DRAFT

pac_nahp.uga

NATIONAL ADOLESCENT HEALTH POLICY

MINISTRY OF HEALTH,
DEPARTMENT OF COMMUNITY HEALTH
REPRODUCTIVE HEALTH DIVISION
P.O. BOX 7272
KAMPALA, UGANDA

Table of Contents

1.0 PREAMBLE

1.1 Definitions

The term "adolescents" refers to those aged between 10 and 19, and "Youth" as those between 15 and 24, "Young people" is a term that covers both age groups. i.e. those between the ages of 10 and 24.

Adolescence is a period of physical, psychological and social transition from childhood to adulthood and may fall within either age range.

This policy defines youth as all young people, female and male from the age of 10 to 24 years. It will however be flexible and accommodate other young people, depending on their social and economic circumstances.

Many times the words "adolescence", "youth" and "young people" are used interchangeably. Whenever specificity is desired this will be made clear in the policy.

1.2 Principles

1.2.1 The National Adolescent Health Policy is an integral part of the National Development process and reinforces the commitment of the Government to integration of young people in the development process.

1.2.2 The Policy complements all sectoral policies and programmes and defines structures and key target areas for ensuring that adolescent health concerns are mainstreamed in all planning activities.

1.2.3 The Policy recognises the critical roles adolescents themselves can play in promoting their own health and development and emphasises the need for their participation in planning, implementation, monitoring and evaluation of programmes.

1.2.4 The Policy remains sensitive to the economic, social and cultural realities of Uganda without giving in to the aspects of these realities that are manifest/dangerous to the health of adolescent.

1.2.5 The Policy further seeks to strengthen and to provide an enabling social and legal environment for the provision of high quality, accessible adolescent health interventions.

1.3 National Commitment

1.3.1 IN PERSUANCE of the goal of according a place of priority to the health and development of adolescent members of the population of Uganda within the context of the nation's overall development, such that adolescents in Uganda achieve and maintain total health as defined by the World Health Organisation.

1.3.2 GUIDED by the principles deriving from the Constitution of Uganda, National Population Policy, The National Gender Policy and Local Government Act, The Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the International Convention of the Rights of the Child, the International Conference on Social Development in Copenhagen, the Fourth World Conference on Women, the United Nations World Programme of Action for Youth for the Year 2000 and Beyond and other relevant statements of commitment to the health of young people.

1.3.3 ACKNOWLEDGING the interest of both local and international agencies in the promotion of the health and development of young persons in futherance of the above commitments, and appreciating that the various programmes and projects currently being implemented or planned require to be co-ordinated, in accordance with the priorities, principles and strategies indicated in this Policy.

1.3.4 CONFERING upon the Ministry of Health and Local Government the mandate to mobilise the necessary resources from the health and other sectors to effect the re-orientation of existing and planned services, at all levels, to address the health and related needs of adolescents.

1.3.5 RECOGNIZING the need for a specific policy framework to facilitate effective response, in terms of rearranging the nation's priorities to better address the needs of young people, and knowing that such a policy framework as hereby articulated was hitherto non-existent.

1.3.6 CONVINCED that optimal health of the adolescent population of Uganda will increase their productive capacity to contribute to the nation's development, the GOVERNMENT OF UGANDA hereby adopts this document as the NATIONAL POLICY FOR ADOLESCENT HEALTH FOR UGANDA hereinafter referred to as the policy.

2.0 RATIONALE

2.1 Uganda has a predominantly young population with 47.3% being under 15 years. One in every four Ugandans (23.3%) is an adolescent; and one in every three (33.5%) is a young person.

2.2 Adolescence is characterised by dramatic physical, psychological and social changes that are often not well understood by adults. The adolescents also lack skills to cope with these changes. Accompanying this transition is the dilemma adolescents face between a desire to adventure and experiment and on the other hand the need or desire to become socially acceptable adults. While adolescents feel capable of performing almost anything independently, adults still see them as children incapable of handling major responsibilities. What makes the adolescents particularly vulnerable is, on one hand, their dependency, and inexperience and, on the other hand, lack of clear legal structures and systems, conflicting social value systems, social change and economic constraints.

2.3 The youth are believed to enjoy robust health since they are not expected to suffer childhood diseases and are not yet susceptible to the ailments of old age. This belief although true in some aspects has led to serious neglect of adolescents by the health system.

2.4 Although the overall burden of disease may be lower in adolescents compared to children and the older people, there are specific conditions that are much more common and have more devastating effects in the adolescent age group. These include reproductive health problems such as early/unwanted pregnancy, unsafe abortion and STI/HIV/AIDS; psycho-social problems such as substance abuse, delinquency, truancy, sexual abuse etc.

2.5 The youth have special needs that must be met by the social service sector. These needs include among others education, recreation, shelter, and adequate income. The special health needs of adolescent have hitherto been ignored.

The young people in particularly difficult circumstances need special attention. They include young orphans, street children, refugees, single parents, people with physical and mental disabilities, war veterans and those in war or conflict areas. Their needs should therefore be given special attention.

2.6 The health of adolescents if affected by both personal and external environmental conditions. The life styles and behaviour patterns acquired during adolescence are life long. Timely intervention during adolescence may avert the negative consequences. It is therefore essential that young people be provided with an environment with minimum health risks and that they have access to health services

that are sensitive and relevant to their particular and wide ranging health and development concerns.

2.7 Prevention is usually better than cure. Since most of the adolescent health and social problems are behaviour related, timely interventions could offset higher costs which would be required to manage these problems at a later stage of development.

2.8 Adolescent of today are the future of this country. For them to develop their full potential and participate effectively in national development, they should be nurtured in an environment of opportunity and dignity where their needs are met and rights safeguarded.

2.9 Adolescent health concerns are increasingly being seen as critical areas of action at global, regional and national levels as exemplified by: The 1994 International Conference on Population and Development, Cairo; The 1995 Forth World Conference of Women, Beijing; World Summit for Social Development, 1995, Copenhagen; United Nations, New York. Statements on adolescents from these conferences are interrelated and underline the basic principle that young people are essential in the achievement of their goals both as a target for intervention and, at the same time key partners in action.

2.10 A national policy on adolescent health separate and distinct from, but without prejudice, to other policies is important for guidance, prioritisation and should focus on relevant interventions and activities that are geared towards concerns for adolescence health.

A policy is necessary to spell out resource mobilisation strategies, co-ordination of adolescent health programmes and cost-effective interventions for sustainability of programmes. A proper system of monitoring and evaluation is achieved through concerns on indicators for measuring processes and impact of planned and implemented action.

3.0 POPULATION AND HEALTH PROFILE

3.1 Population Size and Growth rate

The Population of Uganda, according to the 1991 census was 16.7 million with an annual growth rate of 2.5%. The current population is estimated to be 20.8 million. The population is projected to reach 22.2 million in the year 2000, 28.4 million in the year 2010 and is expected double in 25 years.

3.1.1 Age Structure

The population pyramid of Uganda is characteristically broad based. The youth comprise a large proportion of Uganda's total population. According to the 1991 census, the proportion below 30 years was 78% of the total population. Of the total proportion, 37% was 0-10 years, 24% were 10-19, 33% were aged 10-24 and 43% aged 10-30 years. This population structure indicated a high dependence ratio.

3.1.2 Fertility

According to 1995 UDHS, fertility in Uganda may be starting to decline. The total fertility rate has declined from 7.1 in 1991 to 6.9 in 1995. However, it should be noted that childbearing in Uganda begins early with just under half of women becoming mothers by the time they reach age 18. By the time they reach age 20, two thirds have had a child.

Fourty three per cent of teenage women(age 15-19) had begun childbearing, with 34 percent having had a child ready and 9 percent carrying their first child (1995, UDHS). Like other Sub-Saharan African countries, fertility rates among teenagers in Uganda have increased instead of declining. This remains a challenge to all organisations working with young people, since children born to young mothers suffer high rates of morbidity and mortality.

Contraceptive prevalence rate has risen from 5% in 1988/98 to 15% in 1995. But this rate remain low considering nearly universal knowledge of contraceptive methods.

3.1.3 Morbidity and Mortality

The leading causes of illness and death in Uganda are malaria, respiratory infections, diarrhoea, malnutrition and HIV/AIDS. Children below five account for up to half of all deaths.

There is scanty data on mortality and morbidity patterns among adolescents. Adolescents account for a significant proportion of maternal deaths, which are largely due to preventable causes including malnutrition, infections and haemorrhage coupled with inadequate health care and supportive services, particularly in the rural areas. Induced abortion, which remains illegal in the country, also contributes significantly to maternal morbidity and mortality.

The prevailing high incidence of HIV/AIDS has aggravated morbidity and mortality among adults and children under five. A nation wide serosurvey (1987) indicate that AIDS mainly affect individuals in the reproductive age. The majority of cases(83%) are young adults age between 15-40 years with 46 percent cases being between 10-24 years. When stratified for sex, the number of women infected with HIV is higher than that of men. Females develop AIDS at a younger age than males. Stratification by age and sex reveal that the number of AIDS case in the age group 15-19 years is four times higher among females than among males.

3.1.4 Migration

According to the 1991 Uganda's census, immigrants constituted only 2.5 percent of the total population. More than 95% of the immigration in the 1969 - 1991 censuses were from neighbouring countries and were male dominated. This international migration has mainly been characterised by movement of refugees, which has been influenced by the political and economic circumstances in the region.

Meanwhile, the internal migration though not affecting the total population it has a major effect on the population redistribution within the country. The 1991 Uganda census shows 18 percent of the total population born in Uganda as being inter-district migrants. The majority of migration streams were destined to neighbouring districts. The age group 20-24 had the largest share of migrant population of either sex.

However, most migrants to urban areas usually consist of young adults and adolescents concentrated in the age group 15-35. This age selectively usually result in negative consequences such as increased pressure for basic services like housing, education and health care.

Health wise, migration has represented a major vehicle of spread of contagious diseases. This is because as urban male migrants are young, who unemployed, and when there is high cost of living in urban areas. This enhances negative effect on their health.

Because most migrants are single, they are vulnerable to STDs because of the high prostitution in the cities. These negative consequences also apply to temporal migrants such as students who constantly move from school houses.

Meanwhile migration of females to urban areas can possibly expose them to new ideas about production and family planning. This can be beneficial to them.

3.1.5 Gender Concerns

Gender disadvantages that are reflected in later life start from early childhood. Women and men live in worlds that differ in access to education, economic opportunities, health, personal security and leisure time. In Uganda 45% of females aged ten and above are literate compared to 68% of males. This is a result of low enrolment in school, high drop out rates.

In the labour market only 15% of Ugandan women are either self employed, employers of employees. Majority of women employed are in the informal sector and do not get equal pay for equal work. Girls, even at a tender age provide the significant yet unquantified labour in the informal sector as housemaids, hawkers and even prostitutes. The involvement in this sector is characterised by exploitation. The few opportunities of adolescent girls are reflected in and reflected created by gender inequalities in adulthood.

Statistics show that although women in Uganda constitute 70% to 80% of the agricultural labour force, only 7% own land and only 30% have access to and control over proceeds.

Gender imbalances are equally evident in the health sector. Uganda's health indicators reveal that the health status of the population, particularly that of women and children is poor.

It should be noted that measures have been taken to promote the participation of women in decision making position. The mandatory position for women in the local governance structures has improved women's participation in the local councils.

3.1.6 Health Services

Available statistics indicate that at present there are 1393 health units in Uganda, including 96 hospitals, 197 health centres, 133 dispensaries/ maternity units, 11 maternity units. Over 50% of hospitals are in urban areas where only 11% of the population live and most health centres are near trading centres.

The geographic distribution of health personnel does not reflect actual needs. According to the Health facility inventory of 1992, 76% of doctors, 80% of midwives. 70% of nurses and 64% of medical assistants are working in urban areas. Overall, there are 27,000 people for every doctor staff.

The health sector as a whole is very dependent on donor contributions both for capital investment as well as operational cost.

4.0 COMPONENTS AND IMPLICATIONS OF ADOLESCENT HEALTH

4.1 Defining the components of adolescent health

Adolescent health problems and needs can be grouped under several components. Identification of these components is for ease of programming and does not necessarily exclude any other emerging issues. Lack of access to health related information and services appears to be a common trend across all the components identified below.

4.2 Adolescent Sexuality

Adolescent sexuality has been a subject of public concern in Uganda. The overriding feeling that adolescents are more sexually active now than in traditional societies has not been borne out by research. The early age of sexual debut in Uganda today has been confirmed by several studies, conforming to a familiar pattern found in all Africa countries. Sexual activity in adolescence is either voluntary or involuntary. The median age at voluntary first sexual intercourse for women age 20-49 is 16 years. That for men age 25-54 is 17.6 years. Only two-fifths of teenage women have never had sexual intercourse.

Involuntary sexual activity, especially for girls is not uncommon. Although there are no large-scale studies, anecdotal reports indicate common occurrence of both rape and incest in both urban and rural areas. The implications of unprotected sexual acts among adolescents who have little knowledge on the risks are devastating. Unwanted pregnancies, STI and HIV/AIDS are the more obvious and unavoidable consequences. The breakdowns of traditional institutions, socialisation and media influence have been blamed for the changing patterns of sexual activity.

4.3 Fertility Concerns

4.3.1 Contraception

Although UDHS data 1995 indicates that fertility in Uganda may be declining, teenage fertility has instead risen in the most recent five year period. This is attributed to the very low contraceptive prevalence in this age group. According to the UDHS 1995, use of any method in the age group 15-19 was 7.2% compared to the national average of 13.4%. Even amongst married women, the rate was 9.9% in the 15-19 age group compared to 20.7% in the 30-34 year age group.

4.3.2 Unwanted Pregnancy

The median age at first intercourse in Uganda is 16 years which is 1 ½ years lower than the median age at first marriage. By age 15, 30% of women have had sexual intercourse and by 18 years 72% have had sexual intercourse whereas 56% are married by this age. From the low contraceptive use discussed above, it would appear that most of the sexual encounter in this

age group is unprotected. This will expose young girls to both unwanted pregnancy and STDs including HIV.

4.3.3 Unsafe abortion

Unsafe abortion is a major public health problem in Uganda contributing to about 22% of maternal deaths and many more morbidities. It is mostly performed by young unmarried girls who, because of economic and social reasons resort to clandestine services. The concept of post abortion care has now been established as one practical way through which services provided to women with complications from both spontaneous and induced abortions can be improved. Improving access to contraceptive information and services including emergency contraception will reduce the incidence of unwanted pregnancy and induced abortion.

4.3.4 Care of the pregnant adolescent

Adolescents contribute to a disproportionate number of maternal and prenatal deaths. These can be attributed to poor compliance with regard to antenatal care and delivery. To date two out of three births in Uganda are delivered at home where facilities for emergency obstetric care are lacking. Even within the facilities antenatal care and referral is often wanted. Given that adolescents generally have higher maternity related complications, continued lack of antenatal care and delivery by untrained personnel is bound to fuel the already high maternal mortality in Uganda which stands at 506/100,000 live births.

4.3.5 Care of the infant

Children born to adolescents generally have a higher morbidity and mortality rate, which is due to poor prenatal practices and poor adherence to proper childcare practices in the neonatal period. The young adolescent who is still a child is often inexperienced and unable to give proper motherly care. Breastfeeding, although almost universally practised in Uganda, is less likely to be undertaken by adolescent mothers who often leave their babies in the hands of the grand mothers because of economic and social reasons. With poor weaning practices, malnutrition in babies to these mothers is not uncommon. The babies of young mothers are less likely to complete immunization schedule further aggravating the risks of infant death.

4.4 STIs & HIV/AIDS

STIs and HIV/AIDS have been identified as serious health and socio-economic problem in Uganda. In addition to the morbidity & mortality, STIs have various long-term effects on the individual & future fertility. It is estimated that 1.5m Ugandans are infected with HIV while another 350,000 have already developed AIDS. The youth form nearly 50% of the total number of those infected. The male: female ration with regards to HIV infection in Uganda is 1:4 for the teenage compared to 1:1 for adults. Social & economic conditions giving rise to the "sugar daddy" phenomenon partly explains the high

incidence of STIs & HIV/AIDS amongst girls. The frequency of genital ulcer among sentinel clinic attendees at some sites is reported to be as high as 45%. Diagnostic and treatment services for both STIs and HIV/AIDS are still limited in Uganda, and, where available are often inaccessible to the youth.

4.5 Harmful Traditional Practices

Like in any other multi-ethnic society, Uganda has many traditional practices that impact on adolescent health and development. This includes early marriage, female genital mutilation, food taboos and wife sharing/inheritance. These practices are deeply rooted in the cultures of various ethnic groups. Much as they may be justified on cultural/traditional grounds, their overwhelming negative impact on the nation and adolescent needs to be addressed.

4.6 Substance Abuse

Substance abuse is not uncommon in Uganda and is on the increase. Few studies conducted so far are focused on street children and urban secondary schools. The most commonly abused substances are; tobacco and alcohol. The use of hard drugs is on the increase and can be expected to grow even faster given that the East African region is rapidly becoming a transit point of drugs from Asia through West Africa into South Africa and Europe.

The use of cannabis sativa (marijuana) has its roots in some traditions, but has now obtained commercial proportion. Studies elsewhere have documented the close relationship between drug abuse and violence and reckless sexual behaviour with consequences of unwanted pregnancies, STDs and HIV/AIDS. Habituation and drug addiction is a problem that has multiple devastating impacts on the youth, their health and social structure. Rehabilitation of drug addicts is an expensive undertaking that even developed countries have been unable to fund it adequately.

4.7 Mental Health

Monitoring the mental health of young people is important especially in a world where they are currently exposed to multiple pressures and demands from families, society and peers. Traditionally our societies have recognised only the extreme manifestation of mental illness (madness). More focus needs to be placed on subtle deviant adolescent behaviour that may be a manifestation of a troubled environment.

Poor psyschosocial development reflects in lack of confidence and self esteem which will affect academic and social performance of both boys and girls. Self inflicted mental problems in adolescents can also result from the use and/or abuse of psychoactive drugs and medications. Recognition, prevention and rehabilitation of afflicted youth should be a priority in adolescent health care.

4.8 Accidents

By virtue of their level of activity and willingness to take risks, young people are prone to all kinds of accidents. Many of these will lead to physical infirmity and even death. What the adult society sees as risks is perceived by young people to be both exciting and challenging.

Accidents and their consequences on adolescent health is an area that has often been ignored in developing country programmes. Given the limitation of resources and facilities for rehabilitation, attention needs to be focused on essential preventive interventions.

4.9 Adolescents with Disabilities

It is estimated that 2.2% of young have disabilities. According to 1991 population & housing census, 190,000 persons in Uganda had disabilities. This included persons with different degrees of visual, audio, mental and physical impairments. The common causes are malnutrition, birth injuries & poliomyelitis and trauma, which are preventable. Most of these causes occur in childhood or soon after.

The afflicted face great difficulty in coping with activity related demands of adolescence. Chronic childhood diseases such as sickle cell disease, juvenile diabetes, asthma, etc. may limit the activity levels and opportunities during adolescence.

Traditionally such people have been marginalized and denied the opportunity to participate fully in the social and economic development of the country. There is increasing recognition of the need for special facilities in education, building, transportation and work environment to facilitate their integration in society. More details is needed on adolescents and disabilities including related health problems.

4.10 Occupational Health

Young people form a sizeable proportion of the workforce in Uganda. Because of limited employment opportunities, many are forced and subjected to inhuman conditions of work in both formal and informal sectors.

Young people are sometimes subjected to occupationally hazardous jobs by their employers with little regard to their health. Child labour is rampant and young girls become vulnerable to men who take advantage of their poor socio-economic status and are easily driven into prostitution. Existing labour laws and industrial regulations need to be reviewed and implementation strengthened for the benefit of the youth.

4.11 Nutrition

The typical picture of malnutrition (kwashiorkor or marasmus) is rare amongst adolescents but they are prone to disease resulting from micronutrient

deficiencies(e.g. iodine, iron and vitamin deficiency) and those arising from changes in eating habits.

Because adolescence is a period of rapid physical growth, poor nutrition at this stage will result into long term consequences that can affect their health in adult life. For the girl-child, adequate nutrition during adolescence is particularly important as they prepare for pregnancy and child bearing. Deficiencies resulting in physical and physiological problems e.g. short, stunted and anaemia are prescription for maternity related complications and even death. Poor nutrition and hunger will affect performance in school and may be a factor in school drop out.

4.12 Oral Health

Oral health remains a neglected area of health care in Uganda. As part of growing up, young people exhibit great concern over oral health e.g. mouth odour, dental carries, etc. There is need to build a strong oral health e.g. mouth odour, dental carries, etc. There is need to build a strong oral health component as part of the national adolescent health programme.

4.13 Socio-economic Consequences

Social and economic consequences of adolescent health can be felt at individual, family, community and national levels. An unhealthy adolescent population consumes disproportionate resources from the health sector, contributes to major wastage in the education system, limits their contributions to national development and threatens the stability of the future generation and the country.
For these broad reasons it is critical that the country invests appropriately in the health of its young people.

0 GOAL, OBJECTIVES, BENEFICIARIES AND TARGETS

5.1 Goal

The overall goal of this policy is to mainstream adolescent health concerns in the national development process in order to improve the quality of life, participation and standard of living of young people.

5.2 Objectives

5.2.1 To provide policy makers and other key actors in the social and development fields, reference guidelines for addressing adolescent health concerns.

5.2.2 To create an enabling legal and social-cultural environment that promotes provision better health information and services for young people.

5.2.3 To protect and promote the rights of adolescent to health education, information and care.

5.2.4 To promote the involvement of adolescent in conceptualisation, design, implementation, monitoring and evaluation of adolescent health programmes.

5.2.5 To promote adequate development of responsible health related behaviour amongst adolescent including relations based on equity and mutual respect between genders and to sensitise them to such gender issues as they grow into adulthood.

5.2.6 To provide legal and social protections of young people especially the girl child against harmful traditional practices and all forms of abuse including sexual abuse, exploitation, trafficking and violence.

5.2.7 To train providers and reorient the health system at all levels to better focus and meet the special needs of adolescents.

5.2.8 To advocate for increased resource commitment for the health of adolescent in conformity with their numbers, needs and requirements at all levels.

5.2.9 To improve the capacity of local institutions in research, monitoring and evaluation of adolescent health needs and programmes and to promote dissemination and utilisation of relevant information to create awareness which influence behaviour amongst individuals, communities, providers and leaders concerning adolescent health.

5.2.10 To promote co-ordination and networking between different sectors and among Non Government Organisation/Youth Securing NGOs working in the field of adolescent health.

5.2.11 To promote intervention built on capabilities and resources of youth.

5.3 Beneficiaries

5.3.1 Implementation of this policy should benefit all Ugandans. The primary beneficiaries however, will be the youth , both rural and urban.

For programmatic purposes and priority setting , adolescents will be defined and considered by background circumstance, for example,

- In-school/out-of-school adolescents
- Female/male adolescents (focus on girl child)
- Adolescents living in difficult circumstances – refugees, war zones, disaster areas etc
- Adolescents without employment in both urban and rural areas
- Adolescents in hazardous employment
- Adolescents living with HIV/AIDS
- Adolescents with mental or physical disabilities
- Adolescents with violent behaviour
- Adolescents under conviction of incarceration
- Orphaned adolescents
- Adolescents with substance abuse problems

5.3.2 Parents are seen as important beneficiaries of this policy. In traditional societies parents had the primary responsibility for proper up bringing of children and youth. This must remain so. It is however realistic to recognise the changes societies and families are undergoing, and the fact that children and adolescents of school age spend more quality time away from home than with their parents. This policy should assist parents to re-claim their place of responsibility in the up bringing of the youth despite the prevailing social and economic realities.

5.3.3 Service providers are the most important actors in the efforts to improve access to adolescent health care. As has been shown elsewhere the definition of quality of services and their utilisation by clients, depends a great deal on both the technical competence and attitude of providers. The success of adolescent health programmes in Uganda will owe a lot to the extent to which service providers are willing to adopt new skills and attitudes to health care, and put into practice what is learnt during in-service re-orientation courses.

5.3.4 School teachers remain pivotal in modelling the lives of young people. They are important role models and spend much time with the adolescents during the school term. With the incorporation of adolescent health concerns in school curricula, the teachers will become both a major beneficiary and benefactor of the new policy.

5.3.5 Sectoral extension workers, e.g. agriculture, community development etc. are often the only linkages between formal government programme and out of school rural youth. This policy recognises the value of such linkage and will utilise them postively.

5.3.6 NGOs and CBO shave played a pioneering role in adolescent programme in Uganda. This policy not only recognises their importance, but also further clarifies and conceptualises their contribution. The policy will therefore be facilitatious in enhancing the contributions of NGOs,

traditional institutions and religious groups in the promotion of adolescent health.

5.3.7 Leaders at all levels, from national political positions to local community opinion leaders will be targeted through both advocacy and IEC programmes. Their support for the policy is a prerequisite for success.

5.3.8 Donor support is necessary for adolescent health facilities in Uganda, given the prevailing economic constraints. This policy will make it easier for donors to identify specific components for support and evaluate the impact of their contribution. Co ordination of adolescent health activities to limit over lap and duplication will also enhance more prudent use of the meagre resources.

5.4 Targets

Based on available data from the 1995 UDHS and the 1991 Population and Housing Census, the following targets have been set to guide the Adolescent Health Policy and Programme planning in the next five years. The targets compose both qualitative and quantitative measures.

5.4.1 Reproductive Health

- Contraceptive use rate among sexually active adolescents doubled.
- First childbirth delayed-reduced by half (from 59% to 30%) the proportion of women who have their first child below 20 years.
- Age at first sexual intercourse raised by one year
- The proportion of adolescents abstaining from sex before marriage increased
- Practice of protected/safe sex among sexually active adolescent increased
- Practice of dual protection in sex (against both disease and pregnancy) among adolescents increased
- Post-abortion care integrated in all tertiary and secondary facilities; and appropriate primary care facilities with emphasis on post abortal family planning
- Pregnant school girls readmitted to the education system after they have delivered
- Abortion law reviewed
- Lifetime risk of maternal death in age group 15-24 reduced by 50%
- Percentage of mothers below 20 years receiving at least tow doses of Tetanus Toxoid during pregnancy increased (from 56% to 80%)
- Proportion of mothers below 20 years delivering in a health facility doubled (from 42% to 80%)
- Desegregated data on immunization, and nutrition status and breastfeeding status obtained for children born to adolescent mothers and design appropriate interventions.
- Proportion of adolescents that are knowledgeable about STIs and AIDS

increased
- Perception of the risk of getting HIV/AIDS in adolescents increased in females(68-90%) males (48-90%)
- STI management and HIV/AIDS counselling integrated in all activities of tertiary, secondary and primary facilities
- Concept of home based care for HIV/AIDS with special emphasis on the care of orphans promoted
- Use of emergency contraception in family planning programmes targeting adolescents increased
- Harmful traditional practices through appropriate policies, legislation and programmes reduced
- Girl-child enrolment and retention in schools increased to match that of boys
- Incorporate adolescent reproductive health in the curricula of all health training institutions

5.4.2 Substance abuse and mental health

- Level of awareness about the problem of substance abuse amongst adolescents increased through in school and out of school programmes.
- Establish psychological support services at district level to help in assessment and management of adolescents with mental/behavioural disorders in the school system
- Support a pilot rehabilitation project for adolescents with substance abuse problems in Kampala
- Strengthen psychological support services in the national school health programme
- Increase public awareness about the problems of substance abuse and mental health in Uganda

5.4.3 Accidents and disabilities

- Desegregated data on accidents and disabilities by age, sex and type compiled and design appropriate interventions
- The number of institutions catering for the physical and mentally disabled commensurate with their numbers.
- Train enough teachers to provide special education for adolescents with disabilities within the regular education system
- Support community-based programmes for prevention of accidents and care for adolescents with disabilities

5.4.4 Nutrition and Oral Health

- The nutrition and oral health component in the national school health programme strengthened
- Community-based nutrition and oral health programmes of the Ministry

of Health Strengthened
- Support a national nutritional survey on adolescents

5.4.5 Socio-economic Consequences/Occupation Health

- Review existing public health, labour and industrial laws, relevant to adolescent health
- The enforcement capability of the Ministry of Health and Ministry of Labour strengthened

- Collate data and monitor the soci0-economic consequences of adolescent ill health

6.0 STRATEGIES

In order to realize the aforementioned goals, objectives and targets, specific programmes and strategies shall be pursued.

Broadly, the strategies shall fall under the following levels:

- Advocacy
- IEC
- Training
- Services
- Resource mobilisation
- Research
- Co-ordination

6.1 Advocacy

- Promoting the concept of adolescent health among policy makers, elected leaders, cultural leaders, religious leaders, parents, service providers, teachers and the youth.

- Increasing resource commitments to adolescent health programmes by families, communities, local authorities, government ministries and donors.
- Creating enabling legal and socio-cultural environment for provision of adolescent health services.

- Reviewing existing legal, medical and social barriers to adolescents access to information and health services
- Protecting the rights of adolescents to health information and services
- Re-orienting the health care system to cater for the special needs of adolescents
- Providing legal and social protection for adolescents against all forms of abuse and harmful traditional practices.
- Promoting the understanding of gender issues and imbalances involved in the upbringing of children and adolescents in the context of culture, religion and socio-economic opportunities.
- Promoting networking between government and non-governmental organisations and among youth-serving organisations
- Ensuring Universal Primary Education and retention of children in school with special emphasis on the girl child and those with disabilities
- Enhancing opportunities for adolescents to access health services.

6.2 IEC

Increasing awareness on the importance of adolescents and the impact of adolescent health problems at individual, family, community and national levels.
Sensitising policy makers, leaders, parents, the youth and the community on adolescent health, their special needs, rights and responsibilities.

Reviewing the National IEC Strategy on Population and Development to emphasize activities relevant to adolescent health

Promoting integration of information on adolescent health in activities of the various sectors and institutions both formal and informal

Increasing the scope, content and spatial coverage of adolescent health issues using appropriate and available communication channels.

Promoting the use of traditional communication channels especially drama, folk-media and interpersonal communication

Using the available mobile film units within sectors and NGOs to spread information on adolescent health

Identifying and utilising existing youth networks to facilitate the sharing of accurate information on adolescent health

Sensitizing law enforcement organs about the rights of adolescent and their responsibility in protecting adolescents from exploitation

Reviewing existing IEC materials on adolescent health and facilitating their adaptation and sharing among youth serving organisations and programmes

6.3 Training

Training and re-training of service providers to meet the special needs of adolescents

Building the capacity of institutions and programmes in the field of data collection, analysis, dissemination and utilization

Reviewing training curricula in order to harmonise the content and approach in such areas of common need as advocacy, counselling, peer education and communication skills

Promoting in-service training of workers in other relevant sectors such as education, community development, agricultural extension, sports,/religion etc on the linkage between their work and adolescent health.

Improving skills of young people in programme planning, implementation, monitoring and evaluation in order to enhance their participation in adolescent health programmes.

Training of personnel to take car of the special needs of adolescents disabilities and the rehabilitation of victims of substance abuse, viol and sexual exploitation

Identify the training needs of parents and other relevant gatekeepers designing appropriate interventions

Promoting vocational training and technical education tailored to the r for self sustainance.

Integrating life-coping skills into formal education and informal tra programmes for youth.

6.4 Services

Reviewing the scope, content and utilization of existing health services regard to adolescence in order to identify gaps and their determinant

→ Integrating adolescent health concerns into existing services

→ Improving access to adolescent friendly health services

→ Ensuring equitable distribution of adolescent friendly services in both and urban areas.

Identifying and reviewing laws and policies that hinder establishmen utilization of adolescent health services.

6.5 Resource Mobilisation

Ensuring regular and sustained allocation of resource to adolescent l activities in the national budget

Ensuring the allocation of funds in the annual budget of sector mini districts and urban authorities to adolescent health activities

Mobilising external resources to initiate and supplement inno adolescent health interventions

Promoting community participation and cost-sharing in adolescent h programmes

Promoting adolescents' participation in their own health programmes

Linking adolescent health programmes and income generating activi local levels, to enhance sustainability

Promoting the addition of adolescent health component to existing

programmes, e.g. YMCA, YWCA, Girl Guides and Scouts etc.

Encouraging charities, service organisations and clubs to invest in adolescent health programmes, e.g. Rotary, Lion and Giants

Drawing on the expertise of professional groups, e.g., UMA, FIDA etc to provide support in adolescent health programmes.

Encouraging sharing of expertise and experience between sectors, programmes and organisations.

Identifying and optimally deploying available human resources for the benefit of adolescent health programmes

Enhancing the capacity of institutions to undertake adolescent health interventions using the available local personnel at lower cost.

Establishing minimum facility and equipment standards for the delivery of quality adolescent health services

6.6 Research

Encouraging the compilation of gender and adolescent desegregated data

Promoting relevant policy-oriented and operations research on key adolescent health concerns

Mainstreaming monitoring and evaluation in all adolescent health programmes and promoting the utilization of such data in programme design and re-direction

Facilitating sharing and user-friendly dissemination of research and programme evaluation data

Encouraging researchers and research institutions to focus on local critical issues and concerns of adolescent health in both urban and rural areas

Encouraging the compilation of fact sheets on adolescent health based on research data to enhance public awareness.

6.7 Co-ordination

Establishing a co-ordination structure for adolescent health at national level

Designating co-ordinating functions for adolescent health at district level to appropriate existing committees

Ensuring integration of adolescent health in existing sectoral programmes

Establishing functional network for youth-serving organisations

Promoting the sharing of programme information between youth-serving organisations thus reducing overlap and duplication

Encouraging linkages with other countries, especially in the same region, to share lessons learnt e.g. in the East African Reproductive Health Network

Promoting co-ordinated mobilisation, equitable distribution and optimal utilization of resources

7.0 INSTITUTIONAL FRAMEWORK

The expected institutional framework and roles of Ministries, NGO and other agencies are outlined below:

7.1 National Steering Committee on Adolescent Health

The Ministry of Health is charged with the spearheading and co-ordinating adolescent health programmes. The Ministry of Health shall establish and chair a multisectoral called National Steering Committee on Adolescent Health (NASCAH)

Functions

i. Advocate, promote and co-ordinate the implementation of the Adolescent Health Policy

ii Review and recommend appropriate changes in the Adolescent Health focus in the country and advise the Government accordingly, taking into consideration the political, economic, socio-cultural and legal realities of Uganda

iii Advise Government on resource mobilization and monitoring their utilization to support the implementation of the Adolescent Health Policy

iv Undertake any other relevant activities that will promote sustainable adolescent health programmes in order to improve the well being of young people of Uganda

Membership

The National Steering Committee on Adolescent Health shall be composed of 17
Members with a representative drawn from each of the following:

- Government Ministries and Departments: Ministry of Health, Ministry of Gender and Community Development, Ministry of Education, Ministry of Planning, Ministry of Local Government, Ministry of Labour and Ministry of Justice
- Intergovernmental Agencies; WHO, UNICEF, UNFPA
- Local NGOs – 2 representatives – UAPA
- Bilateral Donors - 1 representative
- National Youth Council - 1 representative
- Parliamentary Sessional Committee on Social Services - 1 representative
- Chairperson Technical Advisory Committee on Adolescent Health National Youth Council - 1 representative

Membership shall be forwarded by the respective Ministries and Organisations

Meetings

The Steering Committee shall meet at least bi-annually. Quorum shall be constituted by simple majority of membership

7.2 The Technical Committee for Adolescent Health (TACAH)

The Steering Committee for Adolescent Health (NASCAH) shall have a technical and advisory committee to re-enforce the technical base required for its decisions. This committee shall be known as the Technical Advisory Committee on Adolescent Health.

The Chairperson shall be selected by members and the secretariat shall be in the Ministry of Health.

Functions

The functions of the Technical Advisory Committee for Adolescent (TACAH) shall be to:

Assist the Steering Committee and relevant Ministries to determine appropriate programmes, tasks and working links among Ministries, districts, agencies, NGOs and institutions working in adolescent health and related fields in the country and also assist to sustain the links so established.

Suggest, provide and review technical guidelines, which shall assist the Steering Committee and relevant Ministries, institutions and NGO in carrying out their work efficiently in the field of Adolescent Health.

Advise the Steering Committee on key and relevant technical matters relating to the implementation of adolescent health and development and related programmes in the country.

Provide any relevant technical advisory services as may be requested for by the steering committee towards the achievement of the objectives in the adolescent health and related field

Membership

The Technical Committee on Adolescent Health shall be composed of 19 members with a representative drawn from each of the following:

Ministries:
- Health (Reproductive Health)
- Gender and Community Development (Youth Dep.)
- Education (School Health)
- Planning (POPSEC – Family Health)
- Local Government(Urban & Rural Health)
- Labour (Occupational Health)

- Justice (Law Reform Commission)

Intergovernmental Agencies:

- WHO (Focal person for Adolescent Health)
- UNICEF (Programme Officer)
- UNFPA (Programme Officer)

Local NGOs	-	2 representatives
International NGOs	-	2 representatives
Research Institutions	-	1 representative IPH
Bilateral donors	-	1 representative
Uganda Medical Association	-	1 representative
Uganda National Ass of Youth Organisation (UNAYO)	-	1 representative

Meetings

The National Technical Committee shall meet at least quarterly

7.3 District Committee on Adolescent Health (DICAH)

Within the framework of the District Local Government under the decentralisation status, the District Technical Planning Committee shall have a subcommittee on Adolescent Health for the purpose of spearheading, facilitating and co-ordinating Adolescent Health activities at the district level.

Functions

The functions of the District Committee on Adolescent Health (DICAH) shall include the following:

- Promotion, co-ordination, monitoring and evaluating adolescent programmes and activities in the districts
- Advocate for greater appreciation and focus on adolescent health within the district
- Promote co-ordination
- Ensure integration of adolescent health issues in district development plans
- Promote collaboration among departments and NGOs engaged in Adolescent Health Programmes and activities in the district
- Initiate and facilitate the formulation and review of district Adolescent Health plans of action
- Advise the District Local Government on resource mobilisation and utilization for Adolescent health activities and monitor their utilisation
- Link district adolescent health activities with national level programmes

- Compile bi-annual district situational reports on Adolescent health
- Programmes activities and submit to the national Technical Committee

The membership of the District Committee Adolescent Health (DICAH) shall comprise of up to 10 members drawn as follows:

i) DDHS
ii) Maximum of 5 Heads of department responsible for Gender issues, Education, Childcare and protection, population and, youth issues. Where any of the officers in 4 above is not a member of the Committee they shall be co-opted to the Adolescent Health and Development Committee
iii) Two members from relevant government NGOs operating in the district in the field of adolescent health
iv) The CAO in charge of health shall be the chairperson
v) One youth representative

7.4 Roles of various Ministries and Institutions in policy implementation

7.4.1 Roles of the Ministry of Health

(i) Strengthen and expand the existing Adolescent Health programmes
(ii) Through primary care provide adolescent health services at all levels of health care delivery
(iii) Design and ensure implementation of adolescent health programmes that are sensitive to tender age cultural and religion
(iv) In collaboration with relevant Ministries and Institutions, strengthen and expand training of all health care providers in the field of adolescent health
(v) Set standards and guidelines for provision of adolescent health services and ensure their effectiveness
(vi) Assist in co-ordinating and monitoring adolescent health programmes of all agencies in the country
(vii) Liase with all agencies involved in HIV/AIDS control programmes
(viii) Expand networks of adolescent health service delivery by increasing the numbers of health with, community based distribution and social marketing systems offering adolescent health services
(ix) Liase with the Curriculum Development Institution/agencies to include health issues in the training curricula of health workers
(x) Undertaken operational research activities in alternative methods of service delivery
(xi) Integrate adolescent health census into the Health Management Information system

7.4.2 Roles of Ministry of Gender and Community Development

(i) Formulate a National Youth Policy that is responsive to Adolescent Health issues

(ii) Promote awareness and integrate Adolescent Health concerns among the youth and the different departments within the Ministry
(iii) Advocate for the elimination of customs and practices that hinder the development of adolescents and sensitise the public on adolescent health concerns
(iv) Build capacity of extension workers for effective implementation of adolescent health programmes
(v) Ensure that Gender concerns are mainstreamed in all programmes on adolescent health
(vi) Advocate for increased resource allocation for Adolescent/Youth programmes at all levels
(vii) Compile and submit reports on adolescent health to the technical committee on adolescent health

7.4.3 Ministry responsible for Education

(i) Integrate adolescent health concerns in the school education system and planning process
(ii) Advocate for resource mobilisation for especially the in school Adolescent health programmes
(iii) Co-ordinate and facilitate activities of schools to ensure effective and efficient resource allocation and use in conformity with Adolescent health policy and strategies
(iv) Monitor with other collaborators the progress made towards achieving the adolescent health policy targets

7.4.4 Roles of Ministry of Planning and Economic Development

(i) Help in the mobilisation of resources for the implementation of adolescent health programmes

(ii) Promote and extend technical assistance to sectoral agencies in the integration of adolescent health and demographic variables in development planning process

(iii) Collect desegregate data (especially during census and surveys) with special emphasis on adolescent health issues

(iv) Participate in the evaluation and monitoring of adolescent related programmes in collaboration with sectoral ministries, academic and research institutions

(v) Determine patterns and trends in adolescent specify activity rates through labour force sample surveys in both rural and urban areas in collaboration with appropriate academic and research institutes and Ministry concerned for labour and occupational health

(vi) Assist the analysis and interpretations of censuses and survey data and

(vii) Disseminate adolescent and district desegregated statistical data

7.4.5 Roles of Ministry of Justice

(i) Revise all the laws pertaining to adolescent health issues

(ii) Amend existing laws and formulate legislative measures designed to be instrumental in:

a. Eradicating all harmful customary practices such as those relating to female genital mutilation
b. Removing restrictions of adolescents against enjoyment of civil rights such as access to information, education, employment, health services etc

(iii) Ratify and incorporate international and regional instruments relevant to adolescent health into domestic law.

(iv) Ensure the protection of the rights of adolescent under the constitution

7.4.6 Ministry responsible for Labour and Social Affairs

(i) Establish mechanism within the Ministry that will permit regular collection. Analysis and reporting of adolescent desegregated data concerning employment
(ii) Monitor the implementation of legislation of recruitment and other personnel matters in the various sectors of the economy with particular reference to adolescents
(iii) Promote understanding of the humanitarian, economic, social and cultural implications of adolescent (child) labour, including orphans for the development process
(iv) Promote and assist in the integration of adolescent health and family monitoring elements in work setting
(v) Introduce special programmes to support the development and integration of persons with disabilities into the mainstream of society

7.4.7 Inter-Governmental Agencies

(i) Provide technical and logistical support to the line ministries, institutions and NGOs implementing adolescent health programmes and activities.
(ii) Co-ordinate donor technical and logistical support for implementing adolescent health services
(iii) Develop indicators and monitoring systems for evaluating efficiency and effectiveness of donor support to adolescent health
(iv) Monitor and evaluate impact of donor support on adolescent health

7.4.8 Non-Governmental Organisations

(i) Establish a national network/an association for promoting Adolescent

Health with the NGO sector.

(ii) Introduce Adolescent Health concerns within the framework of their ongoing activities

(iii) Complement the role of sectoral ministries in the implementation of Adolescent Health programmes.

(iv) Collaborate with the Technical Committee on Adolescent Health

(v) Undertake operation research and share information on Adolescent Health with stakeholders.

7.4.9 Research Institutions

(i) Carry out basic and operational research in adolescent health and disseminate findings

(ii) Monitoring and evaluation of programmes related to adolescent health programmes

(iii) Assist in capacity building for research among institutions and within programmes of Adolescent health

'amework of their

.nplementation of

ɔcent Health
ɔn on Adolescent

ɔcent health and

ıdolescent health

ıtions and within

8.0 MONITORING AND EVALUATION

8.1 Monitoring and evaluation is an important component for effective implementation
of the Adolescent Health Policy, in order to ensure accomplishment of the objectives

8.2 Monitoring and evaluation shall be the responsibility of the Ministry of Health, exercised. Through the National Steering Committee for Adolescent Health (NASCAH). The Technical Advisory Committee on Adolescent Health (TACAH) will develop guidelines for regular reporting of activities by implementing line ministries, districts, institutions and NGOs. Because of the need to collect, collate and analyse information on adolescent health, the NASCAH will organise training courses to build capacity of relevant staff for monitoring and evaluation

8.3 NASCAH shall prepare an annual report on policy implementation and undertake a comprehensive review of the policy after every five years. NASCAH shall also arrange special impact assessment and any other relevant studies from time to time

8.4 Sharing of experiences with other countries is an important way of gauging progress of national programme. NASCAH shall avail itself to such opportunities through regional and international meetings, for a and publications.

9.0 CONCLUSION

The health concerns for younger children, adults and the elderly have hitherto taken precedence over the needs of adolescents. This policy is an effort to highlight adolescent health issues and bring them into the mainstream of health and other social services

Young people are a critical national resource for today, and their health is a worthwhile investment for future growth and development. They have great potential to contribute to the process of decision-making and implementation of programmes for their own benefits as well as the development of society at large. The understanding, adoption and implementation of this policy will contribute positively to the efforts to emancipate young people and integrate them in social development efforts. All persons and organisations with a stake in the lives and health of adolescents are urged to make special consideration of this policy and its ideals in their day to day work.