

Assessing the effects of anti-homosexuality legislation in Uganda on HIV prevention, treatment, and care services

Paul Semugoma, Chris Beyrer, Stefan Baral

Abstract

Uganda's response to the HIV epidemic has been lauded for its robustness and achievements. However, a key component of HIV prevention programming has been missing, for men who have sex with men (MSM). The main reason cited has been criminalization of male homosexual behavior. In 2009, the Anti-Homosexuality Bill (AHB) was introduced in the parliament to enhance existing anti-homosexuality law. A multi-disciplinary team made a Health Impact Assessment of the proposed AHB. The bill as tabled would severely increase punishments, increased closeting. Social capital of MSM would be eroded by clauses mandating reporting by friends, relatives, and acquaintances. Health-care professionals would have to inform on homosexuals. Mandatory HIV testing would be a blow to programming. Probable disclosure of HIV status in a public space (court) would also be a deterrent. Heftier punishments for those testing positive increases stigma and hobbles subsequent care. The AHB argues for exclusion, and more discrimination targeting persons living with HIV and sexual minorities. It will exacerbate the negative public health consequences of the existing legislation. The government of Uganda should review guidance documents published by authoritative bodies including the World Bank, World Health Organization to develop and bring to scale Human rights-affirming HIV prevention, treatment, and care responses.

Keywords: HIV, homosexuality, MSM, Uganda, anti-homosexuality law, criminalization

Résumé

La réponse Ougandaise sur l'épidémie de VIH a été saluée par sa robustesse et ses réalisations. Mais, l'élément clé du programme de la prévention du VIH demeure manquant, pour les hommes ayant des rapports sexuels avec des hommes (HSH). La principale raison invoquée a été la criminalisation du comportement homosexuel masculin. En 2009, le projet de loi anti-homosexualité (AHB) a été présenté au parlement pour renforcer la législation contre la loi sur l'homosexualité. Une équipe multidisciplinaire a été composée pour évaluer l'impact de la santé sur la dite loi (AHB) proposée. Le projet de loi tel que déposé avait sévèrement augmenter de punitions, ce qui augmente closeting. Le capital social de MSM serait érodée par des clauses rendant obligatoire de rapports par des amis, parents et connaissances. Les professionnels de la santé seraient tenus d'informer sur les homosexuels. Le dépistage obligatoire du VIH serait un coup dur pour la programmation. Probable, divulgation du séropositivité statut dans un espace public (tribunal) serait aussi un moyen de dissuasion. Lourdes peines pour ceux qui augmenteraient la stigmatisation en testant positifs et entraveraient les soins ultérieurs. L'AHB plaide pour l'exclusion et la discrimination des personnes ciblées vivant avec plus le VIH et les minorités sexuelles. Il va exacerber les conséquences négatives de la santé publique sur la législation existante. Le gouvernement Ougandais doit examiner les documents d'orientation publiés par des organismes faisant autorité, y compris la Banque mondiale, l'Organisation mondiale de la santé pour développer et mettre à l'échelle les droits de l'homme en affirmant la prévention du VIH, de traitement and de réponses de soins.

Mots-clés: VIH, l'homosexualité, MSM, l'Ouganda, la loi anti-homosexualité, la criminalisation

Background

The Uganda HIV response was described a success borne out by observed decreases in HIV incidence and ultimately prevalence in the mid 1990s. Uganda has been a regional leader in ARV access, and with U.S. PEPFAR and Global Fund support it now has some 200,000 people on ARV therapy (UNAIDS 2010). Current HIV surveillance systems have demonstrated continued declines in

incidence among young women of reproductive age who have higher burden of HIV infection in the population (Westerhaus 2009). But routine surveillance has not evaluated HIV infection levels among certain key populations with limited data on female sex workers and men who have sex with men (MSM). However, there is now data highlighting a disproportionate

Paul Semugoma, MD, African Men for Sexual Health and Rights, (AMSHer) Global Forum for MSM and HIV (MSMGF).

Chris Beyrer, MD, MPH Professor of Epidemiology, International Health, and Health, Behavior, and Society Director, Center for Public Health and Human Rights Associate Director, Johns Hopkins Center for AIDS Research Johns Hopkins Bloomberg School of Public Health 615 N. Wolfe Street, E 7152 Baltimore, MD 21205, USA.

Stefan Baral, MD, MPH, MBA, CCFP, FRCPC, Associate Director, Key Populations Center for Public Health and Human Rights Department of Epidemiology Johns Hopkins School of Public Health E7146, 615 N. Wolfe Street Baltimore, MD 21205, USA.

Correspondence to: semugoma@gmail.com

burden of HIV among MSM in Uganda mirroring other African countries (Beyrer, Baral, van Griensven, Goodreau, Chariyalertsak, Wirtz, *et al.* 2012; Hladik, Barker, Ssenkusu, Opio, Tappero, Hakim, *et al.* 2012). Research among MSM in Uganda has been limited by structural and policy-level issues including that Uganda, similar to other countries with British colonial histories, has longstanding legislation interpreted as criminalizing same-sex practices (Baral, Diouf, Trapence, Poteat, Ndaw, Drame, *et al.* 2010; Kajubi, Kanya, Raymond, Chen, Rutherford, Mandel, *et al.* 2008). The relevant section of the Uganda Penal Code Act states

Section 145. Unnatural offences.

Any person who—

(a) has carnal knowledge of any person against the order of nature;. . .

(c) permits a male person to have carnal knowledge of him or her against the order of nature,

commits an offence and is liable to imprisonment for life.¹

This criminalization has been cited as one of the primary barriers to comprehensive HIV prevention programming for MSM, a well-recognised key population (Beyrer, Wirtz, Walker, Johns, Sifakis & Baral 2011; Smith, Tapsoba, Peshu, Sanders & Jaffe 2009), and key population in HIV epidemiology (Muhaari 2009). The situation is similar throughout much of Mother Africa.

On 13 October 2009, Ugandan legislator David Bahati introduced the Anti-Homosexuality Bill No 18, in the Ugandan Parliament (Olukya 2010). The aim was to enhance existing anti-homosexuality laws. It included heavier punishments and criminalization for direct and indirect support for same-sex practices including a requirement to report perceived homosexuals, and deny shelter and punish those who do not comply. The bill was time barred in the 8th parliament May 2011 and was reintroduced in the current (9th) parliament in February 2012.² Public debate was heated and predominantly one-sided with commentaries in media, churches, mosques (Monitor 2011), and other venues favouring the bill becoming a law. Moreover, there were several well-attended public demonstrations and marches for the bill (Monitor 2011).

While not yet a law, the bill has already had tangible impacts on MSM and other sexual minorities in Uganda. This commentary investigates the potential health effects of the proposed legislation by analysing potential downstream effects on the social and political debates around the law, on HIV risk among MSM in Uganda, and more broadly among others at risk of or living with HIV in the country.

Analysis and results

A multidisciplinary team was assembled including Ugandan physicians, local HIV/AIDS service providers, and international HIV/AIDS prevention experts to complete a Health Impact

Assessment. The HIA assessed key stakeholders for their opinions and expectations of health effects related to this policy by examining the bill text, clause by clause, to disaggregate the varying determinants of health. Literature was reviewed to assess outcomes of similar policy measures on the coverage of health services including provision and uptake of HIV prevention, treatment, and care services.

The Bahati bill is much broader than existing legislation by increasing sanctions for same-sex practices to include capital punishment. Studies among MSM in Africa have consistently described a population that is hidden and reluctant to seek health care because of fear of being purposefully or inadvertently disclosed as a man who has sex with other men (Niang, Tapsoba, Weiss, Diagne, Niang, Moreau, *et al.* 2003). The law would drive these men further underground. Indeed, the most recent study of MSM in Uganda highlighted homophobia as being significantly associated with HIV infection highlighting the importance of this structural barrier in limiting the effective provision of care (Hladik *et al.* 2012).

Yet, the mandate of the bill goes further:

To 'impose a burden on the community to report homosexuals', all 'persons in authority', defined as one with 'power or control over other people because of your knowledge and official position . . . including . . . social authority' are by law required to report them within 24 hours to authorities. Failure to report leaves one liable to a fine or imprisonment.

This clause can apply to health care consultations when sexual practices and/or orientation is disclosed, voluntarily or not. Standard of care in health care settings implies that confidentiality is maintained unless there is imminent risk to self or others, posed by non-disclosure. Such violation of the Hippocratic Oath, and of professional ethics across many fields would decrease the likelihood that clients would disclose their sexuality to receive appropriate care or services. Separately, in a homophobic environment providers could be un-willing to provide services to these men. Through the limitation of the uptake of services and provision of services, coverage of HIV prevention, treatment, and care services to a population that has been demonstrated to carry a very high risk for HIV will decrease.

Provisions in the bill defining and criminalising 'aiding and abetting homosexuality' would punish landlords, healthcare providers, lawyers, and even friends, for failure to disclose alleged homosexuality. This is an assault on community structures, preventing the development of social capital among MSM, including that focused on 'institutions, relationships, attitudes, and values that govern interactions among people and contribute to economic and social development'. The limited ability to develop social capital has been shown to be associated with low self-efficacy and a dearth of community infrastructure among MSM, arguably limiting the effectiveness of HIV prevention interventions. The development of community-level social capital for MSM itself, even as a means of preventing HIV infection, would be criminalized.

The bill specifically defines and criminalises 'promotion of homosexuality' targeting the 'funding', 'sponsoring', 'offering premises for ... homosexuality or promotion of homosexuality'. There is a definition and criminalisation of 'conspiracy to commit homosexuality'. A service provider that provides HIV-risk-reduction counseling, peer education, condom and condom-compatible-lubricant distribution, irrespective of the source of funds, would risk fines and/or imprisonment. This portion of the bill potentially prohibits all HIV prevention, treatment, and care services for acknowledged MSM, and even sexual health education programmes mentioning homosexuality. The Ministry of Health in Uganda has a programme for most at-risk populations (MARPS) in Kampala focused on HIV prevention which includes MSM. In the context of the proposed law, this programme would be illegal and would have to terminate. In April 2009, a UNICEF teenage peer-education handbook, focused on providing sexual health education, was vilified as promoting homosexuality because it included a passage on same-sex attraction (Hobbs 2011),³

For HIV seropositive MSM;

Clause 3 (1), b 'A person commits the offence ... aggravated homosexuality where the

b) Offender is a person living with HIV'...

Clause 3 (2) 'A person who commits the offence of aggravated homosexuality shall be liable on conviction to suffer Death'.

This clause highlights further penalties for MSM living with HIV, with life imprisonment in some cases. HIV-positive MSM would receive life imprisonment for 'attempted aggravated homosexuality', compared to seven years if HIV-negative. Moreover, measures by the person living with HIV to limit transmission including use of condoms, disclosure of HIV status to sexual partners, and undetectable viral load through treatment with antiviral therapy are not mitigating. Thus, disclosing HIV serostatus and same-sex practices to anybody, including health care workers, would result in those workers being forced to report the patient within 24 h potentially resulting in a life imprisonment. Thus, MSM living with HIV would be expected to be less likely to disclose their sexual practices resulting in risk misclassification with HIV case-based surveillance systems. Also, this clause with increased penalties may result in MSM being less willing to be tested for HIV limiting awareness of status and increased uptake of treatment for those who are living with HIV. Given the importance of addressing the needs of those living with HIV in controlling HIV epidemics by limiting onward transmission, this clause further highlights the interactions between the bill and biomedical interventions. Separately, disclosure of serostatus to likely sexual partners is also a risk because of the fear of blackmail thus compounding the stigma of being MSM and living with HIV.

Clause 3 (3) Where a person is charged ... that person shall undergo a medical examination to ascertain his or her HIV status'.

Potentially, any charge of homosexuality is followed by legally mandated HIV testing of the accused. HIV status would then be disclosable in a court of law, a public space, whether guilty or not of homosexuality. In effect, the bill writes into law effectively having the state sponsor the homophobia and homophobia already prevalent in the country which has now been established as a significant risk factor for HIV among MSM in Uganda.

Discussion and conclusions

The global response to HIV has made protection from discrimination of HIV-infected persons a cornerstone of programmes and policies. Inclusion of persons most at risk in HIV prevention, treatment, and care, has been a signature achievement of the fight against AIDS. The Bahati bill in Uganda is a marked retreat on all these fronts. It argues for *exclusion, for more discrimination* targeting persons living with HIV and sexual minorities. It is regressive, punitive, and, will exacerbate the negative public health consequences of existing legislation.

Predicted downstream consequences of the bill as a law include heightened HIV risk and crippled access to care for MSM, and indeed, among all people of reproductive age in the country by limiting the ability to provide evidence-based HIV prevention treatment and care. Debate of the bill resulted in fear and hiding in the community; adoption of the bill would likely be much more significant given the clauses ranging from aggravated homosexuality as a capital crime to criminalization of service provision.

The recommendations of this analysis are that the government of Uganda should review guidance documents published by authoritative bodies including the World Bank, World Health Organization to develop and bring to scale Human Rights-Affirming HIV prevention and treatment programming (Beyrer *et al.* 2011; WHO 2011). There are regional models that the government of Uganda can follow including the pragmatic approach of the government of Kenya, where despite criminalisation of homosexuality, comprehensive HIV prevention programming is being provided (National Aids Control Council OotPK, Population C 2008). As a country that receives both significant PEPFAR and Global Fund for AIDS, Tuberculosis, and Malaria (GF) funds, the Ugandan government can look into the recent guidance document from PEPFAR on MSM and HIV and the 2009 Sexual Orientation and Gender Identities Strategy of the GF (GFATM 2010; PEPFAR 2011). These documents describe evidence-based programmatic norms and a commitment to Universal Access to HIV care, both of which this bill would undermine.

Gay men and other MSM have been shown to carry a disproportionate burden of HIV and other STIs in Uganda. Those men that are still HIV-negative need and deserve preventive services. HIV-positive MSM need evidence-based disease management. Uganda is better off following Kenya in embracing the needs of these men and addressing effectively as like other vulnerable populations in the country.

Notes

1. Bill No. 18, The Anti-Homosexuality Bill 2009, Bills Supplement No. 13, 25th September, 2009, Uganda Penal Code, Ministry of Justice, Kampala.
2. Uganda, G. <http://gayuganda.blogspot.com/2011/05/parliament-closes-without-bill-becoming.html>
3. <http://www.newvision.co.ug/D/8/12/676939>. UNICEF book supports teen homosexuality New Vision, 2011.

References

- Baral, S.S.P., Diouf, D., Trapence, G., Poteat, T., Ndaw, M., Drame, F., et al. (2010). Criminalization of same sex practices as a structural driver of HIV risk among men who have sex with men (MSM): The cases of Senegal, Malawi, and Uganda (MOPE0951). In IAS (Ed.). International AIDS Conference 2010, Vienna.
- Beyrer, C., Baral, S.D., van Griensven, F., Goodreau, S.M., Chariyaletsak, S., Wirtz, A.L., et al. (2012). Global epidemiology of HIV infection in men who have sex with men. *The Lancet*, 380(9839), 367–377.
- Beyrer, C., Wirtz, A., Walker, D., Johns, B., Sifakis, F., & Baral, S. (2011). *The Global HIV Epidemics Among men who have Sex with Men: Epidemiology, Prevention, Access to Care and Human Rights*. Washington, DC, World Bank Publications.
- GFATM (2010). *Global Fund Information Note: Sexual Orientation and Gender Identities*. Geneva.
- Hladik, W., Barker, J., Ssenkusu, J.M., Opio, A., Tappero, J.W., Hakim, A., et al. (2012). HIV infection among men who have sex with men in Kampala, Uganda – A respondent driven sampling survey. *PLoS One*, 7(5), e38143.
- Hobbs, A. (2011). *The Teenager's Toolkit: Youth-to-Youth Peer Education Activities*. Kampala, HealthLink Worldwide.
- Kajubi, P., Kanya, M.R., Raymond, H.F., Chen, S., Rutherford, G.W., Mandel, J.S., et al. (2008). Gay and bisexual men in Kampala, Uganda. *AIDS Behavior*, 12(3), 492–504.
- Monitor (2011). Religious leaders to stage antigay demonstration. <http://www.monitor.co.ug/News/National/-/688334/833490/-/wgovug/-/index.html>
- Muhaari, A. (2009). High HIV-1 Incidence in Men who have Sex with Men Mombasa, Kenya. Durban, South Africa, MSM Satellite Meeting.
- National Aids Control Council OotPK, Population C. (2008). *The Overlooked Epidemic: Addressing HIV Prevention and Treatment among Men Who Have Sex with Men in Sub-Saharan Africa*. Mombasa, Kenya.
- Niang, C., Tapsoba, P., Weiss, E., Diagne, M., Niang, Y., Moreau, A., et al. (2003). 'It's raining stones': Stigma, violence and HIV vulnerability among men who have sex with men in Dakar, Senegal. *Culture Health and Sexuality*, 5(6), 499–510.
- Olukya, G. (2010). David Bahati, Uganda Lawmaker, Refuses To Withdraw Anti-Gay Bill. *Huffington Post*.
- PEPFAR (2011). *Technical Guidance on Combination HIV Prevention Among MSM*. Washington, DC, USAID.
- Smith, A.D., Tapsoba, P., Peshu, N., Sanders, E.J., & Jaffe, H.W. (2009). Men who have sex with men and HIV/AIDS in sub-Saharan Africa. *Lancet*, 374(9687), 416–422.
- UNAIDS (2010). *Report on the Global AIDS Epidemic 2010*. Geneva, United Nations.
- Westerhaus, M. (2009). Estimating incidence of HIV infection in Uganda. *JAMA: The Journal of the American Medical Association*, 301(2), 160.
- WHO (2011). *Prevention and Treatment of HIV and Other Sexually Transmitted Infections Among Men who have Sex with Men and Transgender People*. Geneva, UN.