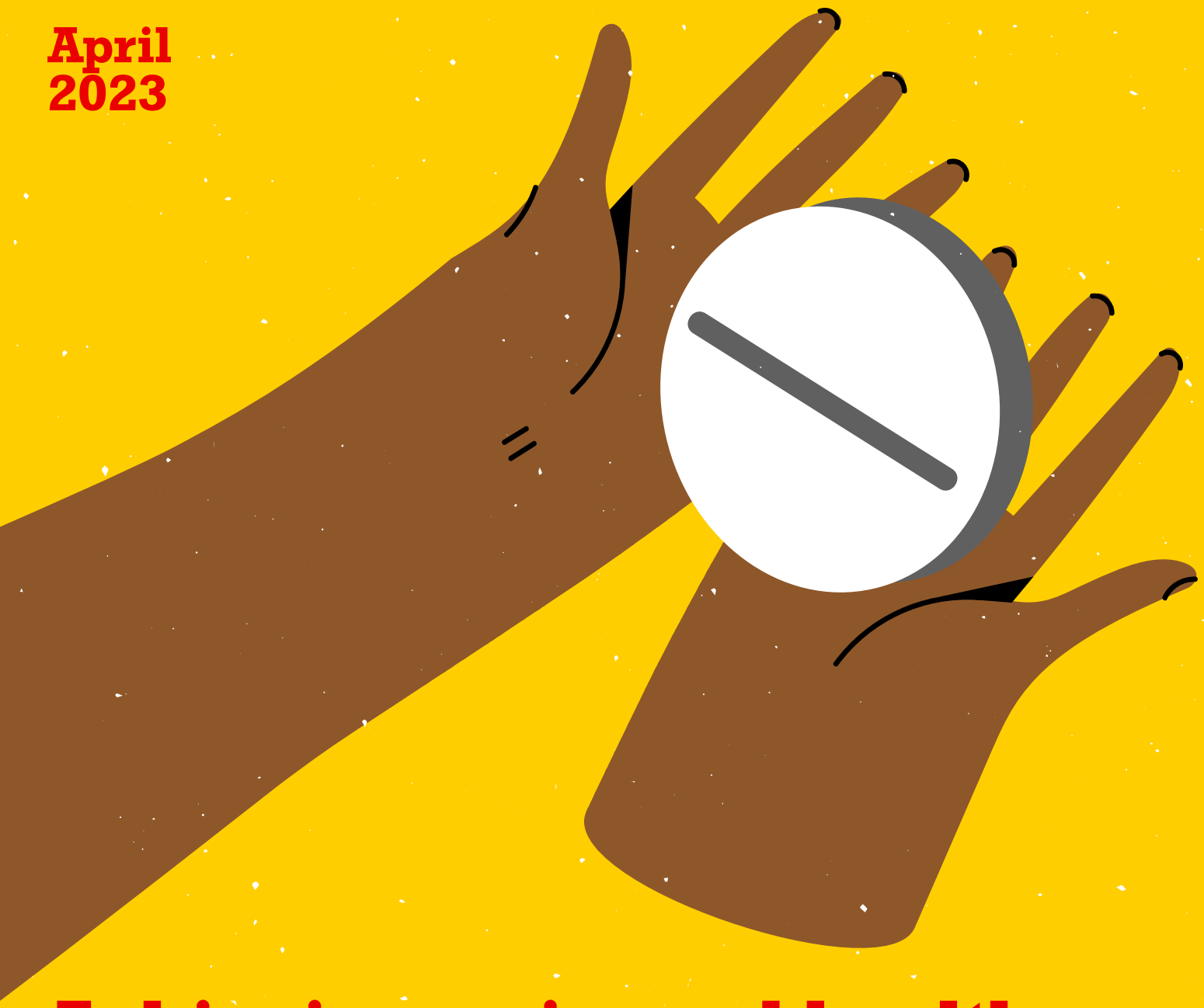
April 2023



Achieving universal health coverage for young people in Uganda

through realising their sexual and reproductive health and rights, and scaling up selfcare for health

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PATA PATA

GLOBAL NETWORK OF YOUNG PEOPLE LIVING WITH HIV

Developed by African Alliance

Universal Health Coverage and self-care: Uganda

April 2023

TIAN JOHNSON – FRANCESCA ALICE – ANNA MATENDAWAFA

BASHEERAH MOHAMED – ACHOLA CAROLINE

Introduction

In September 2023, governments will meet in New York during the second United Nations High-Level Meeting (HLM) on Universal Health Coverage (UHC) to agree on new commitments to realise UHC by 2030. In 2019, during the first-ever HLM on UHC, an ambitious Political Declaration was adopted to guide countries in their efforts to reform health systems, increase funding for health, and address barriers that prevent people from receiving the health services they need.

The world has fundamentally changed since 2019, with the COVID-19 pandemic demonstrating the devastating impact of weak health systems, underinvestment, and harmful policies and laws that prevent vulnerable, marginalised and stigmatised populations from taking care of their health.

This new HLM is critical to get world leaders back on track and agree on the need to invest in long-term, sustainable responses to ensure life-saving health services are guaranteed for everyone, particularly in the face of the ongoing effects of the COVID-19 pandemic – and the potential impacts of future pandemics. In addition, there needs to be a continued push for sociocultural and economic change; intersectional, human-rights based and gender-inclusive approaches to health; inclusive engagement of civil society in developing, implementing and monitoring health policies and funding. Empowering and equipping people to meet their health needs, including scaling up self-care interventions for realising sexual and reproductive health and rights (SRHR).

Self-care has never been more relevant than during the COVID-19 pandemic, where, globally, public health systems failed to meet the demands and needs of citizens. Governments increasingly stepped up self-care and digital health interventions to reduce the burden on public health systems and give people choices to access the services they need despite COVID-19-related service restrictions related to the emergency response measures, including movement restrictions, total lockdowns and social distancing – affecting people's ability to reach clinics, but also – with the demand on emergency health services – resulting in increasing shortages of healthcare workers.

Solutions such as HIV self-testing, self-sampling for sexually transmitted diseases (STIs) and digital health information offer new options for people who are unable or willing to access clinic-based services. This is not just due to COVID-19-related limitations but also poverty, gender-based violence (GBV), (dis)ability and other vulnerabilities, as well as a lack of privacy and the related fear of stigma and discrimination that prevent adolescents and young people (AYP) from accessing sexual and reproductive health (SRH) services in public clinics.

Thus, self-care provides a crucial contribution to realising UHC, where UHC is defined by the World Health Organization (WHO) as all people having access to the health services they need, when and where they need them, without falling into financial hardship. The "*where and when they need them*" is the very essence of self-care, where this approach means people are not dependent on the availability of doctors, nurses or the capacity or accessibility of health clinics for all of their health needs. It also increases people's autonomy, choice, and power about their health.

For this reason, the partner organisations implementing the YouthWise and YouthCare projects in Malawi, Uganda, Kenya, Tanzania and Zambia are advocating for governments to commit to scaling up self-care in the 2023 UHC Political Declaration as a crucial component of health systems strengthening; self-care services and commodities must be included in national UHC plans and budgets.

Purpose of this Document:

To inform this advocacy, the African Alliance ('the Alliance'), funded by Aidsfonds, conducted a series of policy analyses for the five countries above to understand better why self-care is critical to improve the SRHR needs of AYP and achieve UHC. The analyses assessed the policy landscape; lived experiences around UHC, SRHR and Self-Care; and the current limitations AYP face in accessing the services they need – and used this process to develop a set of country-specific advocacy messages for partners in the five countries to take forward running up to the HLM.

Country Snapshot: Uganda

KILE KILE HLM JUU YA UHC INAHITAJI KUSIKIA -NA KUFANYA!

Idadi ya watu nchini Uganda ni vijana na hilo halitabadilika hivi karibuni. Viongozi wanapaswa kujua kwamba kuwaweka vijana hai, afya, kutoka kwenye umaskini na katika uongozi kunakuza moja kwa moja maendeleo na jukumu la Uganda kama kiongozi wa kanda. Viongozi lazima wazungumze na watoe haki za afya na utu ambayo ni haki ya kuzaliwa ya kila raia wa Uganda - katika utofauti wetu wote.

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

Uganda's population is young, and that will not change anytime soon. Leaders need to know that keeping young people alive, healthy, out of poverty and in leadership directly advances Uganda's development and role as a regional leader. Leaders must walk the talk and deliver the health rights and dignity that are a birthright of every Ugandan – in all of our diversity.

Uganda's population is currently 48.4 million, with 46% of the population aged 0-14 years and 21% of the population aged 15-24, which means that nearly 70% of the population is below the age of 25. The Government's third *National Development Plan* (2020) estimated that about 78% of the population is aged 30 or below.[1] Uganda has a high fertility rate for both women and adolescents (118.8 per 1000 women aged 15-19).[2]

Most young people in Uganda are unemployed, with an unemployment rate in 2021 of 4.33%[3]. This means they do not have a source of income that provides them with the finances they may need to access health facilities and medications. However, there are gaps in Uganda's poverty data, which is highly concentrated at the national and regional levels; there has been no official publication of district and parish-level poverty statistics since 2014.

In terms of the **HIV landscape**, in 2020, there were 1.4 million people with HIV and 1.3 million people on anti-retroviral (ARV) treatment. Due to rapidly expanding HIV treatment, the number of AIDS-related deaths in Uganda halved between 2010 and 2020. Uganda has rapidly expanded viral load monitoring in recent years and in 2019, HIV self-testing kits became available for free from public health facilities and bought from pharmacies[4]. However, behaviour change efforts, including age-appropriate sex education and targeted HIV prevention campaigns, have not been widespread enough to reduce HIV infections

1 National Planning Authority (2020). P xvi.
2 Uganda Bureau of Statistics. (2021)
3 Macro Trends, (2022).
4 Be in the Know (2022)

as much as is needed. While intimate-partner violence, which helps to drive HIV, remains common, HIV-related stigma remains an issue. Around one-third of people in Uganda hold discriminatory attitudes towards people with HIV, and a third of people with HIV hide their status from others[5]. In addition, activists warn that the recent anti-homosexuality legislation will essentially criminalise inclusive HIV programmes and undermine the country's efforts to end AIDS by 2030[6]. For young people, and especially those who may identify as LGBTIQ+, this means that,

"When young people walk into a health facility that does not have a safe space like a youth corner, it makes it hard for them to feel free while accessing these services."

(Male, youth-led organisation).

"This bill really pushes for policing, increased stigma and discrimination, but also reporting of LGBTI identifying persons, which will create a very precarious state where people go into hiding, and it will be very difficult for people to even access services because they'll be scared the doctor will report them."

(Richard Lusimbo, national director of Uganda Key Populations Consortium)[7]

5 Be in the Know (2022).
6 Fallon, A. (2023).
7 Fallon, A. (2023).

Young People's OF SRHR Services Access

NINI HLM JUU YA UHC INAHITAJI KUSIKIA - NA KUFANYA!

Vijana wa Uganda wanahitaji kuwepo katika nchi ambayo inawalinda dhidi ya unyanyasaji wa kijinsia na ubakaji (mara nyingi hujificha kama ndoa ya utotoni, inaruhusu kufanya maamuzi yanayoungwa mkono na sahihi kuhusu miili yao na mustakabali wao, inawaheshimu kama wanadamu kamili na wakala na sauti, proac. -tively inawapa taarifa sahihi na zenye ushahidi kuhusu ulimwengu unaowazunguka na haki zao na kuwapa nyenzo na bidhaa za kugeuza haki hizi kuwa ukweli!Viongozi lazima wajue kuwa sheria zinazoaibisha, kuharamisha na kunyamazisha sisi ni nani tu. kutuweka mbali na huduma za afya na kutuweka wagonjwa, hofu na kutuweka kwenye vurugu kutoka kwa Waganda wengine.Vijana katika utofauti wetu wote lazima wawe huru katika Uganda yetu ili kuchangia mafanikio ya nchi zetu.Viongozi wetu lazima watulinde - sisi ndio mustakabali wa nchi hii Wazazi pia wanahitaji kuungwa mkono kwa taarifa na usaidizi wa kimazingira na kiutamaduni ili kukuza jumuiya ya upendo na heshima kwa vijana na uchaguzi wao.

WHAT THE HLM ON UHC NEEDS TO HEAR – AND DO!

Young Ugandans need to exist in a country that protects them from sexual violence and rape (often disguised as child marriage, allows them to make supported and informed decisions about their bodies and futures, respects them as full human beings with agency and voice, proactively provides them with accurate and evidence-based information about the world around them and their rights and gives them the tools and products to turn these rights into a reality! Leaders must know that laws that shame, criminalise and silence us, keep us away from health services, keep us sick and afraid, and expose us to violence from other Ugandans. Young people in all our diversity must be free in Uganda to contribute to our country's success. Our leaders must protect us – we are the future of this country. Parents also need to be supported with contextual and culturally relevant information and support to foster a community of love

Some of the specific realities for AYP that impede their health service access are outlined below.

Age of consent to sex and marriage:

The minimum legal age of marriage is 18. However, child marriage (girls aged 18 or younger) is still a huge challenge. It is estimated that there are 5 million child brides in Uganda; 1.3 million were married before the age of 15.

Access to contraception:

Of women aged 15-49, 55% are satisfying the demand for family planning using modern contraceptive methods. Within this group, 36.3% are using modern contraceptive methods; while 26% have an unmet need for family planning[8].

8 WHO (2021). P 5.

Access to abortion:

Abortions are only legally permitted under limited circumstances. Examples include a pregnancy that puts the woman's life at risk or results from rape, defilement or incest, or if there are foetal abnormalities[9]. In Uganda, only a doctor can perform an abortion, a prohibitive issue in countries like Uganda where it is partially decriminalised, as women struggle to obtain accurate information about when and where it is legally available. This is compounded by the social, religious and legal stigma of abortion, particularly where a majority of the country identifies as Christian. Coupled with the unclear and often confusing abortion laws and policies, many women turn to unsafe, clandestine abortions with devastating consequences. These are a major cause of deaths and health complications in many African countries[10].

Age of consent to health services:

There are no laws requiring parental consent to access SRH services, i.e. counselling and screening for contraceptive use, which includes HIV and STIs,[11] however, the *HIV Prevention and Control Act* lists 12 as the age of consent for HIV testing and counselling, and does not expressly allow children younger than 18 to independently consent to HIV treatment. [12]

Comprehensive Sexuality Education (CSE):

26-50% of all primary schools and 51-75% of all secondary schools in Uganda fully implement the national CSE policy.[13] However, Uganda has lagged in the development of CSE curriculum due to the insistence of the state in promoting the ABC[14] campaign as the main solution to SRH challenges. The resulting misconceptions of SRHR have resulted in fear that more comprehensive CSE curriculum will promote and increase promiscuity, empower and make females rebellious, and increase women's decision-making over their sexuality.[15]

Criminalisation:

Same-sex, sexual conduct is criminalised via a colonial-era law which prohibits 'carnal knowledge' among people of the same sex. [16] Transmission, exposure, or non-disclosure of HIV is criminalised, and sex work is fully criminalised.[17] Trans identities are prosecutable, and LGBTQI and sex worker organisations are not able to be legally registered[18.] In March 2023, the criminalisation of non-conforming sexual identities went further, with the introduction of an 'Anti-Homosexuality' Act prescribing life imprisonment for homosexual acts and the death penalty for "aggravated offences" such as those involving minors or people with disabilities. The new legislation also includes a duty to report same-sex acts and imposes up to six months in prison for failing to do so, as well as prescribing conversion therapy[19]. UNAIDS has warned that if the Act becomes law, it will curtail "the human rights of people living with HIV and some of Uganda's most vulnerable people-saving-saving services.[20]

9 Alice, F. (2020). P 16.
10 Alice, F (2020). P 24.
11 Sexual Rights initiative (2020).
12 UNAIDS (2022).
13 WHO (2021). P 7.
14 **A**bstinence, **B**e faithful, use a **C**ondom.
15 UNFPA & UNICEF (2019). P 13.
16 Human Rights Watch (2022).
17 WHO (2021).
18 Alice, F. (2020). P 16.
19 Fallon, A (2023).
20 UNAIDS (2023)

The consequences of this landscape in practice, sees myths and misconceptions about SRHR and self-care information and services leading to promiscuity and rebelliousness (see above) in the community, and contribute to the lack of accurate information and open discussion of SRH and rights issues, inhibiting access to service further. Yet AYP want to know where to access service and feel strongly that there is a need to

"create more awareness of where services can be accessed so young people can benefit from these projects."

(Female, young person).

Other key issues in practice include information not being tailored to youth needs or age-appropriate, so young people either miss out on key messages or misinterpret the information and draw conclusions based on a first encounter or shared experiences with friends. These assumptions stand in the way of young people accessing services when they need them. Compounding this is the healthcare providers, who are often not friendly, don't promote confidentiality and patients aren't treated well.

The fear of being stigmatised/talked about by others is also a barrier. Many young people with HIV fear going to health facilities because of stigma and discrimination. This can also affect treatment adherence. People living with HIV are still being treated differently in the community:

> *"Sometimes they do not want to even share a plate of food with them or drink from the same cup"*
>
> **(Female, young person).**

Finally, lack of support from parents or caregivers is a key issue: young people need role models that they can look up to. However, sometimes they are sidelined by their parents or caregivers, looking for comfort or answers in the wrong places because parents do not want to discuss sexuality education. In Uganda, sex education is considered immoral and goes against the traditional values of society.

In the face of these barriers and experiences, young people have often (where they can) resorted to using telecommunication or online sources to learn more. For example, Rocket Health[21] uses SMS technology to provide SRH information to those without internet access, while Reach a Hand[22], a youth led SRHR advocacy organisation uses a combination of digital platforms and USSD codes[23] for those without smartphones.[24]

21 See: https://www.rockethealth.shop/

22 See: https://www.facebook.com/reachahandug/

23 USSD (Unstructured Supplementary Service Data) is a Global System for Mobile Communications (GSM) protocol used to send text messages. USSD is similar to Short Message Service (SMS) but uses codes made up of the characters available on a mobile phone.

24 Ntezza, M (25 March 2022).

Health Policies & Funding

KILE KILE HLM JUU YA UHC INAHITAJI KUSIKIA -NA KUFANYA!

Zaidi ya miongo miwili viongozi wetu waliahidi mjini Abuja kwamba wangetenga angalau asilimia 15 ya bajeti zao za kitaifa kuboresha mifumo ya afya. Hiyo ilikuwa kabla hata ya vijana wa Uganda hawajazaliwa. Ahadi hiyo ilikuwa tupu na kwa kweli tunatumia kidogo na kidogo kuwaweka Waganda wakiwa na afya njema na hai. Tunahitaji viongozi ambao wataweka afya na ustawi wetu mbele, ambao wataongeza sio kupunguza uwekezaji katika huduma ya afya kwa ajili yetu sote. Ina maana gani kwa mustakabali wetu wakati sehemu kubwa ya huduma zetu za afya zinafadhiliwa na wafadhili? Uganda ninayotaka kuona ni Uganda ambayo ina mifumo thabiti, inayowajibika na endelevu ya afya kwa wote - na ambayo inahitaji uongozi wenye maono!

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

Over two decades, our leaders promised in Abuja that they would allocate at least 15% of their national budgets to improving healthcare systems. That was before many young Ugandans were even born. That promise was empty, and today we are spending less and less on keeping Ugandans healthy and alive. We need leaders who will put our health and well-being first, which will increase, not decrease, investment in healthcare for all of us. What does it mean for our future when the bulk of our health care is being funded by donors? The Uganda I want to see is a Uganda that has strong, accountable, and sustainable healthcare systems for all – and that needs leadership with a vision!

Policy landscape

The *Constitution* (1995) commits to fulfilling the "fundamental rights of all Ugandans" to ensure that all Ugandans enjoy rights and opportunities and access to [among other things] health services. To achieve this Government is working towards a national insurance policy to ensure that people get the best healthcare services at the lowest cost. This includes working to improve infrastructure so there are health facilities within a 5km radius of where people live.

In terms of SRHR policies, there is a *National Adolescent Health Policy* (2004) and the related *National Adolescent Health Strategy*, as well as a *Multi-Sectoral Framework for Adolescent Girls* (2011-2015), the *National Strategy to End Child Marriage and Teenage Pregnancy* (2022-2027) and a *National Sexuality Education Framework* (2018). There is also a clients' charter, the *National Policy Guidelines and Service Standards for SRHR* (2006) that speaks to how services should be offered to young people without discrimination.

In terms of UHC, while, for example, the *Uganda Vision 2040* doesn't mention self-care specifically, it does discuss universal health insurance, highlighting the need for a policy shift in the health delivery system from a public-centred to a strategic public-private partnership approach in order to, for example, increase the proportion of the population accessing UHC from 44% in 2018 to 60% in 2025, as outlined in the *National Development Plan*. To achieve this shift to public-private, the Government is closely working with agencies like the United Nations and partnering with civil society organisations (CSOs) to reach people and places and provide the services they may be unable to provide.

Financing for health[25]

Uganda has made significant progress in Reproductive, Maternal, Newborn, Child and Adolescent health (RMNCAH) and UHC across sub-regions, though huge disparities still exist within the country. On average, Uganda's UHC stands at 59% leaving a huge gap of 41% of the population at risk due to weak coverage of RMNCAH services. Before the COVID-19 pandemic started in 2020, Uganda had made progress in many areas of health, including maternal, newborn and child health, nutrition, and HIV. However, COVID-19 has put a huge burden on the sector, which could threaten gains made.

Spending on health has been increasing in both nominal and real terms since 2018/19. Total health spending increased from UGX2307billion in 2018/18 to UGX2781billion 2020/21. Based on the approved allocation for 2022/23, health budget is projected to increase to UGX3,722billion. However, the overall growth in the budget Is not reflected in the health budget, which has declined as a proportion of the total Government expenditure. Before COVID-19, the health sector budget had begun to decline as a proportion of total budget, from 7.06% in 2018/19 to 6.11% in 2020/21. On the back of this, health spending increased from 6.1% in 2020/21 to 7.73% in 2022/23, mainly as Government increased health expenditures to contain the spread of the virus. Despite this increase, the total percentage allocated remains way below the Abuja target of 15%.

The health system in Uganda continues to be financed by many different stakeholders, including Government resources, borrowed funds (internal and external), domestic revenues for subnational governments, and external grants. With lower spending levels on health, the sector sees high out-of-pocket spending and frequent disruptions in service delivery. During 2014–2016, out-of-pocket spending oscillated between 41–42%, while external financing was reported at about 42–43%.

The health sector also receives significant off-budget support, estimated at 27.5% in 2020/21, compared to the decline in domestic spending on health from 64.4% in 2019/20 to 58.1%. While external financing towards the sector greatly supplements the limited domestic resources, it is unsustainable and risky for a crucial sector like health to be so dependent on external donors.

25 This section draws on the most recent UNICEF Health Budget Brief for Uganda(2023).

Inclusion of SRHR and self-care in policies and funding

Most of the policies shared above speak about youth-friendly services and access to services, but no emphasis has been put on self-care as an explicit strategy to engage AYP. This is quite likely due to the "morality" aspect surrounding SRH information and services. That said, Ugandan partners have been practicing self-care interventions in SRHR and HIV-related work, particularly during the height of the COVID-19 pandemic where there were extended lockdown periods and social distancing measures; at this time self-care grew in practice as services and commodities were delivered to homes, for example, self-testing. Partners shared that many medical facilities started teaching clients how to: self-administer pregnancy test kits; use HIV testing kits; utilise sayana press[26] as a family planning method; and take ARVs for those people living with HIV. These services did not require a healthcare provider to be around.

There are opportunities to leverage these good practice examples and scale up to integrate self-care more explicitly into SRHR frameworks and approaches for young people. However, for this to be successful, there is a need to define and to popularise self-care as an approach and explain why it is so important for young people – and this should be communicated in all communities, in both non-technical and local languages so that every young person and their broader sphere (family, community healthcare practitioners, traditional and faith leadership, etc.) can understand:

> *We need to think about it because the opportunities are enormous. Let the populace know that they need to put themselves first. When I work with boys and men, there are social norms like men are the provider, but this makes men forget about themselves. So the question for men is, what have you done for yourself or bought for yourself [in the context of health]? "*
>
> **(Male, youth-led organisation)**

At a Government level, this is slowly being realised, with the development of a test *National Guideline for Self-Care Interventions for SRHR* in 2020 to optimise opportunities for self-care uptake within the existing healthcare system. This saw the document itself developed and successfully tested during the first phase, with the second phase intending to integrate the guideline into the existing health system. The lessons learned from the testing will be applied to finalise and officially launch the guideline. Six task-force teams, namely Quality of Care (QoC), Social Behavioral Chance (SBC), Finance, Human Resources, Medicines and Supplies, and Monitoring Evaluation Adaptation & Learning (MEA&L) have been formulated to facilitate seamless integration of self-care within the existing health system[27].

26 See: https://injectsayanapress.org/

27 Mutoru, P; Omari, A; Kosgei, S (2021).

Voices of young advocates

Some of the **key barriers and issues** shared by young people engaged in this process include limited awareness about the available services in the community or through health facilities.

> *"[There is a need to] create robust awareness about those available services, and ensure people utilise these services without bribing. (Using T-shirts, social media, TV and Radio to advertise or create more awareness on the subject matter)."*
>
> **(Female, young person)**

For the small number of health facilities that do have youth-friendly service corners, young people do not like waiting in line or having a health worker who is very old attend to them. Most health facilities in Uganda do not have youth corners and the few that do lack commodities and medications and don't adhere to service standards (i.e., patient confidentiality and AYP-focused or younger healthcare workers). A youthful atmosphere (in addition to quality, tailored services) would better attract young people to seek and access services:

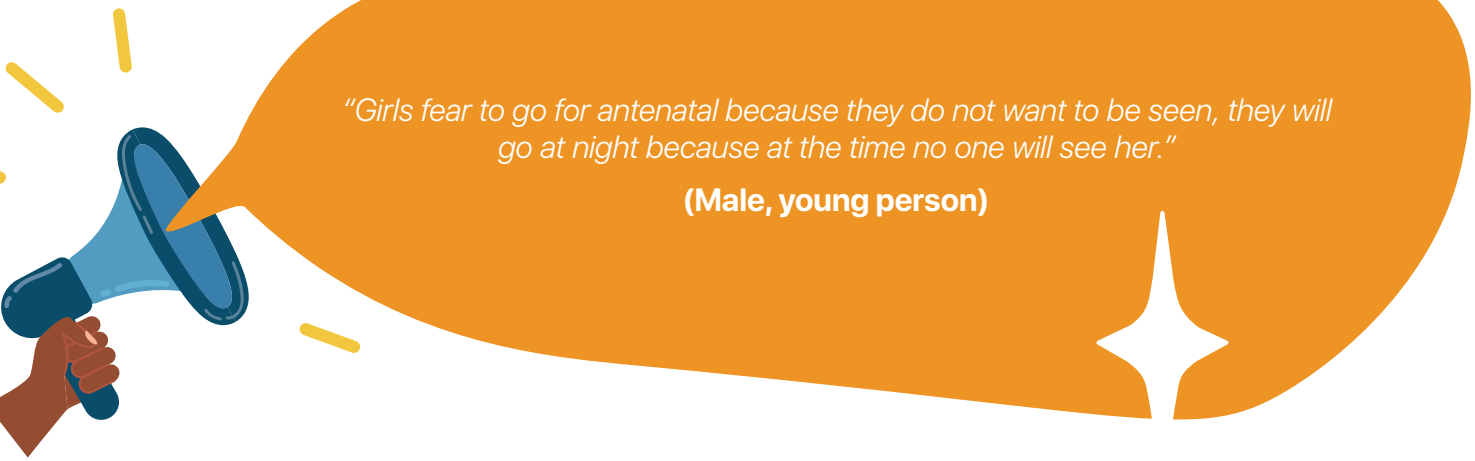
> *"The health care providers are older than and have an attitude, when you reach the health facility they look at you a certain way which makes us not to go there."*
>
> **(Female, young person).**

In addition, the lack of support from parents and caregivers (especially where consent is needed to access a particular service) is a significant barrier to AYP seeking SRHR services and commodities. While no laws require parental consent (unless under the age of 12) to access SRH services or contraceptives, including condoms, hormonal or long-lasting contraceptives, and HIV self-testing, the practice in health centres is different. Linked to this is the distinct lack of role models or peers to look up to in terms of being more confident to access services or simply be themselves.

These issues are compounded by socio-economic challenges, where most of the youth in Uganda are unemployed (4.3% in 2021 of the economically active population aged 15-24 are currently actively seeking work),[28] which makes them financially unable to get the SRHR services or commodities they need, despite Government efforts to ensure family planning methods are accessible at all public health facilities at no cost:

> *"There is a need to follow-up on the organisation and government bodies that implement projects to ensure that services reach people."*
>
> **(Female, Young person)**
>
> *"A lot of things we use for self-care, like condoms and pads, are essential products that, Government should cut costs on so that youth can access them to take care of themselves."*
>
> **(Female, Young person)**

Stigma and discrimination are significant issues that stand in the way of accessing services, especially for people with HIV. They don't want to be seen to be accessing services:



28 O'Neill (2022).

Key Advocacy Messages

A clear set of recommendations emerged through this process:

YOUNG LEADERS ARE LEADERS!

Young people must be involved in making these linkages between SRHR, HIV and UHC – and how self-care can be a practical approach to strengthening health systems. This was resounded in the youth discussions where they advanced the clarion call of "nothing about us without us". Overall, young people want to be engaged; they want knowledge and information and inclusion in critical processes and decision-making on what services should be provided to them. They want to see young people serving and working on their issues, not older people and ensure that parents are actively engaged and supporting them. Young people want to, and must, lead!

> *"Young people want to be heard and respected and to work with fellow peers who have been there before, have privacy, and confidentiality, and do not want to wait at the health facility but have someone there waiting for them and attending to them so they move on to the next thing."*
>
> **(Female, SRHR Organisation representative)**

> *"Young people want economic empowerment to ably manage their health-related issues and have access to health services."*
>
> **(Female, Youth-led Organisation representative)**

LEADERS MUST LEAD!

Despite significant UHC policies and strategies, there is a clear gap in terms of implementation – as well as integration with HIV and SRHR policies - with the need for:

- Regularly updated standards and guidelines to reflect current realities, linked to regular review and update cycles for SRHR-related policies;
- Accessible standards and guidelines (at key levels of the health system) that translate the policy into tangible practice for service providers and users;
- Processes to ensure that civil society (CSOs) and community-based organisations (CBOs) are adequately involved at the design and implementation stages;
- Greater inclusion of AYP, their communities and service providers through human rights literacy training (with a specific focus on health rights and how these can be realised within the context of the SRHR and HIV response in each country), tailored to how AYP best receive information (online, via Apps, via peers, and so on).

LEADERS MUST ACCOUNT!

There are many opportunities for communities to hold leaders accountable practically. However, the mechanisms to do this can be very opaque. Some examples of how to hold leaders to account at different levels include:

- Leveraging the regional and international instruments Uganda has signed onto and their inbuilt accountability mechanisms. CSOs can check the status of these various treaties online29 to identify meaningful advocacy opportunities, for example, by submitting Shadow Reports to supplement Government reporting on women's rights.
- Similarly, understanding the national policy frameworks – and the gaps – provides a foundation for influencing through national bodies, such as national HIV and AIDS councils' review cycles for their National Strategic Plans or Technical Working Groups' reviews of key strategies and guidelines for AYP SRHR services.
- Ensuring all SRHR-related policies and any associated strategies, plans and guidelines have regular review cycles and a schedule that can be accessed by civil society to influence policy updates by ensuring they reflect current realities on the ground.
- Influencing through targeted information campaigns catering to key audiences' information preferences, e.g., hardcopy posters, dialogues, and activations in communities, or online (via Apps and social media) or via peers for AYP.

29 See: https://www.ohchr.org/en/countries/uganda

LEADERS MUST UNITE!

Uganda has a strong network of stakeholders engaged in different ways in the SRHR and HIV landscape. There is, however, a clearly articulated need to meaningfully involve and – as part of that - better resource local CSO networks – particularly youth-focused and youth-led - to support a critical and representative mass of stakeholders who can support and drive the rights agenda. This can include:

- catalysing around a shared issue to leverage different expertise and resources
- making available joint funding for shared action (campaigns, movement strengthening)
- making available unrestricted funding for non-traditional forms of advocacy that local groups can implement without 'sign off' from a donor.
- leveraging off the significant work already being done by CSOs in Uganda, for example, many of the stakeholders identified in Annex 3 engage in youth-led advocacy, which takes the form of involving youth in developing proposals, collecting information, analysing the data, presenting findings, and interpreting and defining what key issues are to inform decision-makers; young people are also involved as major stakeholders in project planning, implementation and monitoring - guaranteeing higher levels of acceptance among young people; and engaging different stakeholders (adults and teenagers) to support young mothers' access to quality services at health facilities.

LEADERS MUST INVOLVE!

Participation and engagement at all levels are key. AYP want to be involved at all levels – they want knowledge and information about the processes to actively influence decision-making on what services should be provided to them. Ultimately, they want to see young people serving and working on their issues, not old people and they want to ensure that parents are actively engaged and supporting them.

> *"GBV, SRHR or gender training should start at the senior three levels in school; once they know at an early age, they can fight for themselves and make better choices."*
>
> **(Male, Young person)**

> *"Involve parents, so they feel they are part of the whole process; this will also require guidelines so that organisations know what to discuss with parents."*
>
> **(Male, Young person)**

LEADERS MUST EVOLVE!

While significant policies guide AYP SRH services in Uganda, the term 'self-care' is rarely used. Instead, language such as 'youth friendly' and 'adolescent friendly services' was prevalent and written from a top-down perspective. Similarly, the term' family planning' is extensively used in policy documentation. This is problematic where it often replaces terms such as 'reproductive health', 'reproductive rights', 'sexual and reproductive health and rights', and 'reproductive justice' and assumes the individual is using contraception to plan a family, as opposed to people who want to use contraception solely to exercise their right to choose and to be safe; it also assumes a very heteronormative version of a nuclear family and procreative path. The term' family planning' does not include access to safe and legal abortion, yet family planning is often used for all pregnancy prevention. The concept is best placed within a broader SRHR framework founded on the understanding of choice.

These language issues present significant opportunities for advocacy, where partners and communities can influence at different levels (policy influencing and community-based activism) around more inclusive, rights-based language that, in the You(th) Care project context, prioritises AYP's agency in accessing services and making decisions about their SRHR – and that also reflects that we do not live in a heteronormative paradigm of identities, orientations or choices:

"Self-care is something that has been here for some time but is restricted to some health conditions and has not been aligned with the SRHR. This has led to women doing unsafe abortions with drugs from the clinic because they could not access these services at the health facility, and by the time they come to the health facilities, they are having major complications."

(Female, SRHR Organisation)

TAKE SRHR INFORMATION ONLINE!

There is a need to use technology in innovative ways given the many examples of the use and access of the internet through mobile phones (or other online channels) by young people in the country to access health information/self-care as a potential mechanism to enact different advocacy and influencing initiatives, alongside the provision of comprehensive, accessible SRHR information and referral information for key health services:

> *"I first search online before I go to the doctor. Even with the flu, I rarely go to the hospital. I try self-medication before going to the hospital; for instance, if I have a backache, feel pain when urinating, or lose muscle or lose weight, I will search about it before I go to the hospital."*
>
> **(Male, young person)**
>
> *"It is one thing to assume that young people will listen to the radio or be on TV to get information, but the way young people access information varies because they are not homogenous. We need to think of ways young people access information."*
>
> **(Male, SRHR organisation representative)**

ANNEX 1: Research Methodology

In August 2022, following reflections from You(th)Care consortium partners about gaps in knowledge of the policy landscape for SRHR and HIV in each programme country, Aidsfonds commissioned the African Alliance ('the Alliance') to undertake an initial country-specific (Kenya, Tanzania and Zambia) policy analysis to provide the consortium with insights into each country's policy environment to support partners to better promote and realise AYP's SRHR and HIV self-care needs, including AYP access to self-care services and commodities.

This first phase of work focused on mapping policies, strategies and guidelines related to AYP aged 10–25, as well as identifying key stakeholders and the specific barriers or enablers to progress in improving SRHR and the practice of self-care. To that end, the Alliance engaged stakeholders from the You(th) Care consortium cohort (partners and young people) alongside a small sample of thought leaders working regionally, continentally, and globally on SRHR and self-care to understand better the policy landscape and what opportunities may exist for You(th) Care to inform its adaptation and future implementation. The policy analysis process sought to understand the state of the national adolescent and young people's SRHR and HIV response in each country and the possibilities to practice self-care; key policies and guidelines that influence adolescent and young people's SRHR and HIV vulnerability and access to self-care; barriers and opportunities for improving adolescent and young people's SRHR, the practice of self-care; the main stakeholders; recommendations to impact on adolescent and young people's SRHR, the practice of self-care and HIV/AIDS in the country.

The process was phased, consisting of an initial briefing with You(th)Care colleagues from Aidsfonds, a desk review, and country-based semi-structured discussions with consortium partners and the young people (aged 18-25) they work with. A second phase was commissioned in September 2022 to add an analysis of Malawi and Uganda and build on the initial process with an adjusted focus to consider what commitments or policies on UHC each country has in place and how they are being implemented.

In Uganda, the following stakeholders were engaged in this process:

1. Youth Livelihood Development Company (staff and young people)
2. International Community of Women Living with HIV Eastern Africa (ICWEA)
3. Community Health Alliance Uganda (CHAU, staff)
4. Reproductive Health Uganda (staff)
5. National Youth Advocacy Platform (NYAP) (staff)
6. Ngabo Youth Friendly Service Centre (staff)
7. Men Engage Alliance (staff)
8. Uganda Youth and Adolescent Health Forum (UYAHF, staff)

Through this approach, the Alliance sought to draw from the base set of findings from the desk review and build on these through the in-country processes, ensuring that the data collected is meaningful and nuanced rather than repetitive to draw a clearer picture of what is happening in each country from multiple perspectives. The Alliance used thematic analysis to compare the findings in each country and draw out country-specific advocacy recommendations. Where possible, useful examples of good practice are identified in the narrative. Findings are presented as individual country snapshots, with a summary' global brief' that also considers the profile of self-care in regional and global debates. Illustrative quotes are used throughout this document, extracted from the in-country conversations with partners and AYP.

Limitations

- Any instance of participants not feeling comfortable using English was largely mitigated by conducting face-to-face conversations in local languages (Luganda in Uganda with young people). The recordings were transcribed and translated into English and used to generate synthesis reports of the conversations.
- The sample of young people (aged 18-24) who participated in the conversations was limited due to i) insufficient time to organise discussions with adolescents (age 10-17) due to the lead-in time required to coordinate informed consent processes with their parents and guardians; and ii) the time of year the second phase conversations took place (November-December) where stakeholders had competing deadlines before the end of year break; iii) consultations were held in urban centres (Kampala in Uganda) which meant that only those young people who could reasonably travel to the meeting locations (i.e. those living in proximal urban or peri-urban areas) participated.

ANNEX 2: Key policies and guidelines

National policy landscape

In addition to the Constitution, a sample of current and recently available key policies, strategies, and guidelines include, but are not limited to:

Policies

- National Health Policy (2000)
- National Adolescent Health Policy (2004)
- Constitution Amendment Act (2005)
- Children's Act (2016)
- National Health Insurance Bill (2019)
- National Development Policy III (2020/21-2024/25)

Strategies and guidelines

- National Policy Guidelines and Service Standards for SRHR (2006)
- Patients Charter (2009)
- National Adolescent Health Strategy (2011-2015)
- Adolescent Health Policy Guidelines and Service Standards (2012)
- Uganda Vision 2040 (2013)
- Health Sector Development Plan (2015/16-2019/20)
- Multi-Sectoral Framework for Adolescent Girls (2017/18-2021/22)
- National Sexuality Education Framework (2018)
- One Health Strategic Plan (2018-2022)
- National Family Planning Advocacy Strategy (2020/21–2024/25)
- National HIV and AIDS Strategic Plan (2020/21-2024/25)
- National Comprehensive Condom Programming Strategy (2020 – 2025)
- National Strategy to End Child Marriage and Teenage Pregnancy (2022-2027)

The regional and international policy landscape:

Significant international and regional law, through treaties, conventions, protocols, covenants and declarations, exists to interpret human rights within the Framework of Health and specifically to apply those rights to respect, protect and defend human sexuality and human reproduction. These resound with the rights to freedom, equality, non-discrimination, privacy, and human dignity and confer on states that are party to each treaty the obligation to provide, domestically, for the highest attainable standard of health. Uganda is obligated under several international and regional treaties to provide healthcare, including to promote and protect SRHR, and this is reflected varying extents in the suite of policies, strategies and guidelines developed to realise these promises. A snapshot of some of these international and regional treaties is provided below.

International treaties and guidance

Universal Declaration of Human Rights (1948)

International Covenant on Civil and Political Rights (1976)

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)

Joint General Recommendation No 31 of the CEDAW

International Covenant on Economic, Social and Cultural Rights (ICESCR)

Convention of the Rights of the Child (1989)

General Comment No 4 on Adolescent health and development in the context of the Convention on the Rights of the Child (2003); General Comment No 18 of the Committee on the Rights of the Child on harmful practices (2014); and General Comment No 20 on the Implementation of the Rights of the Child during Adolescence (2016)

Fast Track Commitments to End AIDS by 2030

International Conference on Population and Development Programme of Action (1994)

The Framework of Actions for the Follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014

The 2030 Agenda for Sustainable Development

Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030

UNAIDS Agenda for Zero DiscriminHealthcarelthcaree Settings

Regional treaties and guidance:

- African Charter on Human and People's Rights (1981)
- African Charter on the Rights and Welfare of the Child (1990)
- African Women's Protocol to the African Charter on Human and People's Rights (2003)
    - General Comments on Article 14 (1) (d) and (e)of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2012); and General Comment No 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2014)
- African Youth Charter (2006)
- Continental Policy Framework for Sexual and Reproductive Health and Rights (2005)
- Maputo Plan of Action on Sexual and Reproductive Health and Rights (2006)
- Model Law on HIV in Southern Africa (2008)
- The ESA commitment made by ministers of health and education in 21 ESA countries to scale up comprehensive sexuality education (CSE) and SRH services for AYP (2013)
- Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016)
- Southern African Development Community (SADC) Gender Protocol
- AU 2063 Agenda
- SADC Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region
- SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations (2018)
- AU Catalytic Framework to End AIDS, TB and Malaria in Africa by 2030
- The organisation of African Unity, Abuja Declaration on HIV/AIDS, TB and Other Related Infectious Diseases (2001)
- AU Addis Ababa Declaration on Population and Development in Africa Beyond 2014 (2013)
- SADC SRHR Strategy and Scorecard (2019-2030) (2018)

This is not a comprehensive list, but the examples shared give some sense of the extensive international and regional relationships between states and the shared values of the international and regional communities. This provides a basis for engagement of civil society at the national level, as well as within and between states, for shared international and regional accountability, recognising that, while it can be difficult to 'enforce' the implementation of the content of these documents, they are important to be aware of as each comes with its own set of review mechanisms that can provide a point of advocacy and influencing for civil society engagement. For example, the African Union (AU) Summits (for the Maputo Protocol) and the CEDAW country reviews, among others.

ANNEX 3: Key UHC stakeholders

In addition to the various state actors responsible for developing policies that affect young people, there are a range of civil society organisations like Action Aid, Raising Voices, Child Fund, Watoto, Katika, Educate an Orphan, Poor Kids Foundation, Save the Children, International Community of Women Living with HIV Eastern Africa, UNICEF, Tusitukirewamu, and Muwala Asobola who are supporting youth with information and services on SRHR and self-care. They organise community outreach activities and carry out awareness campaigns that bring information and services closer to young people.

Organisations like UNFPA, CEHURD, UNAIDS, UNICEF, RHU, YADNET, CHAU, NYSC, YLDC, Marie-Stopes, and the CSO League work to track Government commitments to the UHC agenda in terms of ensuring that health services are provided.

In addition, the following stakeholders were engaged in this process:

9. Youth Livelihood Development Company (staff and young people)
10. International Community of Women Living with HIV Eastern Africa (ICWEA)
11. Community Health Alliance Uganda (CHAU, staff)
12. Reproductive Health Uganda (staff)
13. National Youth Advocacy Platform (NYAP) (staff)
14. Ngabo Youth Friendly Service Centre (staff)
15. Men Engage Alliance (staff)
16. Uganda Youth and Adolescent Health Forum (UYAHF, staff)

Ugandan members of the Civil Society Engagement Mechanism (CSEM) for UHC 2030 include:

- Agapewo Ministry Uganda
- Action Group for Health
- African Centre for Global Health & Social Transformation
- Africa Foundation for Community Development
- African Palliative Care Association
- Anointed Divine Word Ministries International, Uganda
- Budondo Intercultural Center
- Calvary Chapel
- Center for Health, Human Rights and Development
- Children And Youth Empowerment Link
- Civil Society Coalition on UHC Uganda
- Coalition for Health Promotion and Social Development (HEPS Uganda)
- Coalition on Girls Empowerment
- Community Care Foundation-Uganda (CCFU)
- Community Health Empowerment Development and Relief Agency (CHEDRA)
- Community Health Movement Uganda
- Foundation for Integrated Rural Development
- HENU – Health Nest Uganda
- Hope Centre Foundation
- Human Rights Research Documentation Centre
- Innovations for Development- I4DEV
- Kapotec Foundation Uganda
- Kawempe Youth Centre Uganda
- Living Goods – Uganda
- Love to Love Organisation
- Most At Risk Populations' Society In Uganda (MARPS in Uganda)
- Ngabo Youth Friendly Service Centre
- People Living with HIV/AIDS-Lyantonde (PLAS)
- Philomera Hope Center Foundation
- Public Health Ambassadors Uganda
- Rainbow Mirrors Uganda
- Rural Aid Foundation Limited
- Rwenzori Center for Research and Advocacy
- Teenage Mothers and Child Support Foundation
- Twogere Community Initiatives
- Uganda Development and Health Associates
- Uganda Non-Communicable Diseases Alliance
- Uganda Youth and Adolescents Health Forum
- West Nile Development Links (WDL)
- World Action Fund – Uganda

ANNEX 4: ADVOCACY ROADMAP

Timeline - UHC Negotiation Schedule

The UN Language Compendium is a useful tool for high-level United Nations negotiations and can be used for community advocacy to advance human rights commitments — particularly regarding access to healthcare and sexual and reproductive health and rights: https://hivlanguagecompendium.org

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You(th) Care
My health, My responsibility

aidsfonds

ARASA AIDS Law & Health Alliance for Southern Africa

NYP+

PATA

COPPER ROSE ZAMBIA

GLOBAL NETWORK OF YOUNG PEOPLE LIVING WITH HIV

Developed by African Alliance