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(NAFOPHANU)

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Civil Society Fund

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More than a Bedroom Affair

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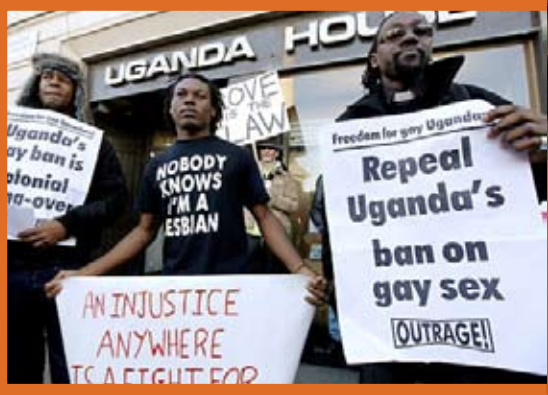

What is your risk level of HIV infection?

By Rita Tusubira

For a fact, HIV/AIDS disproportionately impacts certain groups. These groups today are commonly referred to as Most At Risk Populations (MARPs).

Early in the epidemic, HIV was most closely identified with men who have sex with men. In the early 1980s, heroin addicts, hemophiliacs and Haitians were other groups at high risk of infection .... *Page 3*

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Content

Cover photo: What is the risk level of HIV infection of this Medical personnel?

Editorial Team

Address
P. O. Box 70233, Kampala Road
Plot 213 Sentema Road - Mengo
Email: nafophanu@infocom.co.ug
Tel: +256 414 270976

Message from the National Coordinator

As the struggle to fight the dreaded disease continues, the majority of Ugandans are unaware of their status, leaving them unable to seek treatment and care or to change behaviors that might put themselves and others at risk of HIV infection.

According to recent studies, persons living with HIV/AIDS in Uganda total to over 1.300.000 with a total of approximately 350,000 people (including 50,000 children) in urgent need of treatment, but only approximately 170,000 adults, including 16,000 children are receiving treatment. Uganda loses about 65,000 people to HIV/Aids and 130,000 get infected annually. However, we can't confidently say that these figures portray an accurate statistical representation of the magnitude of the HIV/Aids problem in Uganda - precisely because only 21 per cent of the adults in this country know their status and many PLHIV receive treatment outside the country while others on private treatment are off record.

PEPFAR, the primary funder of treatment access has flat-lined its budget at $38.6 million to Uganda. PEPFAR country representatives have been instructing major treatment implementers not to enroll any new patients on treatment. Off course, this is the same with all other service providers including the MILDMAY, some of whom have even closed some ART clinics. With a few exceptions, new treatment 'slots' are only available if a patient who is already on treatment dies or in some cases if the patient's CD4 count is extremely low. For example, the Joint Clinical Research Center on AIDS (JCRC) reports that approximately 800 people in need of treatment are being turned away from clinics each month.

One of the key challenges to HCT is stigma and discrimination, yet knowing one's HIV status is the entry point into behavior change. Also research has it that if HIV infection is diagnosed early, it can be treated to reduce morbidity from opportunistic infections to prolong life.
We cannot over emphasize the need for preventive measures such as educational campaigns. However, it is imperative that the government invests more resources in efforts to enabling people live what they are, at the same time control the virus since it cheaper than maintaining patients on ARVs. One key area of prevention where government MUST heavily invest is treating those with the virus since science has indicated that proper treatment and adherence reduce the risk of transmission from an infected to a non infected.

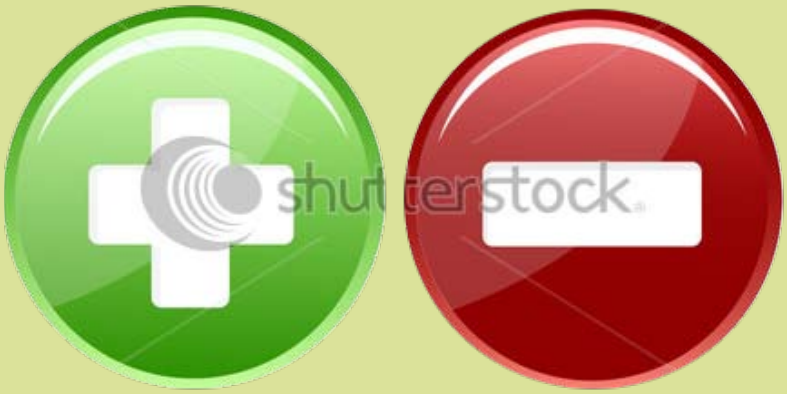
Additionally, a range of policy and program issues require attention for people who are living with HIV. NAFOPHANU has sensitized the public on factors that make individuals and communities vulnerable to HIV infection, strategies for managing them, meaningful involvement of PLHIV in program development and implementation, as well as policy making.

I would like to thank all partners, donors, and in particular Civil Society Fund, Great Lakes Initiative on AIDS, Partnership Committee/fund for enabling the Forum keeping afloat. For people living with HIV/AIDS, this is the time to carry out an assessment of our presidential and parliamentary candidates for 2011 to ensure that in their manifestoes, HIV/AIDS treatment is given priority, since life for a PLHIV is based on availability of ARVs.

Together, let's fight to improve the relevance, acceptability and effectiveness of HIV counteraction.

Kibanga Samuel James
Executive Secretary/National Coordinator
National forum of PLHIV net works in Uganda

What is **your risk level** of **HIV infection?**



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In recent years, the risk of infection has tremendously increased for other groups. Persons in these groups are usually under-represented in prevention or treatment interventions. In addition, they often suffer social stigma, isolation, poverty and marginalization, which place them at higher risk of infection. Their lack of economic opportunity may impede the use of prevention methods and access to treatment and care.

Though the risk of transmission through blood transfusion is very low in most countries, particularly where there is low prevalence of HIV or where HIV testing is conducted, it also remains a huge problem in sub-Saharan Africa.

Who are the MARPS?

- Women, children and young people are vulnerable because of their age and sex.

- Injecting drug users
- Commercial Sex Workers
- Men who have sex with men are vulnerable because they may be unable to protect themselves with safe sex
- For others, their environment or high levels of mobility leave them more susceptible to HIV infection. This mobility may be voluntary, as for migrant workers, or forced, as for victims of trafficking and refugees and internally displaced persons. Isolation from families and communities makes them more susceptible to multiple and unsafe sexual encounters.
- The uniformed forces; Army, Police and Prison.

It should be noted that other people at risk though not listed in MARPs include medical personnel, any one who does hair cuts in saloons, commercial nail/cutex polishers, among others.

Women

Around the world, women and girls are at high risk of HIV infection. Over the past 10 years, the proportion of women living with HIV has remained stable. Women comprise nearly 50 percent, or 15.5 million, of the 33 million people living with HIV/AIDS.

Young women and girls make up a growing proportion of those infected in Asia, Eastern Europe and Latin America and 43 percent of those living with HIV/AIDS in the Caribbean. They often are powerless in decisions to have sex or use a condom.

Women who are married and faithful to their husbands are at risk of HIV infection. In Uganda, the highest rates of increase of HIV transmission occur among married women.

Though marriage may appear to offer sexual health benefits for women, recent research in Kenya and Zambia revealed that this is not always the case. Married women are particularly at risk if their husbands have extramarital affairs which are common and neglect to use condoms, or inject drugs.

Women and girls have greater biological susceptibility to HIV infection.

Male-to-female transmission of the virus is twice as likely as female-to-male.
Tear and lesions, resulting from forced sexual encounters, increase the likelihood of HIV transmission, especially among younger women and girls. In Zambia, Kenya and South Africa, for example, 20 to 25 percent of women reported that their first sexual experience involved physical force.

Adolescent girls

Disadvantaged girls (poor) are often unable to access education, which decreases their access to productive employment. They are often denied the protection of property and inheritance rights.

A young woman's HIV infection or the death of her husband from AIDS may leave her without a home, unable to support herself and her children. Without job skills – or the opportunity to acquire skills – women and girls may resort to transactional or commercial sex to provide for themselves and their families, greatly heightening the risk of contracting HIV.

In 2007, it was estimated that 5.5 million young people were living with HIV – 3.4 million in sub-Saharan Africa alone. Of newly infected adults in 2007, roughly 45 percent were estimated to be aged 15-24.

In 2005, the Working Group on HIV/AIDS of the UN Millennium Project Task Force on HIV/AIDS, Malaria, TB and Access to Essential Medicines proposed a target of reducing prevalence among young people to 5 percent in the most affected countries and by 50 percent elsewhere by 2015.

Where injection drug use and men having sex with men are primary modes of HIV transmission, young males are at a greater risk of infection. Where heterosexual sex is a primary mode of HIV transmission, young females are at a greater risk for infection than young males.

In Eastern Europe and central Asia, most people infected with HIV are younger than 30; the primary mode of transmission is injecting drug use.

Interventions to stem the rise of new infections among women and girls are especially needed: keeping girls in school, providing for economic independence through vocational training and micro-credit, assuring that youth have accurate information and access to services, and addressing sexual coercion and gender-based violence.

Orphans of the AIDS Epidemic

More than half of all of the orphans in sub-Saharan Africa are between the ages 12 and 17. About 90 percent of orphans are cared for by a single parent or other family members; while most double orphans are cared for by grandparents.

Though orphans may be living with family members, they may not receive sufficient or adequate food, vigilance or support, putting them at increased risk of engaging in unsafe sexual and drug-related behaviours.

Some are forced to move several times, from home to home or from guardian to guardian. The main challenge rests in finding the most effective and appropriate ways to prevent and treat infection in these vulnerable groups without inadvertently increasing their stigmatization.

The author is Admin Assistant, NAFOPHANU

More than a Bedroom Affair

By Anna Mugambi

"WE WILL NOT ACHIEVE PROGRESS AGAINST HIV UNTIL WOMEN GAIN CONTROL OF THEIR SEXUALITY."

(Dr. Gro Harlem Brundtland, director-general, WHO, July 11, 2000.)

One week, late January 2010, Ugandans woke up to one of the most gruesome cases reported resulting from Domestic Violence. 26 year old Brenda Karamuzi was found bludgeoned to death and her body stuffed in a septic tank. One of the more lurid newspapers in Uganda promptly and rather tastelessly called her "The Septic Tank Gal". (Incidentally, it is curious but very interesting that Brenda ceased to be called by her name and instead became "The Septic Tank Gal", while her alleged murderer, a former lover, was referred to by the nickname that his friends had for him). The implication in the initial stories is that she was a "party girl" and therefore, in one way or another, deserved her fate. The suspected murderer was a 37 year old man who is by all accounts an educated man who has had more opportunities than thousands of others of his age group in Uganda where poverty levels are high.

That same week, a doctor, apparently incensed when his girlfriend refused to have sex with him, chased her down whilst she was on a boda boda (motor cycle taxi); deliberately hit the boda boda with his car and both the girl and the boda boda driver died. The day after February 14, Valentine day 2010, Ugandans again woke up to the news that a senior military officer had shot his wife to death over allegations of infidelity after finding an "incriminating" text on her phone, before he turned the gun on himself.

Yet another local newspaper that week was awash with another gruesome murder… a man killed his nine months pregnant wife, removed the fetus and buried them both, again on the alleged grounds of infidelity. Salacious headlines and horrifying photographs of women corpses are breathlessly touted by newspapers EVERY DAY. What should worry Uganda is the fact that many more are never reported. What should also ring alarm bells is the degree of violence involved … hoes, machetes; cars and all manner of weapons are used against women all over Uganda.

If this is the case, why are Ugandan women not on the streets to show their shock and anger at the implied worthlessness of their lives? Why does the image of Brenda in a septic tank not enrage women to demand for their due respect from a community that appears reluctant to address the twin issues of Domestic and Sexual Violence? Why are newspapers so quick to apportion blame on women for their plight? Why have we not had Civil Society Organizations calling for the enactment of the Domestic Violence Bill? Where is FIDA? Where are the Human Rights Organizations to educate the public on Human Rights violated and about what treaties providing for women's rights to protection against violence and to health, Uganda has ratified both internationally and regionally? Where are the mothers, the sisters and the friends of these murdered women?

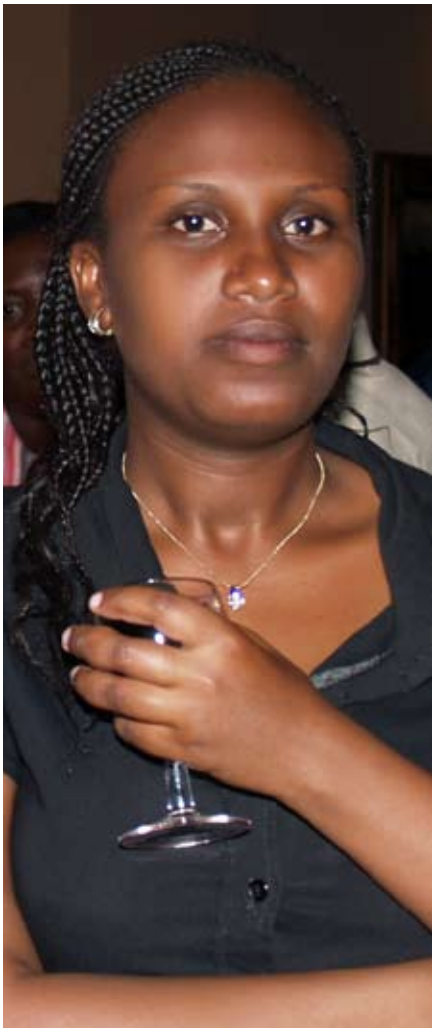
Traditional thought in Africa says that culture, economic dependence and impunity are major causes of persisting Domestic Violence in African society, but it is clear that this has now changed.

Uganda, what is going on?

Is it just me or is the Ugandan woman's growing assertiveness being paralleled by increasing violence in homes? Could the reason for an increasing number of reported cases of Domestic and Sexual Violence be that newspapers are now everywhere and can report instantly when violence happens? I have heard over and over that "these are bedroom affairs". But are they?

Obviously, not all Ugandan men abuse women, and Domestic Violence is just one of a number of factors that increase women's vulnerability to HIV transmission. Violence against women goes beyond physical beatings. It includes forced marriage, dowry-related violence, marital rape, sexual harassment, intimidation at work and in educational institutions, forced pregnancy, forced abortion, forced sterilization, trafficking and forced prostitution.

Traditional thought in Africa says that culture, economic dependence and impunity are major causes of persisting Domestic Violence in African society, but it is clear that this has now changed. Asking my Ugandan friends and colleagues as to why the murders of these women are so monstrously violent, many issues come up… the use of drugs, alcohol, love portions and property rights being the cross cutting ones. I had one



Late Brenda Karamuzi

'gentleman' ask me a question that I suppose is asked everywhere in Africa when it comes to property rights: 'How can property own property?' This reminded me of what the late Tanzanian president, Mwalimu Julius Nyerere, an early critic of such cultural practices, said during the Third World Conference on Women, (1984): "Women in Africa toil all their lives on land that they do not own, to produce what they do not control, and at the end of the marriage through divorce or death, they can be sent away empty-handed."

Uganda ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1985 and her Constitution accords women "full and equal dignity of the person with men" and prohibits "laws, cultures, customs or traditions" that undermine their welfare, dignity or status. On the other hand, there are certain customary laws and practices concerning land ownership, marital customs and child custody norms that conflict with CEDAW and women's constitutional rights. For example, marital rape is not recognized under the Penal Code, since consent to marriage is interpreted as consent to sexual activity under customary law.

Domestic violence, including marital rape, may only be dealt with under the lesser criminal charge of assault which carries with it a lower maximum sentence of up to five years imprisonment ... *continued on Page 5*

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and it does not deal with other forms of Domestic Violence, including Sexual and Psychological violence. Uganda has no specific law in place prohibiting Domestic Violence, and a draft Domestic Violence Bill has been shelved for years in parliament. The Domestic Relations Bill was tabled in December 2003, but was shelved in 2005 after it came under attack from both legal and parliamentary affairs committee members and… the public.

Working for a national PHA organization here in Uganda, the National Forum for PHA Networks in Uganda (NAFOPHANU) has allowed me to talk to many affected women nationally. Many of these women have introduced another aspect that should get all Ugandans very concerned: Domestic and Sexual Violence are yet other ways through which the rising levels of new HIV infections in Uganda are being linked to by doctors and social scientists.

Maria* is a forty three year old woman who has been HIV positive for the last ten years. Her husband died of HIV/AIDS complications seven years ago. Before he died, he routinely raped and beat her, refused to use a condom during sex even after they both tested HIV positive and publicly humiliated her for his "misfortunes". She is luckier than many - out of her three children, only one, the last born, has tested HIV positive. The similar experiences of many Ugandan women illustrate the ways in which Domestic Violence can play a critical role in rendering women vulnerable to HIV infection. As a result of violence or a fear of violence, Ugandan women are unable to protect themselves from infection and to access HIV & AIDS services.

> Investigations show that Ugandan women become vulnerable to HIV infection as a result of Domestic violence.

In addition to women's greater physiological susceptibility, social, cultural and legal forms of discrimination compound their vulnerability to HIV. Domestic Violence, already a leading cause of female injury, deprives women of bodily integrity by eliminating their ability to consent to sex, negotiate safer sex and determine the number and spacing of their children. In many cases, the threat of abandonment or eviction from their deceased husband's property constrains economically dependent women to remain in abusive relationships, thereby worsening their vulnerability to HIV infection.

Ugandan women confront a male-dominated power structure that upholds and entrenches male authority in the home. Many women view Domestic Violence as a natural by-product of marriage. Customs such as the payment of bride price, whereby men essentially purchase their wives' sexual favors and reproductive capacity, underscore men's entitlement to dictate the terms of sex. Practices such as widow inheritance by a man of his brother's widow can expose women to unprotected and unwanted sex with HIV - positive partners. When women in polygamous marriages are coerced into unprotected sex, they are exposed to a higher risk of HIV transmission as a result of the man having unprotected sex with multiple partners.

Beatrice Were, Executive Director of Uganda Network on Law, Ethics and HIV/AIDS, is on record saying that traditional attitudes insist that women are the physical property of their husbands, which deprives women of any authority over their marital sexual relations. Customs such as the payment of bride price make men feel entitled to dictate the terms of sex and use force. Ms Were is quoted as having said that lack of access to formal education, limited legal literacy and lack of familiarity with the language of the courts may make pressing charges difficult. (http://healthdev.net)

HIV is spreading faster in married couples than in any other group in Uganda. According to the National HIV/AIDS Strategic Plan, 65% of new infections are in established couples. Many married people have sex outside marriage, often without a condom. They have short or long - term girlfriends and boyfriends, some of whom have other partners that similarly don't use condoms. Several studies carried out in Uganda state that women suffer the burden of HIV and its effects more than men. Stigma is deeply rooted in the values of everyday life and causes inequality, particularly in regard to gender, race, ethnicity, and sexuality.

There have been complaints that women and girls spread HIV/AIDS but there are more females with HIV because decisions about their bodies are made by men. Therefore a woman is more likely to be blamed even when the source of her infection is her husband or partner. Infected women may be less likely to be accepted by their communities and in some cases in Uganda, women with HIV may even be rejected by their own families.

Investigations show that Ugandan women become vulnerable to HIV infection as a result of Domestic violence. Most women see Domestic Violence as part of marriage and view sex with their husbands as a marital obligation. Sixty eight percent of women in Uganda have experienced some form of domestic violence according to the country's 2006 National Demographic and Health Survey.

The Ugandan Government has failed to enact laws for the effective prosecution and punishment of acts of violence against women. Inequitable divorce laws make it difficult for women to terminate their marriages legally. The Government has yet to criminalize marital rape. Draft legislation to regulate domestic relations and sexual offenses has been pending since at least the early 1990s, despite vigorous lobbying by many of our local NGO partners. Moreover, none of the pending legislation adequately addresses Domestic Violence - nor will it as long as the Government upholds the notion of the inviolability of marital privacy and fails to address discriminatory marriage and property laws that impede women's escape from abusive marriages.

The first ever Domestic Violence By-Law in Uganda was passed on Friday 5th October, 2007 by Kawempe Division Council. Kawempe Division Domestic Violence By-Law is the first of the kind to be passed by Local Government Council in Uganda. The Local Government Act CAP. 243 of the Laws of Uganda confer upon Local Government Councils powers to make By-Laws that apply to all areas with in the jurisdiction of their Councils.

The Government of Uganda has taken some steps to improve the police response to family matters but has failed to identify and deal

> Sixty eight percent of women in Uganda have experienced some form of domestic violence according to the country's 2006 National Demographic and Health Survey

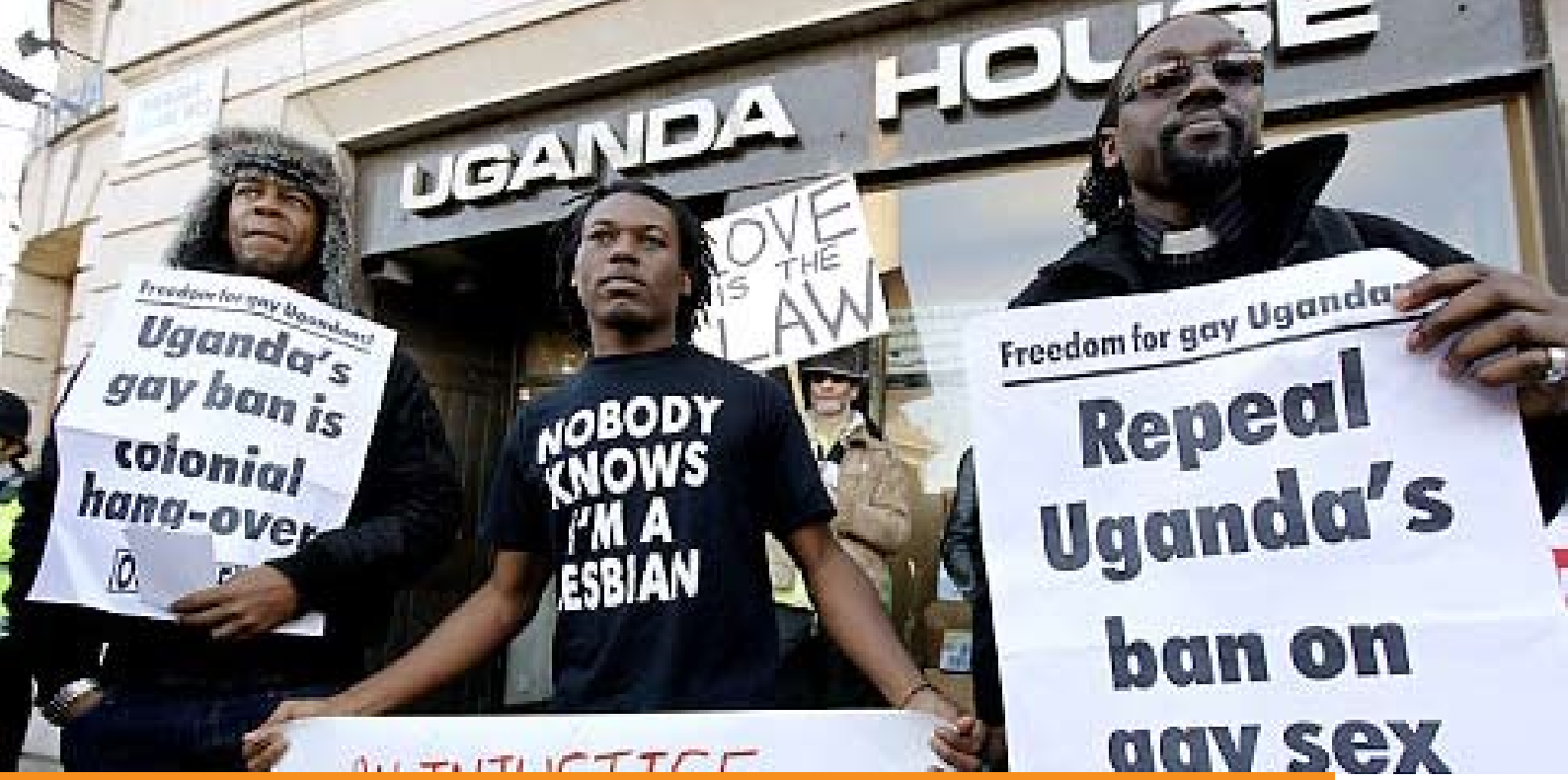
with the effect of violence within long term unions. Meanwhile, the transmission of HIV to women is proving fatal. The fight against HIV/AIDS has not extended to include combating domestic violence and rape within marriage but these are important determinants of HIV risk.

In December 2009,iIn a public expression of political will, the Speaker of the Ugandan Parliament, Hon. Edward Ssekandi, signed on to UNIFEM's Say No – Unite to End Violence against Women Initiative. Hon. Ssekandi committed to passing new legislation for the protection of women and girls by saying that "(We) … shall support other ongoing efforts geared to prevention and protection of people affected by this problem in the country and the sub region. The Parliament shall also strengthen its oversight role to ensure these laws are implemented and that there is accountability."

The correlation between domestic violence and women's vulnerability to HIV infection adds considerable impetus to the need for the Government to address seriously and meaningfully Domestic Violence against women. There is clearly an urgent need for the Government to enact progressive, gender-specific, and effective Domestic Violence legislation, and to make women's rights, health, and physical integrity a central focus of forthcoming strategies.

Is Domestic and Sexual Violence a "bedroom affair"? I hope not. I hope that the realization of the lack of access to justice by women victims of Domestic and Sexual Violence in Uganda may just be the requisite spur to amplify the issue of respect for greater respect for Women's Rights in Uganda.

Anna is a VSO volunteer with NAFOPHANU



New **Anti Homosexuality Bill** threatens HIV/AIDS management

By Kikonyogo Kivumbi

A doctor or any medical practioner who treats, counsels or offers care to an HIV/AIDS gay client risks three years in jail should a new bill tabled before Parliament pass as it is.

The medical practioner shall be required to report their clients using information that has come to them by virtue of their job to the police within 24 hours. This is against the medical ethics of confidentiality and the Hippocratic Oath.

The Anti Homosexuality Bill 2009 tabled by Ndorwa West County (Kabale district), Member of Parliament, Mr David Bahati also seeks to introduce a death penalty or life imprisonment for homosexuals in Uganda. The bill tabled on October 14, 2009 is to be debated starting March this year, after Parliament returns from the festive recession.

The bill's clauses have far reaching negative consequences for the treatment, care, and human rights of people living with HIV/AIDS. Yet many civil society organizations have not come out loudly for fear of being associated with homosexuality – still a taboo in Uganda.

As part of the campaign to senstise the public and CSOs on the implications of the new 'Bahati' bill, Uganda Health and Science Press Association is encouraging members to read the text of the bill, and not merely shun it.

The spirit behind the bill encourages stigmatization of PLHA who are homosexuals, bisexuals or transgender from seeking assistance in medical facilities in Uganda. It also implies that the people who are believed to be gay cannot be treated in Uganda's public health infrastructure, and hence fuelling the spread and poor management of HIV/AIDS, yet many CSOs have fought hard to be where we are as a country in the battle against the pandemic.

Uganda currently has 6.7% of the 33 million populations living with the virus, a sharp decline from over 30% in the 1980s. This has led Uganda to be credited as an example to many countries in reversing the pandemic through openness which the Anti-Homosexuality Bill 2009 is trying to block for fear of imprisonment and death sentence.

One of the outstanding clauses in the bill is the restriction on medical reports to be made public through media reports, citing confidentiality during court trials.

If this bill goes through, it will be a major setback for Uganda, since the Joint United Nations Programme on HIV/ Aids (UNAIDS) classifies gays as one of the most vulnerable groups in the fight against HIV/AIDS.

It will also make HIV/AIDS management difficult since the UNAIDS new study report indicates that men who have sex with men, frequently termed as MSM account for 5 to 10% of the global infections of HIV, although the figures differ from each country.

The term "men who have sex with men" which is relatively new in Uganda describes a behavior rather than a specific group of people. According to the UNAIDS, it includes self-identified gay, bisexual, or heterosexual men, many of whom may not consider themselves gay or bisexual UNAIDS notes that MSM are often married, particularly where discriminatory laws or social stigma of male sexual relations exist. "Largely because of the taboo, the female partners of men who have sex with men are often unaware of their partner's other liaisons, and may therefore be exposed to additional HIV risks," the UNAIDS notes.

There is the potential for rapid HIV transmission within populations of men who have sex with men, especially if the rate of unprotected anal intercourse is high. There is also high potential of prevention benefit of the programmes among men who have sex with men. However the coverage of the prevention has been low: where countries report on coverage, only around 40% of men who have sex with men have access to the HIV prevention and care services they need. Many factors contribute to this situation including denial by society and communities, stigma and discrimination, and human rights abuse.
Also where prevention programmes are in place, potential increase in risk behaviours due to prevention fatigue should be taken into consideration on the programming.

Vulnerability to HIV infection is increased where sex between men is criminalized, as men are either excluded from, or exclude themselves from, sexual health and welfare agencies out of fear.

UHSPA-Uganda has copies of the bill for free distribution to CSOs and any other interested party for free, both in hard and electronic copies.

The writer is Executive Director, Uganda Health and Science Press Association

Society conspires against women in HIV/AIDS

Global coalition of Women Against AIDS in Uganda (GCWAU) capacity building training of women groups at Forum offices in 2009

By Carolyne Katushabe

The HIV/AIDS epidemic has had and continues to have devastating effects on women in Uganda and many other developing countries in sub-Saharan Africa.

Today, about 33 million people globally live with HIV/ AIDS, of which 28.5 million are in Sub Saharan Africa. Women constitute 15.5 million globally and 12 million in sub-Saharan Africa.

Throughout the world, the unequal social status of women places them at higher risk of contracting HIV/AIDS. Women are at a disadvantage with respect to access to information about HIV/AIDS prevention, the ability to negotiate safe sexual encounters and access to treatment for HIV/AIDS once infected.

More than 20 years into the human immunodeficiency virus (HIV) epidemic, women account for nearly half of the 33 million people living with HIV worldwide, with an even higher proportion existing in developing countries.

Women of all ages have borne the brunt of the epidemic with higher infection rates reported across the different regions. Women – be it young girls, married, single, divorced or widowed – are more vulnerable to infection with HIV/AIDS than their male counterparts. Women's higher vulnerability has been attributed to several factors.

First, in the case of young girls, defilement, early marriage, orphanage, forced prostitution, early sexuality due to poverty or societal briefs regarding HIV/AIDS and virginity, among others all operate to expose them to the HIV virus at higher rate than young boys of similar ages.

Many women face risk of contracting the HIV virus. Factors increasing their risk include limited power in sexual decision–making resulting from their powerlessness in their marriage, limited access to condoms, limited ability to demand their use by their spouses or partners, commonly–held beliefs and attitudes towards use of condoms in general and more especially when in marriage or stable relationships.

The situation is further aggravated by the unavailability or acceptability of female controlled prevention measures, which makes them rely on their partner's cooperation for condom use.

Women's vulnerability also rises from lack or limited access to information about modes of transmission of HIV/AIDS, sexually transmitted infections and reproductive health as well as related services.

Violence against women whether it occurs in or out side the home increases women's vulnerability to HIV/AIDS. Outside the home women suffer from gender–based violence through being subjected to rape, at their work places through sexual harassment, during war/civil unrest and in refugee/internally displaced people's camps. In all these cases, women are exposed to the HIV virus against their will and lack the ability to protect themselves. As a result the cycle of physical or sexual violence against women and girls like rape and defilement continues, leading to further vulnerability to contracting HIV.

Specific biological factors place women at a greater risk of contracting HIV than men. The soft tissue in the female reproductive tract tears easily, producing a transmission route for the virus. Additionally, vaginal tissue absorbs fluids more easily, including sperm, which has a higher concentration of the HIV virus than female vaginal secretions and may remain in the vagina for hours following intercourse.

Women's increased biological vulnerability is compounded by their subordinate social status. A woman is more likely to have sexual contact even though she does not want to; women lack the power to refuse her partner's demands (forced sex). When the vagina is not lubricated, the tissue tears more easily, increasing women's risk of exposure to HIV. When comparing the risk of transmission from male to female and vice versa, it has been estimated that women's risk is up to 2 to 5 times higher than men's during anal sex. Another risk factor for HIV infection is the presence of other sexually transmitted infections (STIs). Women are more likely than men to have other untreated STIs, primarily because STIs in women are more often asymptomatic, but also because the shame or fear of visiting a doctor may prevent women from seeking screening and treatment.

The belief that women have sex solely for reproductive purposes while men need sexual release also creates obstacles for HIV/ AIDS prevention programmes that promote female negotiation with their partners.

Cultures that support the femininity/ masculinity dichotomy inhibits adult women's ability to discuss issues that restrict women's access to educational and vocational training, and the sexual division of labour that puts women in lower status jobs, increase women's vulnerability to HIV.

These two determinants limit women's access to employment opportunities. The vast majority of women are employed in low paying, seasonal, and insecure jobs in the informal and semi-formal sectors of the labour market. Unequal standard in employment and channeling the majority of women into low status occupations perpetuates and re-enforces their inferior status in economic relations. These circumstances also make it more likely that women will increase their income by selling sex, and without access to legal, social and HIV prevention services, this limits their ability to negotiate safer sex.

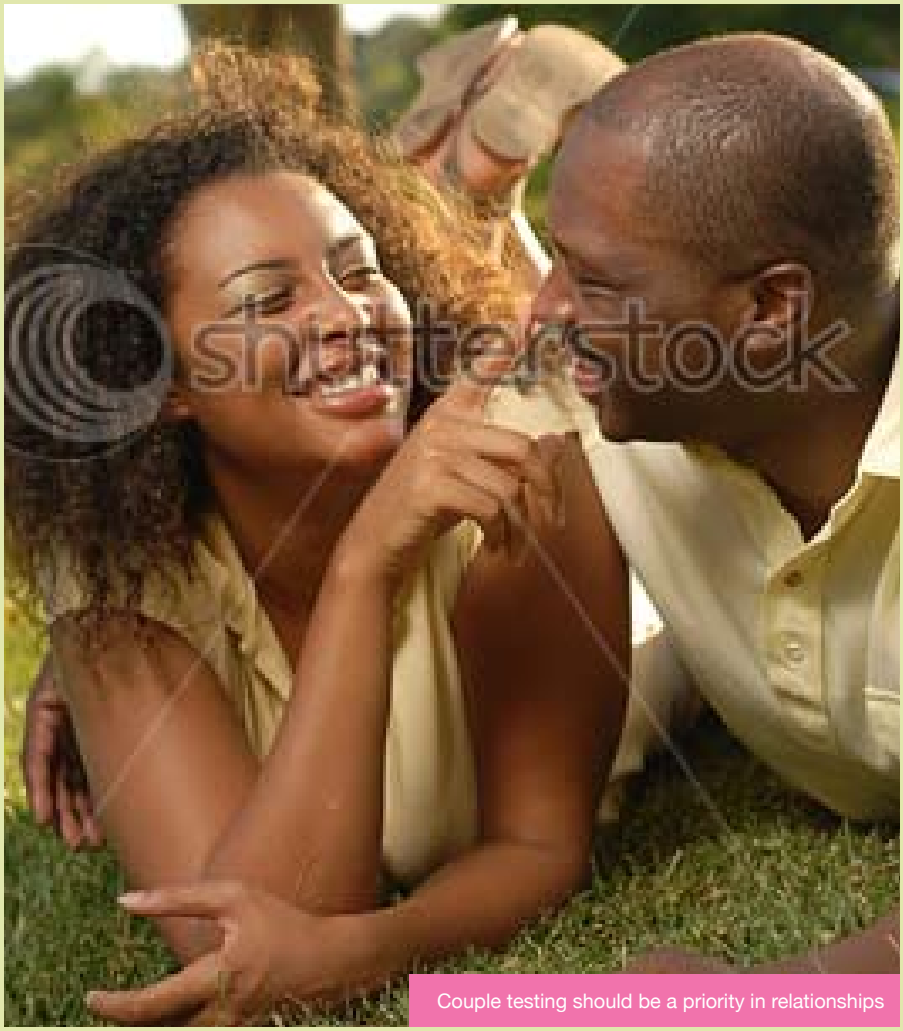
There are various factors like socio-economic developments have contributed to the extensive spread of HIV infection, including the subordinate position of women, impoverishment and decline of social services, rapid urbanization and modernization, and wars and conflicts.

Populations in many parts of Africa are becoming trapped in a vicious circle as the HIV epidemic leads to high mortality rates in young girls and economically productive age groups, and thus leads to further impoverishment. Interventions to control HIV should not only target individuals, but also aim to change those aspects of culture in some parts of Africa which are becoming trapped in a vicious circle as the HIV epidemic leads to high mortality rates. Social determinants of female vulnerability to HIV include gender disparities, poverty, cultural and sex norms, lack of education, and violence. Biological factors [hormonal changes], vaginal microbial ecology and physiology, and a higher prevalence of sexually transmitted diseases. Prevention strategies must address the wide range of gender inequalities that promote the dissemination of HIV.

Carolyne is GLIA Volunteer, NAFOPHANU

Discordance defies HIV script but don't count on luck

By Proscovia Nalunga



Couple testing should be a priority in relationships

Discordance is one of the many puzzles still in the era of HIV/AIDS fight in many countries. Uganda. There are quite a number of these couples worldwide. Discordnace refers a situation where one person among the married is infected and the other is not. That is, either man or woman has HIV but not both. One can also term it as a pair of long–term sexual partners in which the woman is HIV infected and her husband not is infected or vice versa.

Discordant couples are more common in polygamous unions and more among urban couples than their rural counterparts. However, in such situations, HIV negative partners are at very high risk of HIV infection from their positive partners and yet service providers have not yet developed effective counseling messages for discordant couples to prevent further infection. But also the work done by the doctors in Uganda to research on circumstances as to why married couples have different HIV/AIDS sero-status should be acknowledged.

According to the Assistant commissioner National Disease Control in the ministry of Health Dr. Alex Apio, in 2006 the number of discordant couples had increased from 4.8% to 5% making it even more important that couples should use condoms. And according to the HIV/AIDS Sero-Behavioural Survey, 5% of about 4,000 cohabiting couples in Uganda were found to be discordant.

The fact that there are more cohabiting couples who are discordant represents an unmet HIV prevention need for the country. This is because the majority of these couples do not mutually know their HIV status and therefore are not empowered to take action to prevent further spread of the disease. This lack of knowledge increases the risk of infection among the healthy partner because they do not realize the importance of protected sex moreover, the phenomenon of discordance leads to familial conflicts with unpredictable consequences such as separation, divorce and coercion to have unprotected sex.

In Rwanda, this is a situation which is not well known has been demonstrated since 1989 and the prevalence increased from 13.9% of couples tested from April 2000 to 14.9% from April 2000 to April 2001. This increasing number of discordant couples was partly attributed to the increasing number of people on Antiretroviral Treatment (ART).

It is thought that hidden infections which are not detectable by HIV tests are some of the explanations for increasing discordance and also the biggest challenge by these couples is the negotiation of sexual relations. However, strategies to combat this increasing spread of the virus include; often use of condoms, abstinence separation of beds and relationship cessation. They are some of the most important ways in which further spread of the virus can be controlled especially in these couples.

They used protection in the first few months until the man decided that it was time for him to have children with his wife no matter the status, however, even after they had unprotected sex the man did not contract the virus and now they have three children

There are quite a number of couples that have confessed as discordant and have tried to live their lives in this way;

Take an example; there was once a man who fell in love with a positive woman and though the lady disclosed her status the man did not care (because of love) and so he decided to take on this lady. They used protection in the first few months until the man decided that it was time for him to have children with his wife no matter the status, however, even after they had unprotected sex the man did not contract the virus and now they have three children but the husband is still free of the virus. This is one of the many cases there is in the country and so people should note that such cases really exist but do not count on somebody else's luck.

The problem though is that some people especially those in the rural areas really find it hard to believe that these cases are for real so they can never try to believe no matter how much you convince them. This is still a big problem to the community workers whose challenge is to educate the people that this is actually possible.

This does not mean that there is no prevention of harm, yes, it is there and the argument that seems to carry the most weight is offering IVF to HIV discordant couples. In-Vitro Fertilization (IVF) reduces the risk of the virus being transmitted to an uninfected partner and child. This is special for such discordant couples that wish to have children so there's need to prevent infection of the other partner and the child through administration of IVF.

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Therefore denying treatment to such persons won't stop the transmission but rather increase it since the couple may not give up the idea of looking for a child. What is more, if treatment is refused at one centre, the couple could seek treatment at another centre without disclosing their HIV status. This would put at risk staff and other patients would not have the opportunity to decide whether it was a risk they were prepared to accept.

The following points should be put into consideration when handling discordant couples for better results;

It would be useful for the couple to understand that many other couples are discordant, and data are suggesting in as high as 50% of couples where one partner is HIV+, the other partner is negative.

Most couples' anxiety relates to concerns that the partner was unfaithful. Unless both partners tested negative before commencing their sexual careers (including a 2nd test to accommodate the sero conversion period), then it is possible they entered the relationship already discordant and did not know it.

Discordance does not last forever, and ultimately the other partner can become infected. So it is important that sexual activity be fully protected that is; use a condom in each sexual act.

Another important aspect of dealing with discordance is the children. If it is the woman who is infected, there is a chance that she could have infected her children. Thus, it is advisable to test pediatric age children (those under 5) so that appropriate management can begin. If the man is the one who was infected, then the risk to the children is less though not negligible.

It is important that the discordant couple also be aware of non-sexual transmission of HIV, and reduce risk accordingly. For example, the couple needs advice on how to clean products that may have infected fluids, how to deal with blood spills, not to share tooth brushes, razors, etc. It can be particularly challenging in a family setting but can certainly be done.

All in all, offering ART to HIV discordant couples violates no ethical principles and on the whole it seems to likely produce more benefit than harm. These people need our full support and counseling so they can feel free in the society that they live in and also know how to relate with such issues as theirs. Therefore, offering more help to them will be more beneficial to them and the society as a whole other than ignoring them which will continue to silently kill them.

Everyone should be a concerned society member ready to help and save more lives. It is something we have to address quickly because this friendly fire infection is very dangerous to our HIV control measures.

Additional information from the internet.

The author is IEC Assistant, NAFOPHANU

Good Spirit Support Action Center

Supported orphans of HIV/AIDS at GOSSACE offices in Mukono

Good Spirit Support Action Center (GOSSACE) started as a vision conceived by Mr. Vincent Were Wandera who joined Nsambya Home care Aids Clinic having tested HIV positive in 1992.

Wandera looked at his life history and the then HIV challenges and sought friends at the clinic. He later inspired them to form an organization to strengthen the social economical capacity of families affected by HIV. GOSSACE inception sparked off at Nsambya Home care Aids clinic.

GOSSACE therefore started as a support group that was first registered as a community based organization(CBO) to serve in the Districts of Kampala, Wakiso, Mukono and others that could be reached.

The group was first known as Good Shepherd Support Action center until 2003 when the founder members were advised to register it with the NGO Board as Non governmental charitable organization and thus re-branding to the present name of Good Spirit Support Action Center.

The organization runs an orphanage care centre (Home) situated in Mukono district, Ntenjeru Sub County, Bunakijja parish, Golomolo village that keeps 365 children who are either total orphans or vulnerable children of ages between 3 – 15years.

In this home, 230 children are full time accommodated and provided with all the basic child rights like education, feeding e.t.c.

Goal

To improve the standards of living, provide care and support to orphans and other vulnerable children and strengthening the social economical capacity of families for the purpose of ORPHANS AND VULNERABLE CHILDREN and elderly care support.

Mission

To enhance the capacity of people affected and infected by HIVAIDS to actively participate in prevention and care initiatives as a contribution to the national response

Vision

To have a happy improved health status for the infected and the affected, especially children and the elderly.

Specific Core Programs

- Community mobilization, education and sensitization on behavioral
- Change, disease prevention and child rights advocacy campaigns.
- Counseling and guidance for youth in/ out of school, PHAs and other community.
- Orphanage care project.
- Formal education
- Secondary and tertiary institution child education sponsorship program (ORPHANS AND VULNERABLE CHILDREN).
- Youth friendly talks on empowerment and development.
- Home visits.
- Skills development
- Humanitarian Services (i.e. elderly care and support)
- Health care.
- Outreach support program.

An Open Letter to the HIV and Public Health Community in Uganda

The Global Forum on MSM & HIV (MSMGF) applauds efforts by people living with HIV in Uganda to stand up against the proposed "Anti-Homosexuality Bill, 2009", and urges HIV service providers in the country to join them by making a clear, collective public statement condemning the proposed legislation and calling for its immediate dissolution.

If enacted, this legislation will have a profoundly detrimental impact upon the effort to address HIV in Uganda. Implementing organizations dedicated to delivering HIV & AIDS prevention, treatment and care services in Uganda have contributed enormously to fighting the epidemic on the ground, and as

> In low and middle-income countries, MSM are 19 times more likely to be infected with HIV than the general population

such are uniquely positioned to speak out against the bill - especially those implementers receiving significant funding from large global donors like PEPFAR and the Global Fund. Moreover, implementers have an obligation to the health and safety of all people in the communities they serve, including gay men and other men who have sex with men (MSM), their families, their loved ones, and agencies who work to provide them essential health services.

Protecting and promoting public health includes weighing in on any debate that threatens to undermine HIV service implementers' ability to deliver effective public health programs. The Global Forum on MSM & HIV is deeply concerned about the ways in which the proposed anti homosexuality bill will undermine the nation's efforts in addressing the HIV epidemic: First, the bill is very clear with regards to people living with HIV: anyone charged with the offense of aggravated homosexuality will undergo HIV testing, and all those found to be HIV positive are subject to the death penalty. Simply put, one's HIV status is grounds for execution. This proposal not only reinforces stigma, discrimination and violence against people living with HIV, it is an outrageous violation of human rights and should be roundly condemned by all committed to the effort to end HIV.

Second, the extreme criminal penalties proposed in the bill further marginalize men who have sex with men (MSM), a community that is already criminalized in Uganda, as well as highly stigmatized and vulnerable to HIV infection. In low and middle-income countries, MSM are 19 times more likely to be infected with HIV than the general population. The gold standard public health principle for addressing HIV – "know your epidemic, know your response" – necessitates targeting HIV-related services at most-at-risk communities. The harsh penalties in this bill drive MSM underground, fueling

HIV risk and transmission in a context of silence and fear, and making it difficult to (a) assess the HIV burden among MSM, and (b) subsequently reach out to high-risk individuals with essential information and services. Uganda's own AIDS Commission has specifically called for a review of legal impediments to the inclusion of most-at-risk populations – including MSM – in the national AIDS response.

Third, conditions in the bill against the "promotion of homosexuality" are vague, raising serious concerns that AIDS service providers' work to provide critical HIV-related information and services tailored to the needs of MSM may be considered illegal. Without clear guidance on what specifically constitutes "promotion of homosexuality", the materials necessary for HIV prevention among MSM would be classified as homosexual "promotional materials", even though such products and information are integral to save lives and prevent transmission of HIV. The 2009 AIDS Epidemic.

Update (UNAIDS) explicitly highlights the need to implement prevention programs for MSM and other key populations of higher risk as an important part of all national AIDS responsesiii. Given the severe nature of the proposed sentencing - convicted organizations are liable to having their registration cancelled and their executive director imprisoned for seven years - it is reasonable to expect most AIDS service organizations to halt vital HIV-related outreach to key affected populations for fear of possible broad interpretation of the law that would invoke criminal penalties.

Finally, the bill would jeopardize the critical relationship between healthcare providers and patients seeking HIV-related services by mandating that any person, including doctors, report suspected homosexuality to the authorities. In such an environment, people who may be at risk for HIV will delay seeking information and services, or may not present to healthcare facilities at all. Early identification of people living with HIV is a critical public health imperative in the prevention of onward transmission, and these provisions would seriously undermine the ability of the National AIDS Response to do so effectively. In sum, the Anti-Homosexuality Bill will fundamentally compromise the effectiveness of the HIV response in Uganda.

We urge HIV service providers, including international nongovernmental organizations, committed to halting and reversing the spread of HIV in Uganda to stand with us in calling on legislators to withdraw the bill under question immediately. We share a collective responsibility to speak out in the interests of the communities we serve, and every voice is paramount in our work to challenge discriminatory public policy practices that undermine our efforts to end AIDS.

Sincerely, The Global Forum on MSM & HIV

WEEP NO MORE MY FRIEND

By Peace Baguma

Weep no more my friend
Though everyone out there
Discriminates you and blames you
For it is not your fault
You didn't wish to have it

Weep no more my friend
The majority are always in the wrong
And they utter out a lot of trash
Before you thinking they are in the
Right position to accuse you
Don't blame them for they are naïve

Weep no more my friend
You are just one of those innocent
Victims of that deadly disease
That engulfed your soldiers from
Revenging on your behalf
But the battle will soon be won
Weep no more my friend
For you are neither the first nor
Are you the last to be mocked
Of what just came on your way
It was fate and destiny can never be
Taken away but can be changed

Weep no more my friend
This is good news that I have
For you but promise me that you will
Live according to the expectation
Of this wonderful news for this is
The time for you, me and well-wishers
To fight this battle for we believe that
United we stand and divided we fall

Weep no more my friend
There are various organizations
That are helping people like you Such that you have ago ahead in life
By providing drugs for that ruthless disease
And counseling is the first source of hope
That welcomes you to the new world that
You are joining and that's positive living

Weep no more my friend
Lean on **Support on AIDS and Life Through Telephone Helpline (SALT)**
And there you will be rest assured of
Confidentiality, empathy, best referrals
Among others and they will cater for your
Worries about HIV/AIDS and dear friend
HIV is Preventable and AIDS is manageable

Weep no more my friend
This is the right time to prove to your
Foes that they are wrong and you can
Make it; now let's join hands to defend
The precious gift that God gave us is "LIFE."
Guard it in the most desirable way.

Helplines 1:0414 272080
Helplines 2:0414 272082

Knowledge Rooms / Wellness Centres at Mbuya (Kampala), Naluwerere (Bugiri), Rubaare (Ntungamo) funded by GLIA through Uganda Aids Commission (UAC)

CAAT seating at the UNASO offices, 2009.

Press Conference in Nansana on World AIDS Day, 2009.

Stella Kentutsi, Programme Manager introducing Musa Bugungudu, UNAIDS Country Director at the closing of GLIA technical dissemination workshop at Sports View Hotel, Kireka this year

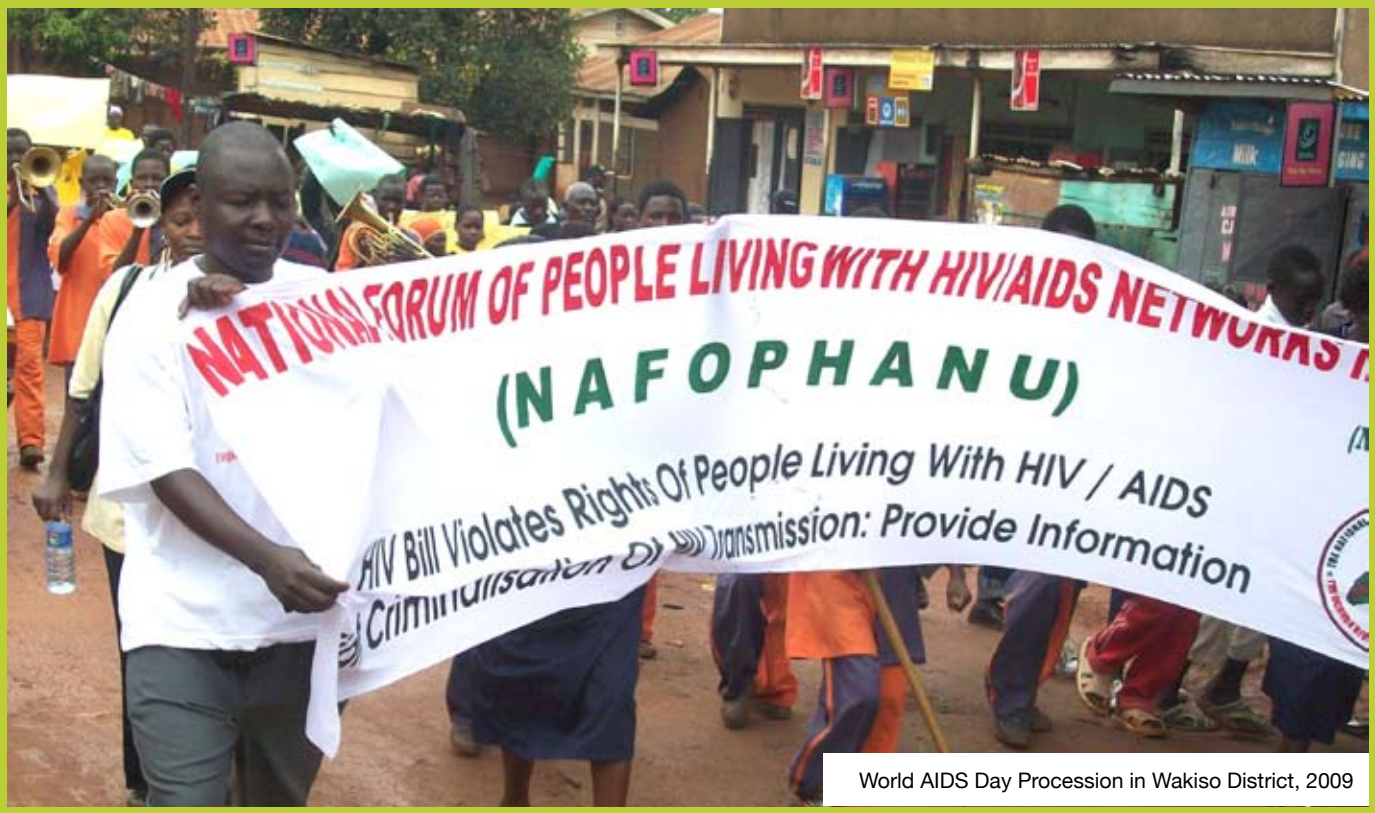
IGAs CSF beneficiaries in Mityana District, 2009

Annual General Meeting in Mbarara, December 2009

CSO workshop on access to essential medicines (Stop Stockouts Campaign) in Zambia, 2009.

My rights! Your rights! Our rights!
Respect to HIV/AIDS and human rights

By Prossy Luzige Nanyanzi



World AIDS Day Procession in Wakiso District, 2009

It is widely perceived that all human beings have equal rights and must enjoy the inherent rights maximally. However, there are circumstances when the inherent entitlements can't be equally enjoyed due to number of reasons and when it comes to HIV/AIDS, the perception dies completely. Do I have the rights? Or, when and how can one experience that enjoyment of the so called 'rights' and what should one do or where should one seek for redress when their rights are violated? These are few questions PHLIV ask themselves whenever they are at crossroads;

At what levels are these rights known and respected? (What is the percentage of Ugandans who are acquainted with the so called human rights and from what back grounds?) Have we done enough to educate the public especially PLHIV to appreciate and demand for their rights? BUT; again do we have capacity or esteem to reclaim for our rights? Are famous violators aware of what they are doing/ responsibility and what is the sentence? For instance, if Iam denied access to health services or information regarding my health or treatment where do I start? Are the health workers literate about our rights or we always end up in hot exchange of words? How bold are citizens to demand for what they deserve.

Human rights

Human rights are defined as natural or civic rights or basic entitlements accorded to every human being. They include; a right to heath; education, employment, property, food, freedom of expression and movement. Knowledge of human rights is very vital in the fight of the same rights of people. Ignorance of various human rights is one of the reasons why some victims of human rights violence do not realize justice- they don't know their rights. In this article a number of human rights violations in communities, reasons for existence of these violations, information on how to seek for justice constitute some information therein.

Despite having numerous policies and legal protection related to HIV/AIDS, Uganda still faces a severe and generalized HIV epidemic with wide spread human rights abuses against people living with, affected by, and at risk of HIV.

While the country has received international praise for its responses to the adverse medical effects of the epidemic, it has paid limited attention to the epidemics legal and human rights implications. This is especially true for marginalized populations who are most vulnerable to HIV related human rights abuses like women (especially young women, widows); sex workers, orphns and vulnerable children(Mukasa s etal 2008)

HIV status is absolutely no ground for degrading treatment or discrimination of a person.

In normal circumstance human rights are violated on hourly, daily, weekly and monthly basis. According to The Uganda Network of Law, Ethics and HIV/AIDS (UGANET) various societies in Uganda are faced with a number of human rights violations which include;

1. Human rights violations suffered by persons living with HIV/AIDS

a) Discrimination

According to chapter 4 (21) of the constitution of Uganda, ''discrimination" means giving different treatment to different persons attributable only or mainly to their respective descriptions by sex, race, color, ethnic origin, tribe, birth, creed or religion, or social or economic standing, political opinion or disability. Therefore to discriminate against a

person due to his or her HIV status (because he or she is HIV positive), is a violation of that persons rights. All persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law.

b) Stigmatization

Stigma refers to the fact that, in some societies some people living with HIV are viewed as shameful and the disease is perceived to be as a result of personal promiscuity or irresponsibility. If not counteracted, such attitudes create biases against those living with HIV/AIDS, stigmatizing and excluding individuals. Ultimately allow societies to excuse themselves from the responsibility of caring for and looking after those who are affected. More importantly, stigma leads to secrecy and denial that hinders people from seeking counseling and testing for HIV, as well as care and support services. In Uganda, efforts have been made to reduce fear and discrimination towards those living with HIV/AIDS.

At the community level, stigmatization is a barrier to people with HIV/AIDS in disclosing their sero-status and getting access to available support, care services and HIV prevention, such as voluntary counseling and testing (VCT) that encourage people to adopt safer behavior.

Therefore, to discriminate against a person due to his or her HIV status (because he or she is HIV positive), is a violation of that persons rights.

Description Of Human Rights

1. Equality, human dignity and freedom from discrimination

All human being irrespective of their status, have inherent right to equal respect, you are a person of value and entitled to the same opportunity in the society. Discrimination and social exclusion of a person because of HIV status is a violation of a right to diginity and equality. (Constitution of Uganda article 21)

2. Right to life, protection to inhuman, cruel and degrading treatment.

Every human being has an inherent right to life. Your life is inviolable. This means your life should be protected from all forms of harm and inhuman treatment. HIV status is absolutely no ground for degrading treatment or discrimination of a person. (Constitution of Uganda, article 22 &24).

Other rights include; Right to health, Property ownership and usage, Right to privacy and confidentiality, Access to justice, Access to work, Reproductive rights, among others

True story about 2 brothers Bazilio and Joel. Bazilio is 3 years old and Joel is 5. Their Father died 2 years back after a chronical AIDS illness. Joel the elder son was tested and found HIV positive and registered with one of the Healthy centre 3 in Mityana district. They are cared for by a grand mother- aunt to their father who is in her late 80s and sickly due to old age. The old peasant didn't go to school but dreams to help the boys to at least acquire the basic skills. Today, Joel's HIV status has deprived him of education to enable his young brother attend school. The old woman's argument is; NO, Joel is sick!!!!! He can't be my son's heir because we are not sure of his life span.

Guess what, as a person living with HIV, who no longer believes in death, I was over powered, speechless and my heart was left pumping terribly. Do the rights based approaches apply in such a condition and who is to blame? We have challenges.

IF YOU were Joel's caretaker, WOULD you HAVE let him ENJOY THE TWO FUNDAMENTAL RIGHTS, RIGHT TO Education and succession right?.

Human rights are rights that all persons; man, women, children, persons with disabilities and other marginalized groups poses because they are human and are necessary for people's survival , existence and development. Every person has a right to an effective remedy for acts violating their rights. At the same time, every person has an obligation to respect the rights of the others .Human rights are fundamental to any response to HIV/AIDS. The promotion and protection of human rights are necessary to empower individuals and communities to respond to HIV/AIFDS, to reduce vulnerability to HIV infection and to reduce the adverse impact of HIV/AIDS on those affected- UGANET

The author is GLIA Project Assistant

HIV/AIDS: From disease **to a human rights issue**

By Musiime Michael Koima

Human rights promotion and protection is central to the response to HIV/AIDS. Denying the rights of people living with HIV and those affected by the epidemic, imperils not only their well-being, but life itself. There are millions of people living with HIV across the globe, and these include women, children and new infections in young people under the age of 25.

International and national response has been made over the past years through provision of anti-retroviral treatment for AIDS (ARVs). The ARVs have reduced the number of deaths in high-income countries but in developing countries, the picture is different since they are accessed by a few compared to those who need them. To make matters worse, human rights violations, including stigma and discrimination faced by people living with or affected by HIV/AIDS, still constitute a major barrier both to prevention and access to care.

Universal access to HIV/AIDS prevention, treatment, care and support is necessary to respect, protect and fulfill human rights related to health, including the right to enjoy the highest attainable standard of health. There is a belief that universal access will be achieved progressively over time. However states have an immediate obligation to take steps, and to move as quickly and effectively as possible, towards realizing access for all to HIV/AIDS prevention, treatment, care and support at both the domestic and global levels.

Uganda being a signatory to the 2001 United Nations General Assembly Declaration of Commitment on HIV/AIDS, it is supposed to report the progress made on the commitment through the developed indicators and policy index which assesses the progress in developing laws, policies and strategies to address HIV/AIDS at national level in relation to prevention, treatment, care and support as well as specific human rights issues.

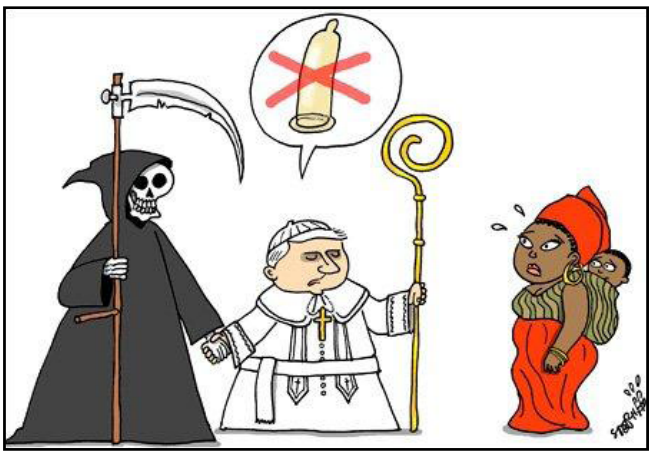
Nonetheless, studies show that people infected and affected by HIV/AIDS in Uganda continue to face gross violation of their human rights in one way or another. These include denial of employment, treatment, stigma and discrimination among others. It is also evident that people move long distances to access health services in rural areas, health centers are not well stocked with sufficient drugs and to make maters worse people incur hidden costs in accessing free services, such as buying gloves and syringes.

It's because of this that UGANET and its partners have designed different advocacy strategies for strengthening Uganda's national response on HIV/AIDS through promotion of human rights and the law. In this response, UGANET developed and produced a booklet with the aim of providing information on basic human rights in relation to HIV/AIDS. It aims at empowering persons with and those affected by HIV/AIDS with information and knowledge that will empower them to defend their human rights and to reduce their vulnerability to human rights violations related to HIV/AIDS. For more information please contact UGANET.

The writer is Programme Officer at Uganda Network on Law Ethics and HIV/AIDS (UGANET). musiimekoi@yahoo.com

Laughter and HIV/AIDS: It's no joke

By Anna Mugambi



"The art of medicine consists of keeping the patient amused while nature heals the disease." (Voltaire)

"Laugh, and the world laughs with you; weep, and you weep alone; for the sad old earth must borrow its mirth, but has trouble enough of its own."
(Wilcox, Ella Wheeler)

One should never rub bottoms with a porcupine.
(Ugandan Proverb)

When I told a friend of mine that I was going to write an article on humor and HIV&AIDS, he looked at me, shook his head and said that I would be totally inappropriate and out of order. To be honest with you, I was just bouncing off ideas on him on the articles ideas that I had. His reaction convinced me to try and find out what was so inappropriate about humor and HIV&AIDS.

True, there is very little to laugh about: Sub-Saharan Africa remains the region most heavily affected by HIV. In 2008, Sub - Saharan Africa accounted for 67% of HIV infections worldwide, 68% of new HIV infections among adults and 91% of new HIV infections among children. The region also accounted for 72% of the world's AIDS-related deaths in 2008. (UNAIDS AIDS Epidemic Update December 2009)

An estimated 22.4 million adults and children were living with HIV in Sub - Saharan Africa at the end of 2008. During that year, an estimated 1.4 million Africans died from AIDS. Around 14.1 million children have lost one or both parents to the epidemic. In Uganda, an estimated 1,300,000 people are living with HIV&AIDS, representing 6.2% of the total population.

But it's not all grimness. I do not intend to laugh at the grim statistics, neither at the situations or the circumstances that People Living with HIV (PLHIV) all over the world find themselves in. Nevertheless, I would like to talk about laughter and humor IN the life of PLHAs.

After in interminable time on the internet (Note to my boss: I did it on my own time I promise! And FYI, you can not believe the lack of material on the internet about humor and HIV&AIDS!), I came across "Laughing At & Understanding Good Humor Seminars (LAUGHS). Their website is http://www.laughsus.com and their seminars "help(s) employees from all walks of life to use their sense of humor as an effective self - care tool to cope with stress". I also came across WWW.HAHACARE.CO.ZA and WWW.PURELAUGHTER.ORG, organizations that are convinced that laugher IS the best medicine. They highlight in their websites the many body, mind, immune, and emotional benefits of laughter.

Many people living with HIV/AIDS find themselves not only coping with the physical dangers of the virus and its treatment, but also with the stress and depression that sometimes go hand – in - hand with HIV.

Have you noticed how easy it is for you to often get sick when dealing with a marital problem, unusually high job stress or after getting some form of really bad news? According to some experts, when one is emotionally distressed, their immune system simply doesn't do as good a job at fighting the source of illness. When all is going well, one doesn't get sick as often.

Life can also be pretty funny. Having been in Uganda for the last 7 months or so, I have come across a few Ugandan "talkisms" (does that word even exist in the English language?) that have brought a smile to my face.

"Here in Uganda we have a small problem"
(Preface to something that is really a BIG problem, like war)

"When did you produce?" ("Produce" means give birth)

What about signs for shops and businesses?

"BE PATIENT PAINTERS" (sign outside a paintshop)

"God Willing Clinic" (Clinic sign)

I will not even touch the tongue in cheek humor so common in one of the daily newspapers in Kampala. I can unashamedly confess that there are some masterpieces that I have kept to take back home with me.

A lot of our problems can come from taking ourselves too seriously and so having a distorted view of them. Those laughing groups that I have heard about are there for a reason. Laughing makes you feel good. It can help to try and develop a sense of humor about your situation. People who have been in stressful health situations who can still laugh seem to cope better. A lot (not all of course) situations do have a funny side and if you can see the funny side to some these situations, it can really help. Or when those negative thoughts seem overwhelming, why not rent your favourite comedy and have a good laugh?

But, comedy sometimes has a dark side and loses its therapeutic value, like when the joke's on you. (I have in mind here any statement or "joke" that touches on my weight. Ladies; can you say "Amen!"?) Maintaining a sense of humor, and staying focused on the positive can put things into perspective and make it easier to cope.

My friend Alex* has been HIV Positive for the last 8 years and he is also, bar none, the funniest person I know. Looking at him, no one can ever suspect that he lost his entire family to AIDS and that he also lost his job of 4 years after his employer thought he was spending too much time in hospital. But he is wont to be the one who sees the funny side of a pretty rough situation in our group of misfits. He has been to hospital so many times, has had so many injections and is losing weight steadily no matter how much he eats (I can testify that I have personally seen him eat a full chicken by himself) that he says he feels he has a slow puncture. Yes, it's grim and gallows humor, but that's just his nature, to try and be optimistic and deal with the situation.

It is absolutely true that in the face of adversity and with the variety of challenges each of us manage each day, there is always room for

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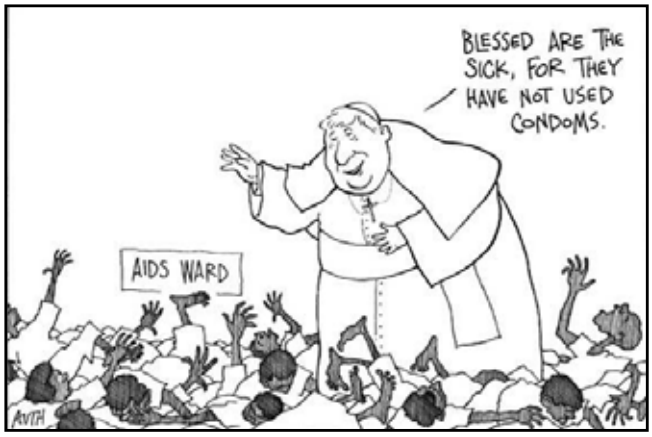

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humor. Will you be negating the actual challenge before you if you turn on Anna ask the office who the comedian is and laugh your head off before your next doctor's appointment? No. Not one bit. But having a sense of humor and focusing on the positive might just be what the doctor ordered.

Now, before I get angry emails in my inbox about my callousness, listen to what experts have to say about humor and your immune system:

"A good howl diminishes stress and pain, and can increase antibodies that help fight disease and combat anxiety. But most of all, humor releases endorphins, the body's natural painkillers", says Lee Berk, Department of Public Health (USA) in Psychoneuroimmunology.(I know, I know, Googled it and according to Wikipedia, "Psychoneuroimmunology (PNI) is the study of the interaction between psychological processes and the nervous and immune systems of the human body." … You are welcome.) "Mirthful laughter …" he continues, "… has a spiritual connotation, and we know that it can change and lower heart rate, lower blood pressure and decrease stress hormones," he says.

In a study that Berk and his fellow researchers conducted at Loma University in California, they found that after men watched hilarious movies, their white blood cells - which help protect the body against disease - increased activity. White blood cells can also attack tumor cells and boost immune system activity. A recent study at the University of Maryland Medical Center in Baltimore reports that a belly laugh may help reduce and protect against heart disease and heart attacks." (L.A.U.G.H.S.)

"Many studies show that laughter significantly boosts the immune system. This is particularly important for PLHIV, as it could help to reduce or prevent opportunistic infection." (International Happiness Institute)

Humor and laughter are not replacements for the treatment you or your loved one are undergoing. But there's every reason to believe that patients make an important contribution to their own treatment by managing their frame of mind or emotional state. Building more laughter into your life helps assures that you'll have all your body's own natural healing resources fully available to you. Your body will be working for you - not against you.

I guarantee we'd bolster our immune systems, have a more positive outlook and make better healthcare decisions if we managed our anxiety with a healthy dose of humor. Taking yourself too seriously is not all it's cracked up to be. There's no evidence that humor and laughter adds years to your life, but humor certainly adds life to your years.

And I will let you in on a little secret: humorous people are very likeable.

Anna is a VSO volunteer with NAFOPHANU

Living positively with HIV, what it entails...

By Elvis Basudde Kyeyune

You are HIV positive! So what? You can still live as long as you would have lived. But through a lifestyle we know as positive living. This is a lifestyle in which someone who has the HIV virus aims at delaying the onset of AIDS.

We have lost many people who should not have died. This includes prominent politicians and musicians, who, doctors say, would have lived longer with a more responsible lifestyle.

Some people still believe that an HIV diagnosis is synonymous with a suspended death sentence. HIV is no longer a death sentence. You can be as vulnerable to death as any other person in your neighborhood.

Granted, finding out that you have HIV is not easy because it is scaring and can torment you. That is natural. But you can be able to live on if you refuse to interpret your condition as terminal, and learn to live positively.

The knowledge that you are HIV positive is a transition. It is starting a new life where you must learn how to cope and focus on what is most important. It is like being in a strange country which has strange rules.

I have been to Nigeria and Rwanda . They drive on the right as opposed to us here in Uganda . I had to abide even when I was visiting. Just imagine the consequences if I insisted that I had to drive on the left in Nigeria .

In the same way, when you are HIV positive, you must learn how to cope with your new status and learn how to live with it. That is what is called Positive Living or Living Positively with HIV/AIDS.

If I drove on the left in Nigeria , probably I would have a chance to appeal for ignorance and be given a light punishment. But there is no appeal if you fail to live positively. The consequence is death!

But you can still live a good and normal life as long as you adhere to positive living. Many of us are already living positively. There are certain things that you must do, because positive living involves a number of undertakings, which contribute to good health and longer life for people living with HIV/AIDS.

ACCEPTENCE
First, it is not important how, when and from whom you got the virus. What is important is your present, tomorrow and treatment. Stop dwelling on the past because you cannot un do what has already happened. Work with your feelings, avoid denial and accept your new status as part of your life. That is the starting point.

ARVs
For those who are on antiretroviral drug (ARVs), it is important to know that these anti HIV drugs are not a cure but improve quality of life. They are life-time commitment and they should never be taken without medical supervision. It is crucial to adhere to the drug regiment for them to help you and avoid resistant strains of HIV, not only for you but also for others as well.

SEX
The principal is safer sex. Even when on ARVs, you can still infect others. Therefore, as far as possible, you must not risk having live sex. Use a condom if you must or abstain.

MEDICAL
When you are ill, seek medical attention immediately. Never treat yourself and make sure that you seek proper medication and strictly adhere to it. Treat all the opportunistic infections.

NUTRITION
Have good nutrition with a balanced diet, which includes body-building, and body- repairing foods as well as foods that provide energy to body. It is important to drink plenty of clean and boiled water.

HYGIENE
You must practice proper personal hygiene, which includes proper washing of the body, hands especially before meals and using latrines, brushing the teeth, grooming nails.

LEISURE
You should have sensible and quality leisure that builds you. Alcohol, smoking should be avoided. Have enough rest.

SOCIALISE/SPIRITUAL
Do not isolate yourself. Avoid self-stigmatization. Join HIV/AIDS networks and interact with your peers. Have a motivation to live on, keep faith in God and pray and seek pastoral counseling.

The writer is an HIV/AIDS activist, self-taught counselor and living positively.

Poor service, no drugs weigh down Wakiso's HIV positive

By Rugarama Neriah

Members of AFYA Group 5000 meet at NAFOPHANU offices recently

I did not have to ask Kato if he was HIV positive, as it was written all over his face and his body weak as he sat outside Wakiso health centre.

A few years ago, Kato was a successful businessman trading in sugarcane; today he has only one thing to show for his business experience – HIV/AIDS.

Kato a.k.a Mulongo Mugaga, was too sick to attend the recent general check up and testing for HIV/AIDS at the Antiretroviral therapy (ART) facility at the district. The facility is one of the interventions by Civil Society Organisations to manage the spread of HIV/AIDS in the district.

Since 2007, Civil Society Organisations and CBOs have launched collaboration with the health centres (e.g. AFYA CLUB 5000); particularly those that supply ARVs to beef up counseling and testing services as the virus continues to the spread at a fast rate.

The counselors and peer educators that have been trained by partners like SCOT have done great job in educating and counseling the community, moreover on a voluntary basis, despite the less recognition of their services by district authorities.

Inadequate facilities

There is uncertainty of ARVs availability at the district. Recently, more than 800 clients spent three weeks without ARVs, putting their lives at risk. The Health Centre IV which is situated next to the district headquarters, has testing equipments like CD4 count machine, therefore clients who test positive have to wait for another two to three weeks before getting their results from Mulago Refferal Hospital or alternatively, to access private clinics in Kakiri which is not only far but also too expensive for the unemployed clients who are poverty stricken.

Some clients fail even to turn up for their clinical appointments due to lack of transport of 1000/=. The centre also lacks basic facilities like drugs. The HIV clinic receives over 120-150 out-patients every Wednesday and other 30-40 who come for testing and counseling. However, all these are attended to by only two health workers.

These workers are overstretched that the clients have to wait for long while the drugs are being prepared and records are being put right. Since there is constant shortage of drugs, health workers give short periods for the next visits in anticipation of getting other supplies from the government stores-or authorities concern. This becomes tiresome and expensive for the clients – some end up missing appointments hence causing drug resistance which finally results into premature death.

Wakiso district has several sub-counties with an estimated population of 1.5 million people. Its vast area stretching on all sides of Kampala city makes delivery of health services a nightmare. Therefore mobile health staff are needed to make home visits, testing and counseling and at the same time bringing the health services nearer so that the venerable people do not have to trek long journeys to the main health centre.

Wakiso district is also very cosmopolitan with several small towns teeming with people of different cultures, many of who are unemployed and school drop outs. This puts the community at a high risk of spreading of the virus.

Despite the desire to help, Wakiso district seems constrained by little funding from government. That is a story replicated from all over the country underlining the challenges in the battle against HIV/AIDS. It's a battle that all stake holders need to work harder to overcome with combined effort.

Neriah is chairman of AFYA Club 5000 in Wakiso district.