

# Monitoring UNGASS Goals

## Women's Sexual and Reproductive Health

Uganda Women's Network

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# 1 BACKGROUND

## 1.1 Overview of Uganda Health System

The health system in Uganda is planned for and guided through the sector wide approach. In this regard government and development partners have agreed to deliver goals and objectives outlined in the Health Sector Strategic plan 2. (HSSP II) The overall development goal as articulated in the National Health policy is *“the attainment of a good standard of health by all people in Uganda, in order to promote a healthy and productive life”*. The programme goal for HSSP II is *“Reduced morbidity and mortality from the major causes of ill-health and premature death, and reduced disparities therein”* - to be attained through universal delivery of the Uganda National Minimum Health Care Package.

The health sector comprises government agencies, NGOs, private and community providers, and various partners. It exists to promote better health outcomes through the monitoring and provision of preventive and curative health services. Its responsibility stretches not only to the public provision of services but also to supervision of the private sector, which provides a very significant proportion of health care in Uganda. Public sector services are provided through a seven-tier structure. Health centers 1-4 provide services at the LC1-4 levels; above these levels there are general hospitals at the district level 163 and regional and national referral hospitals. Village health teams are being introduced to work at the community level. According to the 2002/03 National Household Survey, the majority of out patient consultations take place in the private facilities (including NGO facilities that may be publicly subsidized). Moreover, the poor are proportionately more likely than the non-poor to use the public sector.

## 1.2 HIV/AIDS Policy Framework

Uganda does not have an approved policy for HIV/AIDS rather programming has been guided through several strategic plans that have been developed since the early 90's. In the current National Strategic Plan which is about to be approved namely the National HIV/AIDS Strategic Plan 2007/8 – 2011/12, Uganda demonstrates commitment towards universal access to three priority service areas - prevention, care and treatment, and social support. It is therefore planned to reduce new HIV infection by 40%, to scale up interventions of care and treatment to 80% of those in need, and to expand social support to 54% by the year 2012.

The current vision of **a population free of HIV and its effects** has been maintained. The overall goal is to achieve universal access targets for HIV/AIDS prevention, care, treatment and social support by 2012. The specific goals of the National Strategic Plan are

- **Goal 1:** To reduce the incidence rate of HIV by 40% by the year 2012
- **Goal 2:** To improve the quality of life of PHA by mitigating the health effects of HIV/AIDS by 2012

- **Goal 3:** To mitigate the *social, cultural and economic effects of HIV and AIDS at individual, household and community levels*
- **Goal 4:** To build an effective support system that ensures quality, equitable and timely service delivery.

### **1.3 Uganda Sexual and Reproductive Health Policy**

Reproductive Health and Rights is one of the critical components of the minimum package that was identified for implementation by Government. In 1999, the Maternal and Child Health department was restructured and became the Reproductive Health Division. While reproductive health has remained a priority area in the Ministry in the last 4 or 5 years, inadequate resources have been allocated to support the main activities that are meant to encompass sexual and reproductive health. International donors finance approximately 90% of all investments in reproductive health, so their priorities are critical in shaping policies and programmes. It is also noted that the sector wide approach to development funding in the health sector has not necessarily resulted in increasing funding for sexual and reproductive health.

In Uganda, reproductive health can be understood through the goals of the Reproductive health Division. In a Ministry of Health document titled “a strategy to improve reproductive health in Uganda 2005 – 2010”, the RH division describes the strategy as a minimum package of priority activities that the Ministry of Health and districts must implement in order to improve reproductive health in Uganda. In the policy document, the key objectives of the strategy are stated as increasing access to institutional deliveries and emergency obstetric care; strengthening family planning provision; and implementing goal oriented antenatal care.

The core interventions for sexual and reproductive health and rights as highlighted in the HSSPII are to

- Operationalize EmOC services at HC III, HC IV and hospital level including establishment of maternal death reviews
- Community mobilization and capacity building for reproductive health care including capacity to identify and refer high risk pregnancies and complicated deliveries and also male involvement in SRH.
- Scale up goal oriented ANC including provision of IPT and PMTCT
- SRH to be part of integrated sustainable outreach services (SOS)
- Provision of a range of Family Planning services, with special emphasis on improving logistics and making available to adolescents
- Advocacy and IEC stating the importance and availability of RH services
- Improve capacity at district level to deliver RH services through support supervision

### **1.4 Strategies for strengthening integration of women’s rights in the National AIDS programme.**

The overall national AIDS programme is coordinated by the Uganda AIDS Commission which is a semi-autonomous organization charged with ensuring a coordinated multi-sectoral response to HIV/AIDS. The issues pertaining to women especially with regard to feminization of the AIDS epidemic have been underscored in the various key country programming tools. In the recently

concluded process of formulation of a National Strategic Plan for HIV/AIDS it was identified that one of the key drivers of the epidemic are Gender factors influencing relationship risks which include imbalanced gender relations - domestic and sexual violence, women often unable to negotiate safer sex due to lower status, economic dependence and fear of violence; caretaker roles - Women bear the brunt of caring for sick family members; gender aspects of HIV - stigma for STIs in women (especially among the elderly and PWDs), HIV+ women are more likely to be rejected, expelled from family home and denied treatment, care and basic human rights. All of these issues increase women's vulnerability to HIV infection.

## **1.5 Basic Statistics on the HIV/AIDS Epidemic and Sexual and Reproductive Health. <sup>1</sup>**

HIV/AIDS IS a major cause of morbidity and mortality in Uganda. According to Millennium Development Goals Uganda's Progress Report 2007, over one million cumulative HIV/AIDS, have been reported since HIV/AIDS was first recognized. Uganda has about 2 million orphans out of whom 45% are a result of HIV/AIDS.

A brief overview of the demographics of Uganda suggests the following:

- Uganda has a generalized epidemic.
- There are 29 million people in the country. The Total Fertility Rate is 6.7<sup>2</sup>. The population Growth Rate stands at 3.2(4)% per annum, one of the highest in the world.
- Life expectancy at birth: Male = 48 years, Female = 50 years; projected to be 55 years without AIDS. The infant mortality rate (IMR) = 76 per 1000 live births.

At the socio-economic level, the following is evident:

- Uganda has experienced solid economic growth of 6-7% per annum over the last decade but this is not reflected in the quality of life for most people, particularly the 20% poorest people<sup>3</sup>;
- The Human Development Index position is 145/177 (in 2006);
- Uganda is a low income country with a per capita GDP of \$300/annum; with 31% of its people living below the poverty line (2006)<sup>4</sup>;
- There has been a marked increase in inequality (Gini coefficient increasing from 0.35 in 1997/8 to 0.43 in 2003) primarily due to slowdown in agricultural growth, insecurity, and population growth rate at 3.2% per annum;
- Significant adult underemployment is pervasive in the country;
- It is generally a peaceful country with insecurity and conflict concentrated in the northern part of the country.

Women are infected more than men across the age spectrum from birth to age 45-49 years (60% for women versus 40% for men) and the gender impacts of the disease are significant. Women are often unable to negotiate safer sex due to lower status, economic and fear of violence. Women bear the brunt of caring for sick family members; and are more likely to be rejected, expelled from the family home and denied treatment, care and basic human rights.

Figure 2 shows the trends of median HIV prevalence in both major urban areas and outside. For all the years under study, the level of HIV prevalence in areas outside major towns has been lower

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<sup>1</sup> As highlighted in the National Strategic Plan on HIV/AIDS 2007/2008 to 2011/12

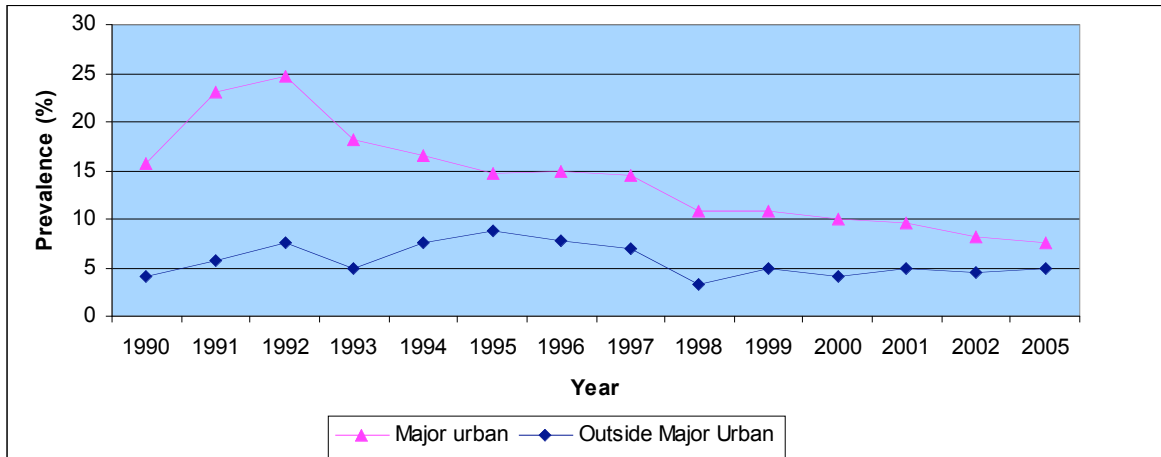
<sup>2</sup> UDHS 2006

<sup>3</sup> UNHS 2002

<sup>4</sup> UNHS 2002

than that in major urban areas but with a nearly similar trend pattern. The median HIV prevalence peaked around 1995 and was lowest in 1998. It started stabilizing in 1999. There is more evidence of stabilization of HIV prevalence in sentinel sites outside major urban areas compared to those in the major towns. Given that Uganda is 85% rural, the trend in non-major towns is more likely to reflect the situation in the whole country<sup>5</sup>.

**Figure 1: Median HIV prevalence of ANC attendees, 1990-2005**



Source: HIV Prevention in Uganda: The Road towards universal Access, June 2006

The Uganda national sero-survey (2005)<sup>6</sup> underscored the importance of understanding the distribution of HIV infection within a population. In conjunction with a survey of sero-prevalence, an analysis of the social, biological, and behavioural factors associated with HIV infection was performed. HIV prevalence was higher in women than men, and it increased with wealth. The results showed that the overall HIV prevalence among the 15-49 and 15-59 age groups was 6.4 and 6.3%, respectively (Table 1).

<sup>5</sup> Wabwire, F.; Tumwesigye, N.M.; and Opio, A. (2006) Accelerating HIV Prevention in Uganda: The Road towards Universal Access. I. A review of the Trends and Projections of HIV/AIDS Prevalence and Incidence in Uganda, June

<sup>6</sup> MoH and ORC Macro (2006) Uganda HIV/AIDS Sero-Behavioural Survey 2004/2005. March. MoH and ORC Macro

**Table 1: HIV prevalence by age**

Age	Women		Men		Total	
	% HIV positive	Number tested	% HIV positive	Number tested	% HIV positive	Number tested
15-19	2.6	2,062	0.3	1,932	1.5	3,994
20-24	6.3	1,803	2.4	1,184	4.7	2,987
25-29	8.7	1,679	5.9	1,123	7.6	2,802
30-34	12.1	1,374	8.1	1,139	10.3	2,513
35-39	9.9	1,029	9.2	868	9.6	1,897
40-44	8.4	823	9.3	745	8.8	1,568
45-49	8.2	621	6.9	524	7.6	1,145
50-54	5.4	513	6.9	452	6.1	965
55-59	4.9	322	5.8	332	5.4	654
<b>Total 15-49</b>	<b>7.5</b>	<b>9,391</b>	<b>5.0</b>	<b>7,515</b>	<b>6.4</b>	<b>16,906</b>

Source: Report of the 2004-05 Uganda HIV/AIDS Sero-behavioural survey

When data was disaggregated by age and sex, the data shows that women are more highly affected at younger ages compared with men. The age- and sex-specific prevalence of HIV for both women and men increases with age until it reaches a peak, which for women is attained at ages 30-34 (12%) and for men at ages 35-44 (9%). Prevalence for women is generally higher than for men at ages 15-49, though at ages 40-44, the male rate is marginally higher than the female rate. At ages 50-59, the pattern reverses and prevalence is slightly higher among men than women.

## **2 INTRODUCTION**

Uganda women's network commissioned a study to monitor the extent to which the UNGASS commitments had been implemented. In this regard five districts were selected representing the major geographical regions of the country namely northern, eastern, western and central. The qualitative study was carried out in five districts namely Lira, Mbale, Kampala, Fortportal and Masaka.

### **2.1 Objectives of the study.**

The objectives of the research was to

1. To report on the progress made by government in implementing UNGASS commitments.
2. To assess the impact of sexual and reproductive health services provided to women and other vulnerable groups.
3. To identify gaps with regards to implementation of UNGASS commitments
4. To recommend actions for ensuring effective implementation of UNGASS commitments.

## **2.2 Methodology:**

Different methodologies were employed and these included

- Observations
- In-depth interviews
- Focus group discussions
- Literature reviews of already existing published researches and other documented information on status of aids and HIVAIDS.

## **2.3 Selection Of Study Areas**

The general idea was to get **qualitative** information from sampled study areas to guard against biases two districts were selected from each of the four regions of the country, namely northern, western, central and eastern. Names of districts were written on pieces of paper, folded and put in a basket and one member was asked to pick one piece of paper per region and read out loudly. The exercise of selection results brought Iira from northern region, Mbale from eastern region, Fortportal western region and Masaka from central region. Lastly Kampala was brought on board because of its location as a capital city where Ministries of health is located, its population is representative of all communities in the country and many policy makers and HIVAIDS commissions and headquarters of civil organisation providing services in areas of HIVAIDS and Reproductive health are situated.

### **3 PROGRESS IN IMPLEMENTATION OF UNGASS GOALS.**

#### ***3.1 Government Leadership in facing the HIV/AIDS epidemic***

**Goal 37 – Government leadership in facing the HIV/AIDS epidemic**

“By 2003, ensure the development and implementation of multi-sector national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalizing; involve partnerships with civil society and the business sector, and the full participation of people living with HIV/AIDS, those in most vulnerable groups and people at risk, particularly women and young people(…)”

**Proposed Indicators:**

- **Effective participation of representative of women and youth living with HIV in the HIV/AIDS Programs, including the decision making spaces and in the UNGASS monitoring actions.**
- **Participation of groups of women assisted by the design, implementation, and evaluation of the programs directed towards them.**

**Findings:** Indeed government has played a key role in improving the health status of all Ugandans and HIV/AIDS has taken a priority position when it comes to implementation of the health programs.

Right from the beginning of 1986, the same year president Museveni came to power, the government launched Aids Control Programme (ACP) to spearhead the struggle against HIV/AIDS. The objectives of the programme were to prevent further transmission of HIV, create mechanisms to care for the infected and the families and create capacity to contain the epidemic. This was a strong start of leadership in Uganda in reversing the AIDS prevalence. In the same year the president toured the country telling people that it was their patriotic duty to avoid contact with HIV. This was a brave approach as many politicians are reluctant to talk openly about sexual issues but the openness paid off as Ugandan subsequent policies have been accredited with helping to bring adult HIV prevalence down from around 15% in the early 1990s to 5% in 2001.

In 1997, the government prepared a document; Poverty Eradication Action Plan which is the overall planning frame work and among its pillars is the direct increase of the quality of life of Ugandan citizens and on this pillar different detailed health strategies have been formulated and

AIDS programming has taken high consideration when it comes to the implementation. In 1999, National Health policy was formulated and Health Sector strategic plan was later formulated with overriding priorities among which was to reduce the burden of HIV/AIDS and also improve sexual and reproductive health status of the population.

The Uganda AIDS commission was established by Statute of Parliament No. 2 of 1992 under the Office of the President. It is mandated to oversee, plan and co-ordinate AIDS prevention and control activities. The AIDS Commission has since guided at a national level the formation of various strategies plans that have been the basis of all programmes and interventions related to HIV/AIDS issues. The commission has as one of its guiding principles the participation of the most affected populations. There is in place a mechanism for ensuring that persons living with HIV/AIDS participate in the key decision making forum. The civil social organizations such as National Association of children and women living with HIV/AIDS NACWOLA and The AIDS support Organization TASO, Uganda Network of Young Positives Association. Uganda network of AIDS service organizations. UNASO.

One of the key principles that have been adopted by the government of Uganda is the bottom up strategy planning starting from villages up to sub- County and district. A quota system for ensuring women and youth are in decision making forum is in place.

However at local government level women themselves had this to say.

**“Participation in plans and budgets processes is the domain of the educated and technical people”**

*Key informant Masaka*

### **3.2 Prevention**

#### **Goal 52 – Prevention**

“By 2005, guarantee that all countries, particularly the most affected, have a broad range of prevention programs that take in consideration the circumstances, the ethical and local cultural values, that include information and communication activities in the idioms they understand better, and respect their cultures, with the objective of reducing risky behavior and promote a responsible sexual conduct, including abstinence and faithfulness; more access to essential articles such as male and female condoms, and sterilized syringes; activities to reduce the harm of drugs consumption; more access to psychological support services as well as voluntary and confidential testing services; access to non contaminated blood, and quick and efficient treatment of sexually transmitted diseases;”

### **Goal 53 – Prevention**

“By 2005, guarantee that at least 90% of youth of both genders, 15 to 24 years old, and by 2010, that at least 95% of them, have access to information, education, including peer education and specific education for youth about HIV, as well as the necessary services to develop the required abilities to reduce their vulnerability to the HIV infection; all of this in collaboration with young people, mothers and fathers, families, educators and health care professionals;”

#### ***Proposed Indicators***

- ***Reach, adequateness and efficacy of sexual health programs for youth.***
- ***Access to unsafe sex post-exposure prophylaxis***

### **Goal 54 – Prevention**

“By 2005, reduce the amount of HIV infected breast fed babies in about 20%, and by 2010 in about 50%, offering to 80% of all pregnant women prenatal services with information, psychological support, and other HIV prevention services, growing the availability of efficient treatment to reduce the transmission of the virus from mother to child and giving access to treatment for HIV infected women and babies, and offering access to treatment for HIV infected women that are breast feeding, as well as efficient interventions for HIV infected women that should include psychological support and the voluntary and confidential testing services, access to treatment, particularly the antiretroviral therapy and, when appropriate, to the substitute of breast milk, and a continuous series of attention services;”

#### ***Proposed Indicators***

- ***Reach, quality and care of services for HIV infected pregnant women.***
- ***Access to adequate treatment to pregnant women.***
- ***Availability of appropriate detection testing.***
- ***Quality of counseling for HIV detection testing in pre-natal services.***
- ***Access to detection of syphilis in the maternity attention services.***
- ***Access to treatment of identified syphilis cases during pregnancy.***
- ***Nutritional support for HIV infected pregnant; anti- HIV prophylaxis during delivery.***
- ***Reach, adequateness and efficacy of programs that guarantee breast milk substitutes.***

The focus of prevention has been on Information, Education, communication (IEC)/behavioral change communication/BCC activities at the field level which have included campaigns at grassroots through drama and meetings, condom distribution Awareness creation and Information dissemination through IEC materials and media.

Other key prevention activities that were found to be implemented at field level included.

- **Male Condoms.** Many health units distribute free condoms but the quality and availability issues raise suspicion. One youth from Fort portal had this to ask

***“why are there different types of condoms being sold at different prices in the open market?” Does it mean the cheap ones are less protective? Female condoms are not widely available and it is un heard of in rural areas. The qualitative study also found out that the youth prefer buying in shops and getting condoms from private health units than government for issues of privacy.”There are many people at government health centre and it is not easy to ask for condom when people of your parent’s age are listening”.*** Focus boys group discussion –Mbale.

- There are at least 400 sites for voluntary counseling and testing (VCT). However there are very few outreach services for youth who test positive as programmes are concentrated in towns.
- There are 177 facilities for prevention of mother to child transmission (PMTCT). But coverage of (PMTCT) is limited especially in rural areas and the service suffers because of poor and limited supplies (e.g. of testing kits) and staff.
- Family planning services are mainly utilized by women. Yet men, who are decision makers on family size are least involved as result the programme does not achieve its aims.
- ARVS are distributed up to health centre 3. However their availability is limited by inadequate supplies and distribution.
- CD4 machines are distributed at regional level people find it hard to access them and they not free because of hidden costs such as transport costs, jumping queue by bribing the staff for quick service. During the study it was reported that when the CD4 machine breaks down, it takes a period over two months to have it rectified. The CD4 Machines are inadequate in terms of reach ness and affordability.
- STI services are provided starting from health 3. But study revealed that there are few qualified staff in rural areas especially the hard to reach and limited facilities such as testing kits, housing and drugs.
- Unsafe post-exposure prophylaxis accessibility is available but only in major hospitals which are far to reach.
- Provision of psychosocial support and nutritional supplements and home based care through outreaches.

- Civil society organisations (465 health outlets) and private sector (47 health outlets) complement government (1,226 health outlets) efforts in providing services such as information dissemination, counseling, condom promotion, treatment of sexually transmitted infections and there are others that provide services regarding HIV/AIDS.
- Monitoring and evaluation of HIV/AIDS epidemic is done routinely through surveillance activities which include; through sentinel surveillance and knowledge, attitude, behavioral change and practice surveys..

### **3.3 Human Rights**

#### **Goal 59 Human Rights**

*“By 2005, taking in consideration the epidemic context and specificity, and that women and girls are disproportionately affected by HIV/AIDS, elaborate and accelerate the application of national strategies that promote women’s progress and the respect for their human rights; promote the shared responsibility of men and women to secure safe sexual relations; train women to freely and responsibly control and decide the issues related o their sexuality with the objective of increasing their capability to protect themselves against the HIV.”*

#### **Proposed Indicators**

- **Reach, adequateness, and effectiveness of government’s policies and programs directed towards the promotion, security, and reparation of women’s rights;**
- **Interrelated policies directed towards women’s rights with the HIV/AIDS National Programs;**
- **Reach, adequateness, and effectiveness of government’s policies and programs directed towards men’s responsibility in sexual and reproductive health issues;**
- **Reach, adequateness, and effectiveness of the policies and programs of protection for vulnerable women’s sexual and reproductive rights;**
- **Access to assisted reproductive services.**

## **Goal 61 – Human Rights**

“By 2005, ensure development and accelerated implementation of national strategies for women’s empowerment, the promotion and protection of women’s full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional customary practices, abuse, rape and other forms of sexual violence, battering and trafficking of women and girls.”

### **Proposed Indicators**

- **Reach, adequateness, and effectiveness of specific laws to prevent, punish, and repair the damage caused by violence against women.**
- **Reach, adequateness, and effectiveness of specific actions against the sexual exploitation of girls.**
- **Coverage, quality, and care of the attention services for women and girls victims of violence or sexual violence, with anti-HIV and anti-STD prophylaxis, emergency contraceptives, and abortion.**
- **Existence of a public system for collecting and publicizing the data about violence against women and girls.**

## **Findings**

The Equal Opportunities Policy is consistent with the following key human rights principles which include Universal Declaration of Human Rights that articulates that all humans are born free and equal in dignity and rights. They are entitled to all the rights and freedoms set out in the declarations without any distinction of any kind such as race, colour, sex, language, religion, political, or other opinion, national or social origin, property, birth or status. The states party to the declaration are to ensure that all people are equal before the law and are entitled without any distinction to equal protection of the law.

1995 Uganda’s constitution article 34 guarantees empowerment of all women of all sorts of life through affirmative action.

Social Development Sector Strategic Investment Plan (SDIP) addresses major challenges of inequalities, inequity exclusion, unemployment and low productivity among the marginalized groups. It articulates interventions for promoting their participation and ability to access and utilize basic services. The plan focuses on strengthening coordination mechanisms and interlinkages among relevant stakeholders at all levels. The policy will promote inclusion and participation of marginalized groups in order to achieve equitable human progress.

Uganda also has gender responsive laws such as law on rape and defilement. Despite all the above laws and policies in place, there is lack of political and technical will to operationalise them as evidenced below

Other human rights issues that need to be advocated for are the minimum legal age for marriage is 18 years. But marriage of younger girls by parental arrangement is common particularly in rural and slum areas. Abortion is only permitted to save the life of pregnant mother otherwise; rape, defilement; HIV/AIDS is not a justification for abortion. Sex work and trafficking are illegal but are a common practice. The female sex workers are commonly arrested by police and charged for being idle and disorderly but men are left to go free. Domestic relations bills which criminalizes marital rape, widow inheritance, property grabbing, domestic violence, and promotes sex rights is not yet enacted yet these mentioned incidences are on increase.

***“None of these laws are being implemented young girls and women are still being raped, defiled and harassed sexually without actions from relevant authorities. Men usually bribe authorities and at times out of court negotiations are arranged between parents of the victim and the offender but the victim is not involved. Regardless whether the raped young girl/women has been infected with HIV/AIDS or impregnated the victim.”*** A Key informant in Masaka

### **3.4 Reduction of Vulnerability**

#### **Goal 62 – Reduction of Vulnerability**

“By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behavior and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys, including for commercial reasons. Such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement.”

#### **Proposed Indicators**

- **Reach, adequateness, and effectiveness of support programs for vulnerable women;**
- **Reach, adequateness, and effectiveness of productive programs or projects (small business) for vulnerable women;**
- **Reach, adequateness, and effectiveness of human rights defense policies and programs for vulnerable women;**
- **Reach, adequateness, and effectiveness of programs that attend the causes and structural problems of women and girls human traffic, without getting into individual criminalizing and discrimination.**
- **Reach, adequateness, and effectiveness of the international agreements, conventions, and treaties application in the country, as well as the effort of federal laws to punish women**

**Goal 63 – Reduction of Vulnerability**

“By 2003, establish and/or reinforce strategies, norms, and programs that recognize the importance of the family to reduce vulnerability, among other things, educating and orienting children, and that takes in consideration the cultural, religious, and ethical factors in order to reduce vulnerability of children and youth with the secured access to primary and secondary schools, with study programs for adolescents that include HIV/AIDS; protected and safe surroundings, specially for girls; broadening good quality services of information, sexual health education, and psychological support for youth; strengthening of sexual and reproductive health programs, and the inclusion, as much as possible, of the families in the planning, execution, and evaluation of HIV/AIDS attention programs;”

**Proposed Indicators**

- **Reach, adequateness, and effectiveness of programs that consider cultures, religion and cultural contexts in the education strategies.**
- **Effectiveness and coverage of the implementation of safe and secure surroundings for vulnerable girls.**
- **Access to housing, education, and food for HIV infected girls.**
- **Reach, adequateness, and effectiveness of integral health programs for adolescents.**
- **Reach and adequateness of sexual and reproductive health counseling at health service centers.**
- **Effective participation of youth in the design, monitoring, and evaluation of programs.**
- **Reach, adequateness, and effectiveness of capacity building actions for teachers in the theme of sexual and reproductive health.**

### **Goal 64 – Vulnerability Reduction**

“By 2003, develop and/or strengthen national strategies, policies and programs, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behavior, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise;”

#### **Proposed Indicators**

- **Reach and effectiveness of government articulations with regional or international partners to strengthen the specific attention programs and activities of sexual and reproductive health to vulnerable women.**
- **Participation of vulnerable women in the regional or international articulation processes.**

### **Goal 65 – Orphans.**

“By 2003, develop, and by 2005, implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans girls and boys infected and affected by HIV/AIDS, including the provision of appropriate counseling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;”

#### **Proposed Indicators**

- **Reach, adequateness, and effectiveness of specific support programs for orphans and children infected and affected by HIV.**  
**Quality of shelters.**
- **Reach, adequateness, and effectiveness of educative programs for orphans and in vulnerable situation because of AIDS.**

### **Findings:**

Vulnerability is a state of being disadvantaged, exposed to many risks (HIV/AIDS, STI and other SR infections) helplessness, disempowered, dependant and inability to make a standing decision against all odds that affect your well being. Its impact leads to social, political, economical service delivery exclusion. The qualitative study found out that women especially married poor women; the young girls, disabled, orphans, single mothers, sex-workers, and elderly are more vulnerable

despite the good policies in place that aims at reducing vulnerability in health sector and other sector.

Much as government has emphasized issues of gender specific needs, the practice portray a different picture. Women especially pregnant poor women and young girls are still being made to wait for long hours while the better financially are given services. Some nurses slap women in labour pain others don't respond at all to request for assistance from women in labour pain.

Most rural and out of school young girls are not well targeted and very few receive information from radio regarding their reproductive health. Major targets are for mostly women who visit health unit. Vulnerability for various groups especially women in particular the married women have been identified as being powerless in terms of negotiating for safer sex and therefore more at risk. A key informant from Lira pointed out that he observed.

***“Married Women who are living with HIV/AIDS are even more vulnerable and do not even have the decision making power on using condoms and ARVs.”*** Key informant Lira.

Other cultural and traditional barriers were noted to increase vulnerability of women some of the issues identified during focus group discussions with youth included

***“ female youth do not access reproductive health services because they are shy.”*** Focus group discussion Fortportal.

***“Some girl children have come to town for commercial sex for survival ”*** Lira Key informant

Orphans and other vulnerable children have been identified as a key programmatic area in HIV/AIDS preventions and social support programming. A National Policy on Orphans and other vulnerable children was launched in 2006. However the Uganda demographic and health survey 2006 identified the key issue as follows.

- Only 55% of children under 18 live with both of their parents
- 15% of children are orphans (one or both of their parents have died)
- OVC are less likely to have the 3 basic material needs.
- The vast majority (89%) of OVCs do not receive any external support.

A focus group discussions in Kampala and Mbale highlighted that

***“Young people start sex early and most of them have sex with more than one partners which increases there risk to getting infected with HIV/AIDS”*** Focus Kampala.

***“Youth prefer to get condoms free but in facilities that are youth friendly other than the government health centres”*** Focus Mbale.  
***Fear for Domestic violence makes mostly married women vulnerable to HIV/AIDS.***

### **Goal 69 – Mitigation of social and economic effects**

“By 2003, evaluate the HIV/AIDS epidemic’s social and economic effects and elaborate multi-sector strategies to face these effects in the individual, familial, community, and national levels; elaborate and accelerate the execution of national strategies to end poverty and face the epidemic in the places, the life styles, and access to basic social services, paying special attention to the people, the families, and the communities that are affected the most by the epidemic; study the social and economic impacts of HIV/AIDS in all social levels, specially women of age, particularly related to their function of support providers in the families affected by HIV/AIDS, and attend their special needs; adjust and adapt the social and economic development policies, including the policy of social protection, to face the effects of HIV/AIDS in the economic growth, in the essential economic services, labor productivity, fiscal income, and the prisons that produce a deficit in public resources;”

#### **Proposed Indicators**

- Availability of data or studies about the social and economic impact of HIV on women;

#### **Findings.**

The social economic impact of HIV/ AIDS has been one of the critical areas of concern for government programming in the context that it is one among major threats to human existence and economic development. The high number of orphans mainly due to the epidemic has made it difficult for extended families and orphanage centers cope with challenges. Equally HIV/AIDS has affected all sectors of the economy but impacted significantly on education system, it has led to absenteeism, claimed both teachers and children<sup>7</sup>. Regarding labor and productivity, HIV has adverse impact. The greater percentage of household income that would support the family is miserably spent on treatment and funeral expenses. HIV/AIDS has caused a number of employers to terminate labor force of sickly employees since they aim at maximizing profits and it has also led to existence of children headed families with inadequate resources to look after their sisters and brothers and other dependants. HIV/AIDS has increasingly caused poverty and discrimination and stigmatization of the victims. Women who lose their dear husbands are accused of in-laws and at times deprived of all resources. However on a positive note HIV/AIDS interventions have been a source of employment. Many people are employed in the AIDS related organizations like counseling, creating awareness, positive living clubs have been put in place to fight stigma and discrimination. Government has been able to extend services at health center iv that provide voluntary counseling and testing, prevention of mother to child transmission, HIV testing and HIV and AIDS education.

According to qualitative study carried out by UWONET in Lira which is one of the districts that have been affected by long term conflict it was observed that HIV/AIDS is still a major threat. A key informant stated that

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<sup>7</sup> 2007, Millennium Development Goals, Uganda Progress Report 2007.

***“Give us three more peaceful years, we shall be able to improve the status of the population especially with regard to their socio economic status” Key informant Lira.***

The Government of Uganda in collaboration with UNDP has launched a major study determining the Macro economic effect of HIV/AIDS this will be a major source of information for the social economic impact of HIV/AIDS at a macro level. Currently it is in the first phase implementation in which literature review has been done. Other key national documents which have been published by the Government of Uganda have emphasized issues related to the socio-economic status these publications include Uganda Demographic and Health Survey, Poverty Eradication Action Plan and the National Household integrated surveys. These various publications confirm that HIV/AIDS has major social economic impacts on the various categories of vulnerable groups but more so on women and girls.

#### **Goal 72 – Research and Development**

“Establish and evaluate adequate methods to investigate the treatment efficacy, its toxicity, side effects, different medicines interaction, and the resistance to them; establish methodologies to survey the treatment effects in the HIV transmission and in risky behavior”

##### Proposed Indicators

- Reach and quality of surveillance systems to detect side effects of ARV independent of sex and gender.
- Adequateness of the health care service provider’s response to the resistance effects and side effects of ARV in women.

**FINDINGS:** There are many interventions aimed at addressing side effects and toxicity of drugs. Medicine is prescribed and administered by qualified health workers. Joint clinical research is Marjory responsible but its coverage is limited to town and those who can afford to reach these health facilities. Women suffer side effects from these treatment .

## **4 MAIN STRENGTHS AND GAPS IN IMPLEMENTATION**

- Key issues or gaps that were identified at field level were a lot of HIV/AIDS funds are spent on administration costs and prevention campaign and inadequate funds is left treatment and psychosocial support to people leaving with HIV/AIDS.
- There is a shift from promotion of condom use to advocating for abstinence and yet the gist of matter is that young people engage in sexual relationships and they need protection.

- Despite excellent policies and strategies against sexual and reproductive health, HIV/AIDS, health services remain elusive to the marginalised and women and girls living in rural areas because of the distances, limited accessibility and affordability of services.
- Family planning campaigns should bring men on board. Although Uganda has reduced the prevalence of HIV/AIDS, prevention and control faces misconceptions and myths about condoms and this hinders their use in some areas.
- Mismatch between knowledge and behaviour as evidenced by very few numbers who turn up for VCT.
- HIV/AIDS funds are greatly mismanaged.
- Human resource capacity in terms of numbers and skills compared to the people who need the serve is still low.
- Inconsistence in the distribution and supply of ARVs and other HIV/AIDS/SR drugs and equipments which makes work difficult and not realising the set goals.

## **5 Recommendations.**

- ◆ Government in collaboration with development partners and other stakeholders should build the capacity of civil society organisation to enable them absorb resources that have been mobilised for the country. Particular attention should be paid to programming for other reproductive health elements such as STI, Family Planning.
- ◆ Government and partners should play a critical role in ensuring that the policies are translated into actual service delivery for the communities especially the most affected who include women, youth especially young girls and the disabled.
- ◆ Government and partners should strengthen their coordination, monitoring and supervision processes to ensure timely delivery of appropriate and adequate services to the infected and affected populations.
- ◆ Key partners should improve their planning, forecasting and distribution mechanism to ensure continuous supply and distribution of ARVs to PLWHA.
- ◆ Reduce vulnerability of women to HIV infection, there is need to develop female effective microbicides and vaccines to curb the epidemic.
- ◆ More funding should be set aside for skills development and economic empowerment initiatives.