and strategies below;:

- Increased safer sexual behaviour and reduced risky behaviours
- Scaling up age appropriate behaviour change interventions through messages on mass media on inappropriate sexual practices
- Reduce multiple and concurrent sexual partnerships through campaigns in mass media
- Outlaw pornography and eliminate sexual début before 18 and childhood marriages

As indicated from the review above, policies and plans generally identify HIV as a feature/problem for the Ugandan population, but fail to focus on any specific target groups (youth or otherwise) to incorporate their specific needs in the targets and strategies**.** Moreover the problem analysis in most cases is very general and does not connect to clear theories of change. Behavior change in most of the policies is included in a number of policies, but not at all explored in its complexity. Financing plans are mostly lacking and if present do not include clear target commitments and rely heavily on outside-of-government financial sources. Overall, it can be summarized that at the policy level the response to HIV/AIDS is lacking coherence.

14 National Prevention Strategy 2011-2015

CHAPTER 3:
National and International Legal Framework on HIV/AIDS and its impact on young people

After the previous overview of the national policy framework in Uganda regarding the topic of HIV/AIDS and Youth, this chapter moves on to analyze the issue in a broader spectrum moving to international, regional and then national level framework documents in its analysis.

1. International and Regional Legal Framework and Policy

Binding instruments to which Uganda is state party include:

- Universal Declaration of Human Rights
- International Covenant on Economic, Social and Cultural Rights
- International Covenant on Civil and Political Rights
- Convention on the Elimination of all Forms of Racial Discrimination
- Convention on the Rights of the Child
- Convention on all Forms of Discrimination Against Women.

In addition to these international instruments, there are regional instruments that deal with region-specific issues in the context of HIV/AIDS.

African regional instruments include:

- African Charter on Human and People's Rights
- Optional Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
- East African HIV & AIDS Prevention and Management Bill
- African Youth Charter
- East African Youth Policy

- The Protocol to the African Charter on the Rights of Women in Africa.

As an example, the Protocol to the African Charter on the Rights of Women in Africa specifically address woman's rights in relation to HIV/AIDS, and to identify protection from HIV/AIDS as a key component of woman's sexual and reproductive rights. Apart from providing women a right to protection from sexually transmitted infections, including HIV/AIDS, the Protocol guarantees woman's rights to adequate, affordable and accessible health services. It also confers a duty on the state to protect girls and women from practices and situations that increase their risk of infection, such as child marriage, wartime sexual violence and female genital mutilation. As of March 2007 only 21 member states had ratified this protocol. Uganda has not ratified it yet. Therefore, these are three examples are forming key regional legislation on the topic of youth and HIV/AIDS:

1) East African HIV & AIDS Prevention and Management Bill

The Bill provides for access to HIV prevention, information, education and communication, voluntary counseling and testing, treatment, care and support, protection against discrimination as well as ethical and lawful research. It offers protection to a wide range of the population, such as children, women,and prisoners etc (however, it does not mention youth). It also excludes the criminalization of intentional spread of HIV unlike the HIV/AIDS Prevention and Control Act 2014 in Uganda.

2) African Youth Charter

Selected relevant articles:

- Article 16: A Young Person's right to enjoy the best attainable state of physical, mental and spiritual health.
- Article 16 (2): State parties shall undertake to implement this right:
  c) provide access to youth friendly productive health services including contraceptives, antenatal and postnatal services,

  e) institute comprehensive programs to prevent the transmission of sexually transmitted infections and HIV/AIDS by providing education, information, communication and awareness creation as well as making protective measures and productive health services available,

f) expand the availability and encourage the uptake of voluntary counseling and confidential testing for HIV/AIDS,

g) provide timely access to treatment for young people infected with HIV.

3) East African Youth Policy

Selected relevant articles:

- Section 2.5: Young people in the East African Community are faced with increased health related issues and risks and constitute a substantial population of East Africans living with HIV/AIDS. The youth are most vulnerable as often they cannot afford the high cost of medical care making access and availability of medication and medical services of deep concern for the youth.
- Section 2.9: The youth demographic is not a homogenous group and within it there are those youth who require special attention. These include, among others, youth living with HIV young sex workers.
- Section 4.3: Healthcare needs to be affordable and accessible as well as equitable. Programs to be established to prevent the spread of HIV/AIDS among young people - the right to timely and affordable access to HIV treatment.

Our recommendation on this is to encourage the law makers and implementers to ensure the laws are complied with by the relevant agencies and bodies dealing with issues of HIV/AIDS. Youth groups could monitor the implementation of these laws.

2. Domestic Legal Framework

Uganda now has explicit legislation regarding HIV/AIDS. In addition, a number of laws have a direct bearing on the Human Rights of people living with, affected by and at risk of HIV/AIDS.

1) The Constitution of the Republic of Uganda (1995)

The Constitution of the Republic of Uganda, enacted in 1995, lacks explicit reference to HIV/AIDS despite the country having recognized the disease

ten years prior to that Constitution's passage. The Constitution has most economic, social and cultural rights imbued within the spirit of the Constitution, but not as justifiable rights, while Chapter 4 on the Bill of Rights is devoted to civil and political rights. Under the National Objectives and Directive Principles of State Policy in the Constitution, there is no specific reference to the right to health; rather it is implied under objectives on provision of basic medical services, access to clean and safe water, food security and nutrition. Under Chapter 4 Article 21, the Constitution provides for equality and freedom from discrimination. This includes equality before and under the law in all spheres, equal protection of the law, and prohibition of discrimination on grounds of sex, race, color, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability. Although health status is not among the grounds enumerated, some have argued that HIV/AIDS constitutes a disability that could be envisaged under this article. It is also possible to argue for a broader interpretation of Article 21 based on Article 45, which effectively imports all other Human Rights, duties, and freedoms not specifically mentioned in Chapter 4.

Other rights guaranteed under Chapter 4 include the protection of the right to life (Art.22), personal liberty (Art.23), respect for human dignity and the protection from cruel, inhuman and degrading treatment or punishment (Art.24), from deprivation of property (Art.26), right to privacy of person, home and other property (Art.27), right to a fair hearing (Art.28), right to education (Art.30) and family rights (Art.31).
Article 32 of the Constitution provides for affirmative action in favor of groups marginalized on the basis of gender, age, disability or any other reason created by history, tradition or custom, for the purpose of redressing imbalances existing against them. The provisions in Article 32 clearly did not envisage health status as a basis or reason for marginalization. Articles 33-36 that follow from this contain provisions specific to groups that are understood to be marginalized: Women, children, persons with disabilities and minorities. It is only with the recent enactment of the Equal Opportunities Commission Act 2007, that health status has been added to the bracket of grounds for discrimination and marginalization, for which equal opportunities should be ensured by law.

Whereas Article 23 puts limitations on the right to personal liberty in the interest of public safety, including "…the purpose of preventing the spread of an infectious or contagious disease" (Article 23(d)), care should be taken that this subsection is not pervasively used to infringe on the rights of people living with HIV.

2) Equal Opportunities Act (2007)

The Equal Opportunities Act of 2007 gives effect to Articles 32(2) and 33(4) of the Constitution, making the Equal Opportunities Commission (EOC) the last constitutional body to be established more than ten years after the enactment of the 1995 Constitution. The EOC Act is significant in that it explicitly provides a legal basis for people living with HIV and those affected to challenge discrimination in any field, including law and policy. This is clear from the Act's preamble, its definitions of "discrimination"[15] and "marginalization,"[16] and its Section 14 on the functions of the Commission. The definition of discrimination includes "health status," while marginalization relates to limitations on the rights guaranteed under the Constitution.

3) The Children's Act (1997)

The Children's Act of 1997 contains provisions on the welfare and rights of children that should apply regardless of whether or not there is HIV/AIDS in the family. Some of the critical provisions in the context of HIV/AIDS and children's rights include:

- A child's right to stay with his or her parents or guardians.
- The duty of the parent, guardian, or other person having custody of the child to maintain the child, meeting all the child's needs and rights including education and guidance, immunization, adequate diet, clothing, shelter and medical attention.

15 The Act defines "discrimination" as meaning any act, omission, policy, law, rule, practice, distinction, condition, situation, exclusion or preference which, directly or indirectly, has the effect of nullifying or impairing equal opportunities or marginalizing a section of society or resulting in unequal treatment of persons in employment or in the enjoyment of rights and freedoms on the basis of sex, race, colour, ethnic origin, tribe, birth, creed, religion, health status, social or economic standing, political opinion or disability

16 The Act defines "marginalization" as meaning depriving a person or a group of persons of opportunities for living a respectable and reasonable life as provided in the Constitution

- The right to play and enjoy leisure.

4) The Employment Act (2006)

The field of employment constitutes a major site of discrimination and oppression for people living with HIV in Uganda. Discrimination occurs in recruitment, termination of employment, transfers, grievance resolution and disciplinary measures, and payment of benefits. Section 6 of the Employment Act of 2006 prohibits discrimination on the basis of HIV/AIDS status among other grounds. This law is stronger and more explicit than the Constitution, and it strengthens the principles of the HIV/AIDS and the Workplace Policy. Moreover, it is reinforced by the Equal Opportunity Legislation discussed above.

The prohibition of sexual harassment under section 7 creates legal protection particularly for female employees who are placed at risk of contracting HIV/AIDS through demands for sex by their employers. A limitation of the provision is that it does not cover sexual harassment between employees, thus failing to recognize power relations between senior and lower ranking staff.

5) The Penal Code

Section 129 of the Penal Code was amended in 2006 with the offense of defilement being classified into two categories, the second one being "aggravated defilement". The circumstances for aggravated defilement include: Where the victim is less than 14 years of age, where the offender to his or her knowledge is infected with HIV/AIDS, where the offender is a parent or guardian or person in authority over the victim and/or where the offender is a serial offender. Although this provision effectively criminalizes deliberate or willful transmission of HIV, in violation of international guidelines on this issue, the amendment has not generated a significant debate on its implications for public health or Human Rights. This may be attributed to the limited information on the amendment within the public, the limited appreciation of its implications and the limited number of organizations or groups working on HIV-related legal and Human Rights advocacy.

The amendment also broadens protection beyond girls under 18 to cover ‘persons below the age of 19 years’; and further provides for compensation to victims of defilement. This means that the law of defilement protects both boys and girls below 19 years of age.

Although largely seen as a deterrent measure to provide protection to young girls and boys at risk of HIV/AIDS through sexual violence and exploitation, it can also been interpreted as discriminatory against people living with HIV. In addition to the potentially stigmatizing effect of creating a special crime of HIV transmission. The provision implies that all persons accused of defilement must be subjected to a mandatory HIV/AIDS testing, thus exposing the zero-status of both victim and offender. International Human Rights experts as well as the United Nations have cautioned against HIV-specific criminal laws, urging that existing criminal law is sufficient to punish the few cases in which individuals transmit HIV with malicious intent. Uganda’s provision needs to be subjected to further review in order to ensure that the protection of vulnerable children does not negatively affect the rights of others.

Another of Uganda’s Penal Code provisions that is relevant to HIV/AIDS is Section 145, which categorizes same sex sexual behavior as conduct against the order of nature, for which one is liable to imprisonment for life. Lesbian, gay, bi-sexual, transgender and (LGBTI) persons are among the most at risk populations for contracting HIV/AIDS, due to factors such as unprotected sex, inaccessible health services, gender-based violence and deep social marginalization. The risk for lesbians is aggravated when they are subjected to rape and other forms of sexual violence as part of efforts to make them “straight”, which they endure in silence for fear of exposing their sexual orientation, while justice eludes them. At the same time, the invisible lives that LGBT persons live cut them off from information and services related to HIV/AIDS.

Similar to the issues of the LGBT community, sex workers are another population in Uganda at high risk of HIV, whose protection is limited due to the criminalization of living off the earnings of prostitution. Sex workers face

harassment by law enforcement officers, who arrest them under the charge of being "idle and disorderly", an offense under the Penal Code. They also face sexual violence and exploitation, which they endure in silence because they lack an effective legal basis for seeking redress.

6) Laws on Marriage and Divorce

Uganda's 2004-2005 HIV zero-behavioral survey indicated that the largest proportion (42%) of people living with HIV are in the category of married or in long-term relationships. The process of amending laws on marriage and divorce towards a more just and gender-equitable family law has gone on for over 40 years in Uganda. During the term of the 7th Parliament (2001-2006), efforts went as far as drafting a Domestic Relations Bill (DRB) in 2003, which invoked a lot of controversy among various stakeholders and ultimately forced government to stall the process. Among the most controversial proposals in the DRB, which also had a direct bearing on women's HIV vulnerability, were to out-law polygamy, marital rape and ensure equal property rights.

By setting out different grounds for divorce for men and women, Uganda's law on divorce for a long time constituted a major hindrance to women wishing to get out of marriages that among other things exposed them to the risk of HIV/AIDS. Risk factors within marriage include extra-marital sex, insistence on unprotected sex and rape. In 2003, the law governing divorce in Uganda was successfully challenged in court, and major sections of it were declared unconstitutional on the grounds of non-discrimination and promoting equality of the sexes. Within the context of HIV/AIDS and Human Rights, the decision enhanced protection for people especially women in marital relationships that placed them at risk of contracting HIV/AIDS from their partners.

7) Criminal Adultery and Succession

Prior to April 5, 2007[17], the Penal Code Cap. 120 contained varying definitions of criminal adultery for men and women. The definitions effectively allowed

17 Date of the ruling on "Law Advocacy for Women in Uganda v Attorney General - Constitutional Petitions Nos. 13 /05 /& 05 /06"

married men to have sexual intercourse with any woman not being married, while married women were prohibited from having sexual intercourse with any man regardless of their marital status. Apart from contravening the principle of equality between the sexes, the law made it difficult for women to prove adultery in divorce proceedings. Moreover, as noted above, the divorce law previously required women to prove an additional ground to adultery in order to seek a divorce. The combination of these two laws left many women trapped in adulterous marriages, leaving them at serious risk of contracting HIV. In addition to the unequal grounds of divorce, the adultery provisions were also successfully challenged in the Constitutional Court on nondiscrimination grounds.

The grounds for challenging the discriminatory definition of criminal adultery were also used to successfully challenge certain provisions in the Succession Act regarding heirship, distribution of intestate estates, appointment of a testamentary guardian, choice of domicile, and remarriage while in occupancy of the matrimonial home. The restriction of heirship to the male child was found to be discriminatory against females; distribution of intestate estates was found to be discriminatory against women in polygamous unions; and widows were indicated to have an automatic right to appointment as guardians with a right to remarry and retain occupancy of the matrimonial home. These are all among the many areas in which widows and orphans affected by HIV/AIDS traditionally suffer much injustice. The successful Constitutional Petition Nos 13/05/&05/06, if disseminated and enforced, can therefore be utilized to protect woman's rights and health.

The constitutional petition created gaps in the laws containing the challenged provisions. In the absence of an amendment of the underlying legislation or the enactment of a new, gender-equal law on domestic relations, courts must handle domestic relations matters on a case-by-case basis. This has its disadvantages in that, if the presiding judge is not gender-sensitive, they could apply discretion to deny justice and undermine the decision in the constitutional cases.

8) The Public Health Act Cap. 281

The Public Health Act consolidates Ugandan law regarding the preservation of public health. The Act defines an infectious disease as one that "can be communicated directly or indirectly by any person suffering from it to any other person" (Section 1(u)). The Act also includes special provisions regarding certain epidemic diseases ranging from small pox to yellow fever and any other disease declared as such by statutory order. Given that HIV/AIDS was neither known nor anticipated at the time of passing this law, the Public Health Act and other related laws such as the Venereal
Diseases Act Cap. 284 need to be carefully examined and reviewed to assess how they apply to HIV and whether they have the potential to advance or undermine Human Rights.

Such a review is important in view of the Joint United Nations Programme on HIV/AIDS and the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (UNAIDS/OHCHR) International Guidelines on HIV/AIDS and Human Rights. Guideline 3 thereof requires states to review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS to ensure that their provisions are not inappropriately applied to HIV/AIDS and are in line with international Human Rights obligations.

9) HIV/AIDS Prevention and Control Act 2014

In recognition of the need to pay serious attention to the issue of HIV/AIDS, the Parliament of Uganda has passed the HIV/AIDS Prevention and Control Act in 2014, nearly 30 years after the first HIV case in Uganda was recorded. The purpose of the Act is to provide for the prevention and control of HIV/AIDS including protection, counseling, testing and care of persons living with and affected by AIDS and to establish the HIV/AIDS trust fund.
This Act is a step in the right direction in the sense that it provides for client-centered information tailored to the behavior and special needs of persons receiving counseling and testing. This inadvertently provides for youth specific information to be prepared and disseminated and this would allow greater access to HIV/AIDS information for the youth.It however provides for

mandatory testing for victims of sexual offenses and pregnant women as well as their partners, and criminalizes the spread of HIV. These provisions may deter individuals from seeking treatment in fear of possible incrimination. They also infringe on the individuals' right to privacy. The Act further violates this right, when it provides for an exception to the confidentiality of results. This is likely to encourage stigma and discrimination especially among the youth. It is generally a significant step for the Ugandan legal framework to have developed such a law and thereby address the need for special consideration of the issue of HIV/AIDS.

However, with the increasing prevalence rate and the fact that the majority of the Ugandan population is the youth, they might have been given more attention and special protections under this Act.

CASE STUDY: Analysis of the HIV/AIDS Prevention and Control Act, 2014

This is the newest addition in Uganda's national legal framework addressing the topic of HIV and AIDS. The Act was assented to on 31st July 2014. Therefore the following section will give a more detailed overview and analysis of the act with its strength and weaknesses.

Purpose: Provide for the prevention and control of HIV/AIDS including protection, counseling, testing and care of persons living with and affected by HIV and AIDS, rights and obligations of persons living with and affected by HIV and AIDS and to establish the HIV/AIDS trust fund

Analysis of key sections of the Act	
Provision:	**Part I: Interpretation and definition of relevant terms**
Implications for Youth and overall Review	This section is limited and may not cover persons such as nurses or medical officers, who are engaged in the administration of medicine and other services to persons living with HIV. Specifically, the definition of a Medical Practitioner does not take traditional birth attendants, who are predominant in the rural areas, into consideration. Moreover, the definition of Health Practitioner is ambiguous as it does not clearly identify who is considered a qualified officer and in which field.
Policy alternatives and recommendations	It is recommendable to define more clearly the terms relating to HIV/AIDS prevention and control, especially in the field of practitioners for purposes of accountability and division of roles and responsibilities, where the medical approach is concerned.
Provision:	**Part III – HIV Counseling and Testing** Section 3: Pre- and post-test HIV counseling

Implications for Youth and overall Review	This section provides for every health unit conducting the screening for HIV to also conduct counseling. This is crucial as the Youth need the availability of services and social support systems to help them with the challenges that come with the testing and management of the HIV and AIDS. However, it does neglect to address the question of availability and implementation responsibility for the identification of such a number of qualified staff necessary for this provision.
Policy alternatives and recommendations	To augment this provision, the Government should put in place a policy for the recruitment and availability of counselors, who are qualified to conduct these counseling sessions to be available at the different health units. The policy should compel all private medical facilities conducting HIV testing to have an on-site counselor.
Provision:	**Part III – HIV Counseling and Testing** Section 4: Counseling to be conducted by trained HIV councilors
Implications for Youth and overall Review	This section provides for counseling to be conducted by well trained HIV counselors. There is no provision for the training and equipping of the said personnel to deal with the different categories of people affected by the HIV scourge. The youth are a group whose interests and unique nature must be considered when training the counselors.

Policy alternatives and recommendations	Policies should be established to regulate the activities and conduct of the counselors. The policy should take into account regular training of the counselors to ensure relevance in the execution of their roles. Moreover, it is important that the government establishes robust training programs to equip the counselors with competent skills to handle dealing with youth. Therefore, the law should be amended to provide for counseling for persons compelled to undergo HIV screening.
Provision:	**Part III – HIV Counseling and Testing** Section 5: Nature of pre-test counseling
Implications for Youth and overall Review	This section provides for pretest counseling and limits it to those, who have voluntarily consented to be tested. This is limiting in a sense that even the persons, who may not directly consent to be tested still deserve to be counseled in order to not only prepare them for the test results, but also to ensure that they have fair treatment as per the constitution. The youth being compelled to undergo testing deserve counseling prior to testing to prepare them for the results. Section 5 (d) in particular is supportive to youth as is calls for client-centered information tailored to behavior and special needs of persons. This takes into consideration youth-specific behaviors and special needs.
Policy alternatives and recommendations	The sections as very strong and promising as it is, therefore the only recommendation can be to ensure proper and diligent implementation of the set standard here.

Provision:	**Part III – HIV Counseling and Testing** Section 6 (2): Post testing counseling – information to be made available
Implications for Youth and overall Review	This section deals with the access to and especially scope of information provided to an infected person. This is crucial to the needs of the youth as it is the only way to enable positive living with HIV/AIDS. However, this comprehensive information should not be limited to HIV-positive persons as aftercare but be used more aggressively in prevention strategies as well.
Policy alternatives and recommendations	Besides this provision of information for HIV-positive persons, there should be increased emphasis still on continuous HIV awareness and education at all levels of society.
Provision:	**Part III – HIV Counseling and Testing** Section 8 (2): Confidentiality of the test results Section 8(4): Criminalization of unlawful disclosure of results
Implications for Youth and overall Review	The sensitivity of the medical information necessitates that the patient is assured that his information will not only be kept safe but also used by the medical practitioner only for appropriate and strictly professional purposes. This necessitates that all persons engaged in the management and treatment of persons living with or affected by HIV/AIDS should ensure that they maintain the strictest confidentiality when dealing with information concerning persons with HIV/AIDS. Therefore, this section is highly relevant and necessary. However, there is no specific penalty provided for this offence, which in effect makes the offence incomplete and non actionable as Section 42 (Offences relating to breach of confidentiality) is limited to offences related to breach under Sections 16 and 17, not including this section.

Policy alternatives and recommendations	This section is in itself highly important, however, the lack of clarify on the issue of the office of breaching confidentiality is leaving it without much impact. It should therefore be better embedded in the overall structure of offences regarding this topic or carry its own penalty guideline. Moreover, the law should not be limited to the identity but also information regarding the results and finding concerned with the patient which must also be kept confidential.
Provision:	**Part III – HIV Counseling and Testing** Section 11, 12 and 13: Mandatory routine tests for victims of sexual offences, pregnant women and their partners
Implications for Youth and overall Review	This section infringes of the legal presumption of innocence. Moreover, mandatory testing in the context of sexual violence is a deterrent to persecuting this strongly under-reported offence. Finally, young mothers and children will disproportionately be affected by the mandatory testing provisions and therefore most likely be subject to increased stigmatization.
Policy alternatives and recommendations	As this section is highly sensitive, it should be reviewed more carefully and augmented with suitable provision to cater for the challenges related to vulnerable people in forced testing situations. Moreover, emphasis should be focused more heavily on encouraging voluntary testing and increasing HIV education.
Provision:	**Part III – HIV Counseling and Testing** Section 14: Testing under a court order
Implications for Youth and overall Review	This is a clear infringement on the right to privacy and encourages discrimination and stigmatization, especially within the legal and penal system.

Policy alternatives and recommendations	This section and all others describing exceptions to the voluntary testing ethos, should be very carefully reviewed and taken out in cases where the protection of the forcefully tested person against abuse of the information or the provision itself cannot be fully guaranteed.
Provision:	**Part III – HIV Counseling and Testing** Section 18 and 19: Confidentiality of results
Implications for Youth and overall Review	The provisions in this section strongly encourages voluntary testing and thereby have a positive effect in information and awareness within the population.
Policy alternatives and recommendations	This section should be strictly enforced and all exceptions to it very carefully considered and possibly canceled.
Provision:	**Part III – HIV Counseling and Testing** Section 20: Exceptions to confidentiality
Implications for Youth and overall Review	Any exceptions to the confidentiality clauses violate basic rights to privacy. Therefore this section giving medical practitioners seemingly autonomous powers to disclose information is in violation of those rights. In practice, Medical practitioners are not permitted to disclose results. Even for medical research, no disclosure of person’s results is permitted.
Policy alternatives and recommendations	This section should be clarified to identify the cases that might lead to disclosure of results and eliminate all that happen outside the medical professional field and without the consent of the person in question.
Provision:	**Part IV – Govt responsibilities** Services/facilities to be provided on a non-discriminatory basis

Implications for Youth and overall Review	This section clearly states the non-discriminatory nature of all HIV/AIDS services and facilities and takes into consideration the most at risk populations. However, the definitions of most at risk populations does not specifically include youth, which means that only sections of the youth population falling into the chosen categories are being considered with special attention. Youth as a whole group however, needs to be taken into consideration.
Policy alternatives and recommendations	The definition of most at risk populations should be expanded to specifically include the youth.
Provision:	**Part V – HIV and AIDS Trust Fund** Section 27: Sources of moneys to the funds
Implications for Youth and overall Review	This sections provides for the funding of the efforts towards HIV/AIDS control and prevention. While it identified a 2% margin of tax income from beers, spirits, waragi, soft drinks and water, this is not an adequate amount to be backing up the national efforts and more sources of funding should be specifically identified.
Policy alternatives and recommendations	The margin of contribution from the tax on beers, spirits etc should be increased from 2% to a relevant amount. Moreover, oil revenues and others should be specifically identified to contribute into the fund.
Provision:	**Part VII – Discrimination on Grounds of HIV Status** Section 32 - 38: Discrimination in all areas of life
Implications for Youth and overall Review	These provisions build a strong basis for the protection of persons living or being suspected of living with HIV/AIDS. Especially attendance and non-discrimination in schools and the work place is of key importance to the youth.

Policy alternatives and recommendations	While a solid basis is established through these sections, its implementation will be a challenge and required diligence on the side of all stakeholders involved. Moreover, while it is positive to include schools as a space for definite non-discrimination, this entry point into the education system should be expanded to also include it in information and prevention efforts.
Provision:	**Part VIII – Offences and penalties** Section 43: Intentional transmission of HIV
Implications for Youth and overall Review	The difficulty in determining 'willful and intentional' transmission makes it a possible deterrence of voluntary testing, as a person unaware of their HIV status would never be threatened to be convicted for this offense and an HIV-positive person dealing with the disease would always be at risk of being convicted for accidental transmission. Moreover, the question of consent that provides the basis for one of the two exceptions to this offense has to be considered in the context of a legal framework that does not recognize marital rape.
Policy alternatives and recommendations	The provision should be reconsidered in light of the two aforementioned concepts of deterrence from voluntary testing and marital consent.
Provision:	**Part VIII – Offences and penalties** Section 45: Misleading information
Implications for Youth and overall Review	This section is highly relevant in a context where ample misinformation on the issue of prevention and treatment of HIV/AIDS exist and form a crucial barrier to effectively addressing the issue.
Policy alternatives and recommendations	This and other sections that include sensible liabilities, should be augmented to include more specific guidance on enforcements of these penalties, especially in this case of misinformation from sources considered as authorities within society.

This analysis reveals a generally strong law tackling the issue of HIV and AIDS. However, with the increasing prevalence rate and the fact that majority of the Uganda population is the youth, they and their special circumstances and needs should be given special protections in this Act.

CHAPTER 4:
Policy Recommendations

After reviewing and analyzing the different policies and laws presented in the paper, the main concern that remains is whether the laws in place are efficient and can be implemented to help prevent, curb and reduce the level of new infections among young people. The recommendation would be to encourage the lawmakers and implementers to ensure the laws are complied with by the relevant agencies and bodies dealing with issues of HIV/AIDS. Youth groups should be empowered to monitor the implementation of these laws, policies, plans and guidelines. The following summarizes the overall recommendations made throughout the analysis and gives additional concluding remarks on areas of concern.

1. Fast track the HIV AIDS Policy and other related policy documents

The Government should pass the National HIV Policy that has been before cabinet for close to two years. Moreover, all other national policies have to be aligned to the HIV Policy in order to ensure policy and strategic coherence and avoid duplication and resource wastage. In the same vein, the Alcohol and Substance Abuse Policy must also be fast tracked given the co-relation between alcohol and substance abuse and HIV/AIDS. It must reflect areas of HIV/AIDS prevention and also specifically cover the drug injecting youth as a risk group.

2. Improve youth access to HIV /AIDS information and services

2.1 Targeted capacity building for youth groups

While lawmakers and implementers should ensure that relevant agencies and bodies act in accordance to HIV/AIDS laws and policies, youth groups must be equipped with the capacity to monitor the implementation of these laws to ensure understanding and compliance, while addressing any emerging ambiguities.

2.2 Provision of a clear definition of "youth friendly services"

Although many policy documents mention "youth friendly services", these are often not supported, made mandatory or specified. This might present a challenge for implementers, who rely on the HIV/AIDS policies for guidance on the provision of "youth friendly services." It is therefore important for the government to clearly define these "youth friendly services" so as to improve youth access to HIV/AIDS information and services.

2.3 Improve Health Worker Attitudes

The attitude of health workers is a major factor in the delivery of youth friendly services on HIV. Medical professionals must be consistently reminded of the need to practice confidentiality and professionalism while delivering information on HIV/AIDS to young people. Breach of these standards may make many young people averse to accessing quality care and support at designated health centers.

2.4 Authorize lower health centers to distribute antiretroviral drugs (ARVs)

Under the current operational guidelines, lower health centers are not authorized to distribute ARVs. However, this policy should be adjusted to allow such health facilities to distribute ARVs with caution. This will result in increased access to life saving and sustenance medication, especially to young women and children living in remote areas which are not close to main hospitals and other designated centers. However, for this strategy to register positive results, the government has to increase health service monitoring and support, so as to identify and close service delivery gaps and also minimize misuse and abuse of medication. This role could be executed in collaboration with young people.

2.5 Youth responsive HIV funding

Youth responsive HIV financing should be prioritized to ensure that youth specific services are supported to increase and ensure access to medication and services in a youth friendly and supportive manner. The current efforts in this area should be bolstered since, as reflected in the initial parts of this

publication, young people still decry the lack of tailor-made treatment and support services for not only young people living with HIV, but for youths in general. More funding thus has to be channeled towards youth tailored treatment, support and information services.

2.6 Acquire youth specific data to inform planning

HIV research and data should be disaggregated by age to clearly identify youth – even among the key at risk populations to improve HIV intervention strategies. The absence of accurate HIV data especially for children transitioning from childhood into adolescence or youth makes development and application of relevant interventions and support a challenge.

2.7 Strategic Management of Interventions

Oftentimes, HIV behavioral surveys have informed national HIV/AIDS interventions. In many instances, they have led policy makers and implementers to focus on one group over the other and also abandon some prevention messages and strategies. However, even in the face of such surveys, it is important to ensure that no age group or category of persons is sidelined. Although the available data clearly shows that there is a worrying increase in HIV among married persons, youth focused interventions should not be put on hold. The government must ensure that the gains made over the years in the fight against HIV are not lost in the course of addressing emerging challenges.

3. HIV Financing

3.1 Promoting private sector financing of the HIV/AIDS sector

There is a need to encourage the monitored involvement of the private sector in HIV/AIDS prevention efforts as part of their corporate social responsibility. This will ultimately supplement government budgetary support to this important cause. In Rwanda for example, MTN Rwanda, one of the largest private telecommunication companies in the country, has been involved in the promotion of HIV prevention targeting young people. This has been done through supplementing the Rwanda Government's HIV/AIDS program expenditure.

3.2 Encouraging Insurance Companies to cover HIV Prevention and Care

Insurers must be encouraged to also extend health cover to HIV infected persons. A deliberate effort/incentive to encourage insurers to provide cover for both HIV infected persons and prevention aspects will go a long way in providing social protection and also reducing the burden placed on families.

3.3 National policy reforms to improve HIV financing

All policies that target HIV/AIDS and youth interventions should include clear national financial commitments that are intended to ensure successful policy implementation and optimize fund allocation. There should be a government budget requirement for all sectors to allocate specific budgets for all cross-cutting issues such as HIV and AIDS.

4. Improve HIV support services at the workplace

Beyond medical insurance, the government, in collaboration with employers and other stakeholders, should encourage the establishment of HIV support and information services at the workplace in order to ensure that the workforce has the timely information and support to be able to live productive lives. Currently, employers that have strengthened HIV support have done so at their own discretion, because law does not largely enforce this aspect. This is an area that needs to be strengthened so as to provide employees with the utmost care and information.

It is however important to highlight a major weakness of the current policy on HIV and the Workplace, which lies in its focus on formal employment leaving a relevant majority of the population out of the picture. The policy also over-relies on the employer. There is therefore need to ensure that other actors take up the “burden” of providing HIV/AIDS supportive workplaces and where employers are excelling, due credit should be given to encourage similar positive and supportive behaviour.

5. **Encourage age and context appropriate sexual and reproductive health education**

Two schools of thought exist on who should be mandated to provide sexual and reproductive health education and the content and depth of the material to be disseminated. While some argue that this role should be left entirely to parents, there are others who hold the view that education institutions have a critical role to play. Although these divergent positions exist, it is clear that there is need to identify mechanisms that allow for age and context appropriate HIV related information to be provided to children and youth in institutions of learning on a consistent basis. This will complement education on the same issues that is already provided to these target groups outside school spaces. Young people and children that are a vital demographic in the wider development context of Uganda will therefore be equipped with knowledge and information on HIV prevention and management.

Furthermore, dissemination of HIV-related prevention and management information should be a joint effort of both parents and educational institutions. There appears to be an emerging gap between in-school interventions aimed at addressing the HIV/AIDS challenges and HIV messaging in different homes and community settings, where children and youth spend an almost equal amount of time. Parents, guardians and caretakers must be brought on board to complement HIV prevention efforts by participating in the formulation and dissemination of HIV prevention messages. In the African context, parents are a source of nurture and authority and to this extent, they have a strong mandate and influence over their children. They must therefore be encouraged to talk to them and support their children on safe sexual behavior. Their increased involvement will in the long-run ensure the effectiveness of HIV/AIDS prevention messaging and guarantee an environment of support and care for young people inside and outside the school environments.

6. **Behavioral Change Information and Communication**

6.1 Young peoples involvement in HIV/AIDS messaging

Young people must be actively involved in the development of HIV prevention

messages since they are well aware of the challenges they face on a day to day basis and may have ideas on how these can be addressed. In addition, young people living with HIV need to be specifically involved in the design, implementation and evaluation of programmes aimed at addressing their needs.

6.2 Revival of prevention initiatives

The government must revive the previously vibrant HIV prevention initiatives that were a major source of identity, information and peer support to young people. These had targeted age appropriate information and messaging and more importantly, ensured that young people, who primarily get their initial sex education and experiences from fellow young people, had the accurate information for prevention and management of HIV/AIDS. The government must therefore work towards an overhaul of the health sector service delivery approach by reinforcing prevention as much as the treatment and management components.

6.3 Emphasize sex education over sex prevention

The harsh reality all policy makers and other stakeholders in the HIV prevention struggle must acknowledge is that many young people are sexually active. Messages should therefore be realistic. Specific definitions on the messaging content, to include sex education over sex prevention (realize ABC± as put in the National Development Plan), should be strengthened to provide for clarity for policy makers, actors and target populations.

6.4 Address emerging trends and HIV/AIDS

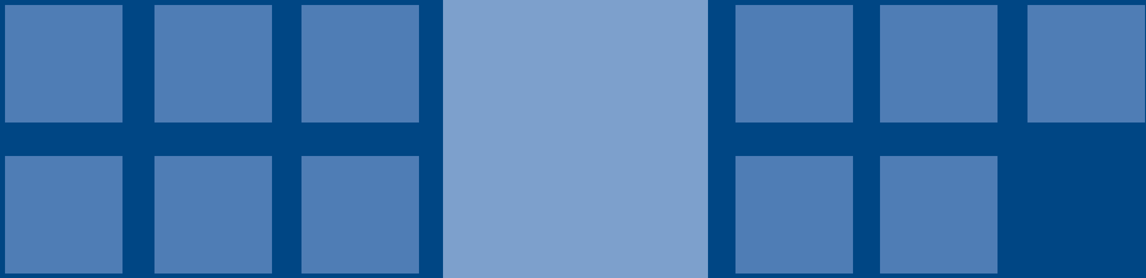
It is important for interventions to address the risky behaviors that are further reflected in popular culture, for example multiple sexual partners, cross-generational sex, substance/drug abuse and swingers among youth. These will inevitably increase the risk of HIV/AIDS, a fact that policy makers and implementers must bring to the notice of young people.

6.5 HIV/AIDS focused community dialogues

Community discussions should be encouraged to enable Ugandans to recount their experiences with HIV and offer their strategic recommendations aimed at ensuring a reduction in the HIV/AIDS prevalence in Uganda and availing the government with the necessary recommendations to ensure that prevention strategies can be realistically implemented. These discussions will also provide for honest exchange and reflection about emerging issues like the increased infection rates due to complacency and compromised behavior by the sexually active populace. It is through such forums that every Ugandan including young people will recognize their role in the prevention and management of HIV/AIDS in the country. Furthermore, government should encourage community/local leaders to occasionally convene open discussions/dialogue on HIV/AIDS related issues within the community. These should feature health experts as well as local resource persons openly educating the community and sharing experiences on HIV/AIDS.

7. Encourage Public Hearings and Dialogues on Human Rights and HIV/AIDS

Public hearings and dialogues must be organized to build consensus on controversies arising within the Human Rights field as a result of HIV/AIDS. The dialogues need to focus on critical issues such as the criminalization of transmission, mandatory testing for sexual offenders and such others. The outcome of such discussions may be used to inform relevant and ethical actions in the fight against HIV/AIDS.



Konrad-Adenauer-Stiftung e.V.Uganda
Plot 51 A, Prince Charles Drive, Kololo,
P.O. Box 647 Kampala, Uganda
Tel: +256 - (0)393 - 262011/2
www.kas.de/Uganda/en