Commonwealth Youth Forum 2007 version

Young people

Health, HIV, AIDS and Development

A case for Uganda

Uganda AIDS Commission in Partnership with the National Youth Council

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1.0 Introduction

Young people 10-24 years of age constitute a big percentage of populations in developing nations. They are a key factor in all development programming not only as consumers and beneficiaries of services but also as a major production resource. Their social and health status, and particularly the dynamics and impacts of the HIV and AIDS epidemic, however, impede the realization of global and national development targets.

Globally, young people are among the populations most at risk of and affected by HIV and AIDS. UNAIDS estimated about 40% of new adult infections occurring among young people in 2006. This situation might continue unabated unless causes of vulnerability to infection among them are clearly identified and addressed within respective contexts.

The dynamics of the epidemic among young people demand for a holistic approach to address both individuals and the social, cultural and economic environments around individuals to enhance social change. There is an urgent need to factor HIV, AIDS and sexual reproductive health issues into development programming to contextualize interventions, promote universal coverage and optimal resource utilization. Yet, the HIV and AIDS epidemic has largely been addressed from emergency approaches. For example, programmes especially for prevention tend to specifically target individual behaviours with limited linkages to development programmes that address environments and young people's vulnerability.

Uganda is among those countries that have registered success in responding to HIV/AIDS. Specifically the country has demonstrated that young people can adopt positive behaviours and reverse HIV incidence and prevalence rates. This paper presents a synthesis on the status of young people in relation to health generally and HIV and AIDS in particular and the resulting impact on development

The paper outlines a background to the current social, health, sexual and reproductive health (SRH) and HIV and AIDS status of young people, and the magnitude and impacts of the AIDS epidemic with specific focus on young people's vulnerability to HIV infection. It provides an overview of Uganda response to HIV and AIDS highlighting policy interventions, strategies, approaches and the contributions of young people in the response. Challenges and emerging issues and opportunities for scaling up the response are briefly explored.

While this paper is primarily intended to provide input into the 6th Commonwealth Youth Forum (CYF) in Uganda November 2007, it does not attempt to synthesize such issues as they pertain in the various Commonwealth countries. Rather, it provides insights into contexts, status, challenges and opportunities that obtain in Uganda as a case study. This should provoke discussion on appropriate strategies and approaches to achieve health rights for young people and to address obstacles to implementation of social and health programs, particularly SRH and HIV/AIDS programmes, even in Uganda.

1.1 Background

Globally, HIV/AIDS is acknowledged as a development issue and security crisis. The dynamics and impacts of the epidemic especially economically productive population groups constrain development efforts at individual, household, community and national levels.

HIV and AIDS has been a priority focus at various global fora and young people are cited as priority in national responses. The 6th Millennium Development Goal on Combating HIV/AIDS, Malaria and other diseases targets reduction in HIV prevalence and reversing the trends. The United Nation's General Assembly Special Session on HIV/AIDS 2001 and 2006 Declarations also provide global guidance on responding to HIV/AIDS at global, regional and national levels within contexts.

It is however acknowledged that national responses especially in the developing world are yet to reach a level that can mobilize and sustain actions that support universal access to services. This is especially so for young people's programmes considering the rapid demographic changes that require consistent intervention repackaging to adapt to changes.

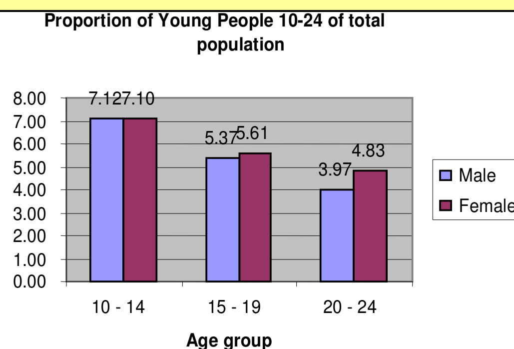
Uganda adopted the multi-sectoral approach to the control of AIDS (MACA) in 1992. This was in recognition of the fact that the dynamics and impacts of the epidemic are beyond the health sector though largely the most strategically positioned to respond. The MACA policy strategy mobilized concerted efforts from the public and non-public sectors, at national, district, community and individual levels. The country has registered modest achievements demonstrated by declining HIV prevalence and incidence from the 1990s. This decline was more significant among urban young women.

2.0 Overview of Young People in Uganda

Any discussion on young people's plight in any location demands for an analysis of who they are, where they are and what they are doing. These variables shape the nature of policies; programmes; and interventions addressing their issues to enable them fully attain their health and human rights.

Different policy documents and programmes define young people variously. This paper embraces the United Nations definition of young people as those people aged 10-24 years. Globally they constitute a big fraction of country populations especially in the developing world with inevitable consequences on social development. Similarly, they are not a homogeneous group due to social, cultural, economic and political contexts that are determinants of their key development indicators.

Figure 1: Proportion of young people to the total country population



Source UBOS, Population and Housing Census, 2002,

Young people in Uganda constitute 34% (8.3 million) of the total population estimated at 28.8 million in 2007. These young people are in different situations in the various parts of the country. The majority of the 10-19 year olds are in school, many of those aged 20-24 are working in the formal & informal sectors and a big percentage especially of young females are married by age 24.

2.1 Socio-demographic indicators

School enrollment and literacy levels

The country's Universal Primary Education (UPE) Policy has tremendously increased primary school enrollment for male and female children from rural and urban areas. The UDHS 2006 put the net enrollment ratio for primary education at 81.8 slightly higher among males than females (table 1). There is however a high dropout rate estimated at 30% in 2003. The Ministry of Education and Sports estimated the transition rate from primary to secondary level at 14.6% in 2004**.** Only 15% have attained secondary education compared to 73% who have attained primary education (see figure 2)

Table 1: Young people education indicators

Indicator	Male value	Female value	Total
Net enrollment ratio in primary education	82.3	81.2	81.8
Literacy rate	69.8	57.7	60.4
Ratio of girls to boys in primary education	-	-	0.95
Ratio of girls to boys in secondary education			0.81
Ratio of Sch attendance of OVCs to non-OVCs (10-14yrs)	0.96	0.97	0.96

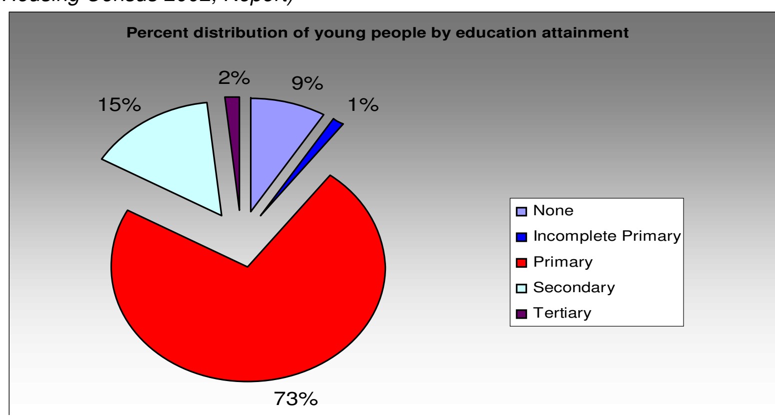
Source, UDHS 2006

About 9% of Uganda's young people have not attained any level of education and only 2% have attained tertiary education (see figure 1). This has serious implications on their skills to engage in meaningful development work. There has been an improvement in the

ratio of school attendance for orphans and vulnerable children (OVCs) as compared to non-OVCs both in primary and secondary schools and both for females and males.

The literacy rate among young people is estimated at 60.4 compared to the national figure of 69. Still literacy is higher among young males at 69.8 than females at 57.7 and among urban than rural residents

Figure 2: Education attainment of young people (Source*: UBOS, Population and Housing Census 2002, Report)*



Marital status

Many young people in Uganda are already married or engaged in long-term sexual relationships, a situation that greatly influences targeting of interventions addressing them especially for females. More females are in marriage relationships than males. About 1/5 of young people aged 15-19 have ever been married. Over half of the girls (56.9%) are married by age 19 compared to 7% of boys. Some 10-14 yrs olds are married.

Table 2: Percentage of young people who have ever been married

	Women 15-24		**Men 15-24**	
Current age	**% who have ever married**	**Number of women**	**% who have ever married**	**Number of men**
15	2	512	0.3	434
16	8.4	461	0.6	444
17	18.1	391	2.2	421
18	41.3	453	6.1	439
19	56.9	368	6.6	331
20	68.9	547	18.7	329
21	74.4	312	26.7	203
22	85.9	408	44.4	291
23	88	301	48.5	186
24	89	364	62.6	253
Total	**50.1**	**4,119**	**16.7**	**3,332**

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

Occupation status

Many young people, especially those aged 20-24 years are working in the formal and informal sectors, the majority are engaged in subsistence agriculture. The 2002 Uganda population and housing Census estimated that the Uganda labor force has about 1.1million young people between ages 20 – 24. The same report indicates that 0.8 million of the labor force is between 14 – 19 years.

Some young people aged 10-14 years are already working. ILO estimated 3 million child laborers in 2005. The majority of these are engaged in cultivation, others in income generating activities and domestic work. The conditions of such children constrain access to age appropriate health and social development information and services.

Some young people are engaged in commercial sex work due to homelessness, to supplement family income, lack of employment, to raise school fees, and from peer influence. About 90% of young people engaged in sex work are females.

Other social indicators

About 2% of young people in Uganda are disabled. Children with disabilities constitute 3% of overall school going population with more males than females

The Ministry of Gender, Labour and Social Development estimates that 62% of the poor are children (0-18 yrs) in Uganda. Most development programmes however target adults.

Some young people especially from northern Uganda have been severely affected by armed conflict and displacement. UNICEF estimated 300,000 children victims of armed conflict in 2001. The inevitable insecurity, inadequacy of the social services infrastructure and family and community social support systems in these environments constrains access to information and services. Many young people are exposed to sexual abuse and violence and survival sex.

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Sexual reproductive health indicators

Early age at firs sex is among the key risk factors for HIV infection. Age at first sex was estimated at 16.7 and 18.8 for girls & boys respectively in 2005. It was estimated that by age 17, half of young women are sexually active while 62.7% have already begun child bearing by the age of 19. More than half of young women and 39% of young boys age 15-19 years have ever had sex while in the age group 20-24, 96.3% females have had sex compared to 87.5% males. There are high levels of intergeneration sex especially among females with most of young women reporting that their first sexual experience with a partner three to 10years older. While early sexual activity trends in the country have been consistent among young women, the National HIV Sero and Behavioural Survey (NHSBS) 2004/5 revealed a trend of young boys initiating sex before age 15. About 14% of females and male aged 15-24 yrs had sex before age 15.

Despite the high levels of early sexual activity, many do not exploit the benefits of safe sex. About 30% of the sexually active young people used a condom the first time while 47% females and 61% males have ever used a condom.

Early sexual activity heightens females' vulnerability to consequences of early pregnancy including unsafe abortion and maternal morbidity and mortality. Teenage pregnancy was estimated at 25% in

2006. The median age at first birth has over the last 30 years been at 18.5 years. 44% of the country's maternal deaths are among the 15 – 24 years old.

Annually, approximately 117,000 unsafe abortions occur in the country, 55% of them among 17-20 years olds. About 2% result in deaths and 23% in serious complications. In 2001, a UBOS report estimated that among the sexually active and unmarried women, 52% (15-19years) and 54% (20-24years) were using some family planning method. The contraceptive prevalence rate among the general population is estimated at 23%; and the rate among 15-24 age groups at 10%. Considering the early age at first birth, this indicates poor utilization of family planning services despite an open policy on family planning eligibility.

Following trends in the general population, the prevalence of STDs among young people is high. The NHSBS estimated prevalence of Herpes Simplex Virus sub-type 2 (HSV2) ranging beteen 20-34% among the 15-24 yr olds. HSV2 has been revealed to be among the key drivers of HIV in the country increasing chances of acquiring HIV to about 4 times compared to rates in the general population. HIV prevalence among young people is estimated at 3% and is much higher among young women than males and among urban young people than rural ones.

Anecdotal evidence indicates introduction and increasing use of illegal drugs including cannabis, heroine, cocaine, especially among those on the streets and those in schools in the country. Alcohol abuse is also prevalent in the country and there is evidence to suggest that some young people engage in sex under the influence of alcohol.

3.0 Status and impact of HIV/AIDS

For many years, HIV/AIDS has been the leading cause of disease and deaths among adults 14-49 years in Uganda. As such it is a major determining factor of health among young people. On the other hand, the social, economic development indicators among young people determine their vulnerability to HIV infection.

3.1 Status of the epidemic

Globally, UNAIDS estimated 39.5 million people were living with HIV/AIDS by end of 2006, 63% of these in Sub Saharan Africa. 4.3 million people were newly infected with HIV while 2.9 million lost their lives to AIDS in 2006 alone. Young people accounted for 40% of new infections among people 15 years and older.

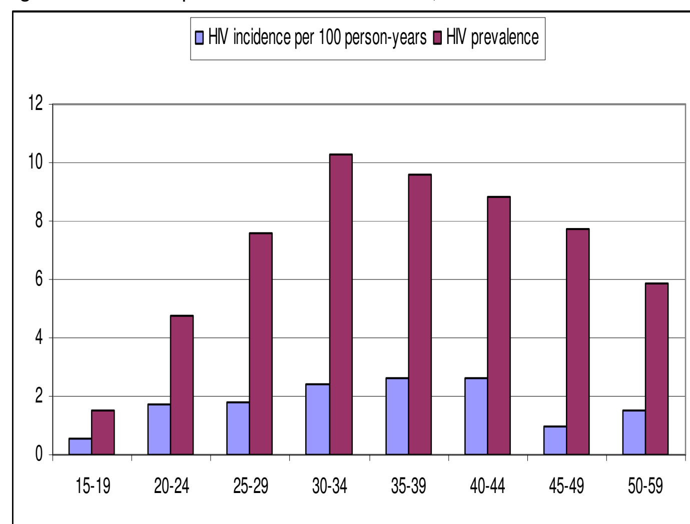
Status and trends in Uganda

The NHSBS 2004/5 estimated about 915,400 adults and children were living with HIV/AIDS in 2005. Prevalence among adults aged 15-49 yrs was estimated at 6.4%, 0.7% among children less than 5 years, and 5.8% among those aged 50-59. The Ministry of Health estimated 132,500 new infections in 2005 alone.

HIV prevalence among 15-24 yr olds estimated at 3% compared to the 6.4% national figure. HIV is higher among females than males. For example young women 20-24 years are 3-6 times more likely to get infected than boys same age (see figure 3). HIV prevalence is highest among young people who have been and those currently in engaged in long-term sexual relationships.

About 80% of all new infections are acquired through heterosexual sex while mother to child transmission accounts for 22-25%.

Figure3: Adult HIV prevalence and incidence (Source UNHSBS 2004



The country is experiencing a mature generalized epidemic implying that every Ugandan irrespective of demographic, social and economic status is at risk of getting infected, though some population groups are more at risk than others.

Uganda is among the first countries to report a shift of the epicenter from young people 19-25 years to older, married or formerly married adults with shifts in peaks. The peak of the epidemic has shifted from 20-24yrs to 30-34yrs for women and from 30-34yrs to 40-44yrs for men. The NHSBS revealed that 77% of new infections occurred among people 25yrs and older.

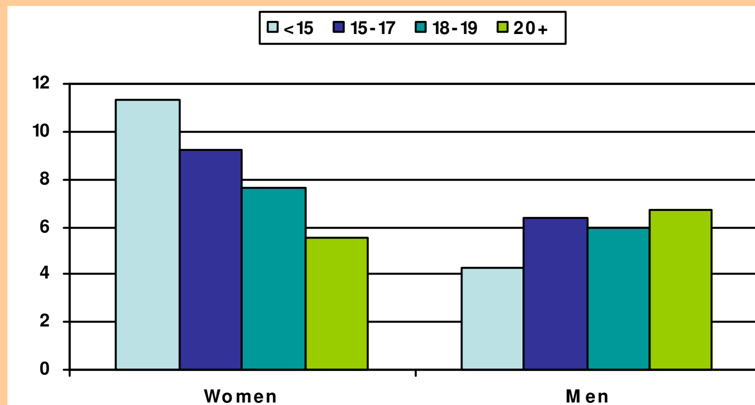
The epidemic is heterogeneous implying that the country is experiencing many epidemics in one with consequences on intervention packaging and delivery. HIV prevalence is higher among adults 25-59 years (see figure 3), among females (7.5%) than males (5.0%), among urban (at 10.1%) than rural dwellers (at 5.7%), and in the central and mid-northern regions than other parts of the country. Studies have also revealed that HIV prevalence is higher among those currently married, widowed, separated, people with other STIs, uncircumcised males, sex workers, and mobile populations e.g. fishermen, truckers etc

3.2 Young people vulnerability issues

While the majority of new HIV infections appear to shift to older age groups, the burden among young people is still very high. An analysis of drivers of the epidemic in the country done in 2006 building on outcomes of the NHSBS 2004-5 revealed a myriad of proximate, biological, behavioural and contextual factors fuelling the epidemic in the country. Key factors include multiple and concurrent sexual partnerships, couple discordance, infection with Herpes Simplex Virus Sub-type 2 (HSV2), and unprotected high risk sex. A combination of economic, social, biological and behavioural factors renders young Ugandans vulnerable to HIV. Consequently many of them are usually not in a position to influence their reproductive health problems due to lack of appropriate information, skills, services and negotiation powers. Adolescence is for example a period of rapid physical and psychological developments that compel young people to experiment with feelings and take risks. Coupled with limited comprehensive knowledge about HIV/AIDS and the resulting low risk perception, these factors heighten vulnerability to HIV infection

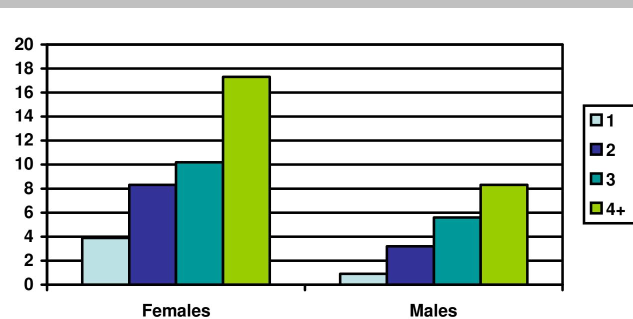
Early sexual debut is strongly associated with HIV especially for women. Girls who initiate sex by age 15 are twice as likely to be infected than those who start after age 20 (see figure 4). Early initiation of sex creates biological vulnerability resulting from trauma to immature sexual organs from sexual experiences. The increasing trends of sexual violence and abuse exacerbate the situation. The NHSBS revealed that 9% of women aged 15-24 report use of force at first sex. There is heightened media reporting on defilement cases from around the country. Sexual abuse is higher in situations of armed conflict and displacement.

Figure 4: HIV Prevalence by age at first sex (Source UNHSBS 2004/5)



Young people especially those in urban areas and tertiary institutions of learning engage in both multiple concurrent and/or serial partnerships that heighten infection rates especially among women. The different sexual partners are perceived to fulfil different needs including emotional and economical aspects. Many are engaged in inter-generational and transactional sex where they are sexually exploited for short-term gains. Some young people especially OVCs are compelled to engage in survival sex due to lack of basic needs. This however results in a cycle of poverty when they get infected.

Figure 5 HIV Prevalence by Number of lifetime sexual partners (Source: UNHSBS 2004/5)



Consistent and correct condom use rates among sexually active young people are generally low. Cited explanations for this trend is limited access especially in rural areas, social stigma attached to condom

use in relation to morality, religious and cultural beliefs and misconceptions. Studies also reveal that consistent condom use in short term intimate relationships among young people is often unsustainable yet the partners do not benefit from HIV testing and counseling (HCT) services and mutual disclosure of results before engaging in unprotected sex.

Sexually Transmitted Infections (STIs) are among biological factors that predispose young to HIV infection. STI prevalence among adults 14-49 years in the country is generally high with almost half of them infected with HSV2. Yet general lack of facilities providing youth friendly services hinders timely access to STI prevention and treatment services.

Uganda has a high couple discordance rate. The NHSBS 2004/5 showed that 8% of married or cohabiting couples had one or both partners infected with HIV. 57% of these couples were HIV discordant, meaning that only one of the two partners were HIV infected. The infected partner either entered the relationship when already infected or acquired it from outside. Most unions however do not benefit from HCT and mutual disclosure of results before the couple engages in unprotected sex. Discordance heightens chances of infection to the negative partners by 12 times compared to the general population. Testing and mutual disclosure of results is crucial for the transition from primary abstinence to being faithful in a long-term sexual relationship among young people.

Alcohol consumption is prevalent in the country and part and parcel of the social and cultural fabric of society. The formal and informal alcohol industry is a major source of livelihood for many households including young people. Studies however link alcohol to irrational behavioural that might lead many to engage in unprotected sex. The NHSBS revealed that 14% of women aged 15-24 had sex in past year when respondent and/or partner were drinking.

Structural sources of vulnerability

Several factors that expose young people to HIV emanate from structural and systems challenges. The dynamics and impact of the epidemic have resulted in increased demand for and complexity of services to deliver and a range of social, cultural and economic environments to address to establish enabling environments for sustained positive change. As such service limited coverage especially for the ever-changing demographic patterns among young people that demand for consistent age specific services has led to gaps that heighten vulnerability.

Barriers to and poor access to social, health and HIV and AIDS services result in ill informed decisions and choices. Many young people have not received guidance about sex and sexuality issues from their parents or guardian and from the health and education systems. Often they resort to peer support and advice that might also be incorrect, incomplete or inappropriate for the situation.

Young people cite lack of life and livelihood skills to apply to situations as a major source of vulnerability. Yet often resources constrain delivery of such training services in a systematic and consistent manner to ensure universal and equitable coverage.

Poverty is prevalent in communities. About 31% of Ugandans live below the poverty line. Lack of access to basic needs including food and shelter has led many young people especially Orphans and Vulnerable Children (OVCs) to engage in survival sex, commercial sex work and early and sometimes forced marriages.

On the other hand, wealth and access to spare income for example among young people in the fishing sector has been established to enhance vulnerability to HIV infection. This largely hinges on the fact that money enhances mobility usually living long-term partners behind and ability to afford multiple partnerships. Similarly global development trends especially through access to Information

Communication Technologies (ICTs) and enhanced intercontinental travel are exposing many to alien behaviours and practices such pornography that are perceived as trendy from development perspectives.

While levels of explicit stigma and discrimination have drastically reduced in the country, there are high levels of inherent stigma still attached to HIV infection and the resultant self stigma that hinder many from accessing preventive, care and support services. Young people are also uniquely affected by layered social and HIV/AIDS related stigma. As an example self-initiated access to SRH services still attracts labels of immorality.

Perhaps the most vital source of vulnerability for young people that also presents as a major challenge to HIV/AIDS programming is the growing trend of normalization. Having to live with HIV and AIDS in the population for the last about 25 years has led to a perception especially among young people that AIDS is just like any other manageable chronic disease that does not require taking preventive precautions at individual level. This appears to have been borne out of fatigue about the epidemic, complacency at individual and organization by the end of the 1990s and ultimately the increasing free access to antiretroviral therapy. Coupled with low risk perception levels among young people, these factors will continue to impact on young people's behaviours towards HIV prevention even when service provision significantly improves.

Several programmatic factors also lead to heightened vulnerability among young people. Reviews have revealed limited focus on the needs of young males, young people who are already married, sexuality issues of those infected young people especially through vertical transmission of HIV, and also young people socialization and gender expectations that render many vulnerable. Similarly, while many existing laws and policies on sexual offences provide an enhancing environment for the HIV/AIDS response, inadequate enforcement and implementation create missed opportunities for HIV prevention in communities.

3.3 Impact of the epidemic

The devastating AIDS epidemic has registered both direct and indirect impacts on individuals and communities that curtail efforts towards human development. These emanate from increased morbidity and mortality rates especially among economically productive age groups of 14-49 year olds. Beyond adult sicknesses and deaths, the impact of AIDS on children and young people is seen in their own risk of HIV infections and diminished social development prospects. As AIDS impoverishes families, young people especially young girls are likely to be withdrawn from school and forced into exploitative situations to survive. Many have been left homeless without emotional and psychosocial support at an age when it is needed most. Such factors deepen the poverty cycle.

Since 1982 when the country's first cases of HIV were detected on the shores of Lake Victoria in Rakai district, cumulatively an estimated 2.6 million Uganda have been infected and 1.6 million have lost their lives to HIV/AIDS related illnesses including 76,000 in 2005 alone. For many years, AIDS has been and is still a leading cause of adult disease and deaths. It is the fourth leading cause of under-5 mortality, directly influencing the realization of MDG goals. Adult life expectancy currently is at 48.9 years (50 years for females and 48 years for males) yet it is projected to have been 56.9 years without AIDS. AIDS is cited among the leading causes of poverty in the country.

There is increased morbidity due to the upsurge of opportunistic infections some of which requiring even more complex expensive treatments than can be afforded. Reviews have established that 50-

70% of hospital admissions are HIV related. HIV has ignited the upsurge of an equally threatening tuberculosis epidemic. About 50-60% of TB cases are co-infected with HIV.

Most of the AIDS deaths occur among men and women of childbearing age resulting in unmanageable increases of Orphan and Vulnerable Children (OVCs). The NHSBS estimated a total of 2.18 million Ugandan orphans by end of 2005. About 47% of these and 81% of the 567,700 dual orphans are due to AIDS. Nursing parents and eventually loosing both of them is among the most devastating impact on the psychosocial development of young people. The magnitude of the OVC crisis in the context of prevalent poverty in communities resulted in a systematic collapse of the traditional extended family – the most ideal social safety net for the infected and affected young people. Consequently orphaned children are more vulnerable to HIV, property grabbing, early marriages and early pregnancies. Rampant property grabbing leaves many homeless, on the streets and others engaged in survival sex and even more difficult to reach with services. Child-headed families are no longer strange in many communities in different parts of Uganda. Studies reflect that about 23% OVCs are receiving some form of external support but this is not usually comprehensive and reliable to sustain them until they reach the legal age to earn their own living.

With improving care and treatment, many of those infected through mother-to-child transmission are growing into healthy adolescents and young people. A few of these are aware of their status considering that only about 13% of Ugandans have tested and received their HIV status results. Fewer still access care and support services due various reasons including lack of specialized care facilities in the country. Many healthy infected adolescents and young people have initiated or would wish to initiate sexual relationships in contexts where consistent condom use is not feasible in intimate relationships, while some have expressed the wish to reproduce. On the other hand, the ill health of infected young people may impact on their participation in social and economic activities including formal education and recreation. The intrinsic stigma and discrimination at points of services delivery also impacts on adherence to antiretroviral drugs (ARVs).

4.0 Overview of the country's response

Uganda's success story is hinged on a number of drivers of the response including:

- Political and leadership commitment and active participation right from President Yoweri Museveni and the First Lady Mrs. Janet Museveni. Their personal involvement has been an inspiration and compelling factor for active involvement of leadership at various levels. Their priority focus on young people and emphasis on values-based approaches have inspired abstinence and faithfulness interventions that greatly contribute to the country's achievements.
- Policy of openness that enhanced common dialogue on problems and solutions and significantly led to reduction in stigma and discrimination levels
- The multi-sectoral policy and strategy that compelled all sectors to contribute to the response from varying contexts underpinned by central coordination approaches to ensure focus on a common problem
- Individual patriotism, community involvement and civil society programming to complement government actions
- Involvement of people living with HIV/AIDS especially in HIV prevention that put a human face to the response and greatly led to dispelling of myths and misconceptions
- Local research into the epidemic and the response that has consistently provided strategic information to inform policy and programming
- Mobilization of resources from both internal and external sources. There has been consistent resource support from global development partners

4.1 Policy environments

A dynamic policy review and formulation environment has underpinned the mentioned drivers of the response. This takes place generally to address social, economical and structural aspects of development thereby addressing contextual factors that predispose people to HIV infection and hinder service uptake.

Such policies have been developed in areas of: poverty eradication; universal primary education (UPE); sexual reproductive health aspects for adolescents and adults; gender equity and affirmative action for the marginalized populations including women; children and youth welfare and involvement in decision making processes; minimum health care package; prohibition of harmful cultural practices; general health and population development issues; decentralized governance; and media liberalization.

These have supported the response directly and indirectly. For example, enhanced school enrollment through UPE provides an easy opportunity for reaching many young people that also serve as community change agents. Similarly, most Ugandans can access radio with about 70% women able to access this media that provides information on a range of issues including HIV/AIDS. The social and economic empowerment of females has also provided a basis for working with women on their causes of vulnerability.

Specific HIV/AIDS policies have also been adopted and others drafted. These include general, sector and theme specific policies including:

- The working draft of the National HIV/AIDS Policy that specifically highlights young people as a priority dynamic vulnerable population, and acknowledges innovative application of Abstinence, Being faithful and Condom use (ABC) as a proven model
- The National Policy on young people and HIV/AIDS,
- Policy on HIV and AIDS in the world of work,
- The education sector HIV and AIDS policy that puts focal the school going young person's welfare
- The HIV counseling policy that acknowledges the need to have children from age 12 to access HIV Counseling and Testing (HCT) services unaccompanied
- The Prevention of Mother-to-Child Transmission (PMTCT) policy that among other aspects stresses primary prevention among all women of reproductive age group and their antenatal welfare
- The Anti-Retroviral Treatment (ART) policy that acknowledges the priority focus on the less privileged particularly the OVC's to free access
- Cotrimoxazole prophylaxis policy that targets enhancing healthy lives of the infected with direct and indirect benefits to infected and affected young people
- The HIV and AIDS district coordination guidelines that stipulate involvement of different local government structures in the national response. The representation of young people on governance structures at district and lower levels provides them with an opportunity to participate in decision making and progress review processes

The extent of implementation of these policies varies from policy to policy and the nature of issue they are addressing. Strategically, the consultative and consensus processes around policy review and development provide opportunities for heightened advocacy around specific issues from the community through to the technical, policy and political levels. This enhances programming, service delivery and ownership of the response.

4.2 Priorities and approaches

HIV Prevention has been the mainstay of the country's response since the mid-1980s. This acknowledges the need to break the cycle of new infections to reduce HIV impacts and particularly the number in need of life-long treatments considering the resource constraints as a developing country.

Within prevention, young people have been a priority population group since the initiation of multi-sectoral national planning processes in 1993. This was a recognition of their uniqueness, primarily as a window of hope for the age group 10 to 16 that consistently has very low prevalence rates. The strategy also acknowledged young people's vulnerability owing to the fact that infections began around age 18-19, increased steeply and peaked around 22-24 years. Despite the shift in the peak of the epidemic, young people remain a priority target in the new National HIV/AIDS Strategic Plan 2007/8-2011/12.

Primary HIV prevention i.e. prevention of infection from an infected to a non-infected person, has been the major focus of interventions with more emphasis on behavioral interventions compared to technological approaches. This has been and is approached through the ABC model applied through a mix of communication and service delivery interventions. Emphasis is put on Information Education and Communication (IEC) and behavior change communication (BCC) actions to promote awareness and knowledge about HIV/AIDS and enhance adoption of positive individual behaviours and social

change. The country's success story has been documented through many studies to hinge on positive outcomes from the ABC indicators.

Other priority primary prevention interventions include HIV Counselling and Testing (HCT) - a crucial intervention for supporting transition from Abstinence to Being faithful (A to B) among young people, STI prevention and management, and blood safety that hinges on blood donations largely by young people. Secondary prevention interventions have focused on prevention of mother-to-child transition (PMTCT) since the late 1990s.

Successive HIV/AIDS country planning frameworks have also prioritized treatment, care and support for the infected and affected. Treatment aspects have evolved from focus on opportunistic infections due to resource constraints to a comprehensive care package that features HCT and of recent routine testing and counseling (RTC), access to the basic care package OI prevention and treatment to prevent progression to AIDS, and free access to ART for those eligible. The package recognizes benefits of improved quality of life of the infected that enables them to contribute to development efforts, raise their children, and relieve the social and health care of the disease burden.

Care and support aspects have largely focused on the welfare of the infected and affected in the community to promote access to basic needs, psychosocial, emotional and livelihood support, and legal aid. OVCs are a priority focus in these areas.

4.3 Programming for and by young people

Quite a number of approaches to young people situations have been employed from the perspective of one off interventions and systems and structural changes to address issues both in the short and long-term. It is worth noting that most young people programmes uphold the principle of integration to offer a comprehensive menu of activities that considers the individual young person and circumstances around that person that influence vulnerability. Specific aspects such as age, residence, gender, education attainment, conflict and displacement, marital status, and occupation are utilized to define target groups. While emphasizing age appropriate interventions, abstinence is the major entry point for young people BCC interventions and faithfulness for those in long-term relationships. Condom education is promoted to give young people proper information. Condom use, however, is basically promoted for young people that have been identified to be sexually active and are not able to take on AB.

The health and education sectors institutionalized school health programmes since the late 1980s that resulted in curriculum reviews to incorporate HIV/AIDS at primary and secondary levels. The current design of the institutionalized PIASCY hinged learner-focused models is a testimony of systems change to address the epidemic

While young people are still major targets of mass media programmes to sustain high levels of awareness and knowledge, most programmes employ face to face interactions through peer support, sexuality and life planning skills development, youth-adult partnership approaches, and edutainment. Several young people centres provide friendly social, health and recreational services around the country for both in and out of school though largely restricted to urban centres. Specialized programs such as the youth truck that enhances information access to hard-to-reach-young people, special young people sessions organized by credible leaders including the First Lady of Uganda and the Queen of Buganda provide the much needed focus on values-based approaches.

Other skills development initiatives are in areas of vocational and livelihoods, leadership development, advocacy and community mobilization, and programme development and management.

Uganda is also a role model in providing specialized treatment, care and support services to infected and affected young people. These initiatives provide a continuum of care from health care facilities to home-based care and livelihood skills and support approaches. There is a growing movement of young people positives working together to enhance advocacy on their plight and providing support to each other.

Young people involvement
Most programming hinge on meaningful involvement of young people especially at formative and evaluation stages. Several youth led civil society organizations have been registered and most young people focused programmes employ appropriately skilled young people to man offices. The country's acknowledgement of young people's contribution in managing and coordinating the response was demonstrated through the establishment, in 2005, of the Young People Self-Coordinating entity as part of the overall HIV/AIDS partnership structure. This structure is intended to provide a direct link to young people to present their voices at various decision making levels in the response, enhance advocacy for focus on issues that affect them, and promote information sharing on the epidemic and the response in their constituency.

At national level, young people specific outcome indicators that also feed into global reporting requirements periodically underscore programming. These include but are not limited to:

- Percentage of young people 15-24 who are HIV infected (HIV prevalence)
- Percentage of new infections occurring among young people aged 15 -24 years
- Percentage of 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
- The percentage of sexually active youths 15-24 years who correctly identify at least two ways of preventing transmission of HIV.
- Percentage of young people aged 15 -24 years who have had sex before the age of 15

4.5 Overview of successes, challenges and opportunities

Uganda's success story amplified achievements largely in the area of HIV/AIDS though this was hinged on pooled achievements from other social, health and economic aspects of national development. The following provides a short analysis of these areas from the late 1980s to-date:

- Reduction in poverty levels indicated by the population living below the poverty line improved from 56% in 1991 to 31% in 2006.
- Net enrolment ratio in primary education increased from 84% in 2001 and 90% in 2006. School enrollment increased by 70% with UPE
- Infant Mortality Rate (IMR) per 1000 live births improved from 81 in 1995 to 76 in 2006 and Maternal Mortality Ratio (MMR) per 100,000 live births improved from 506 in 1995 to 435 in 2007.
- HIV prevalence dropped from a national peak of 18% in 1992 to 6.4% in 2005. This was more significant among urban young women
- **A demonstration that ABC works**

- The percentage of young women aged 18 – 24 who had their sexual debut before age 18 reduced from 74% in 1995 to 58% in 2006 and for young men of same it reduced from 64% in 1995 42 % in 2006. Age at first sex was estimated at 16.7 and 18.8 for girls & boys respectively in 2005.
- Teenage pregnancy reduced from 43% in 1995 to 25% in 2006
- Reduction in multiple sexual partnerships: The GPA surveys documented large declines in multiple partnerships among sexually active, single youth in the early nineties. The percentage of single, sexually active respondents who reported this behaviour dropped from 24% to 18% among women and from 55% to 29% among men between 1989 and 1995. This was driven mostly by declines in rural areas among both women and men.

- Increase in condom use during high risk sexual group: Condom use rate within the "High risk group" has increased from 49.8% 2001 and is currently reported at about 61 percent

- Rapid enrollment of PHAs on Antiretroviral Therapy (ART) from 2003. 35% of those eligible were receiving ART by end of 2005. This is projected to have averted 14,400 deaths in 2005 alone
- 99% awareness and 90% knowledge about HIV/AIDS

4.6 Challenges

Despite the modest achievements, the country is faced with enormous challenges that threaten to erode past gains generally and among young people specifically. These challenges emanate from structural, behavioural, and situational perspectives:

- The NHSBS revealed threats of a resurging epidemic with subtle increases in new HIV infections from different parts of the country including rural and relatively stable regions. Normalization trends and low levels of risk perception in the context of high levels of awareness and knowledge aggravate the situation. Low uptake of available proven interventions such as HCT and PMTCT also demands for innovation,
- The current high population growth rate (3.2%) translates into increased need for service coverage both in the short and long-term perspectives,
- Yet competing priorities impact on resource mobilization for a comprehensive, universal and equitable response.
- The dynamics and impacts of the epidemic have resulted in increased demand for complex services in the health and social sectors that cannot be adequately handled by existing infrastructures especially in the inevitable emergency mode. The breakdown of community social structures do to HIV/AIDS exacerbates the situation.
- The slow pace of the HIV/AIDS mainstreaming process in development programming features missed opportunities for optimal resources utilization and wider coverage
- The gender gap in indicators at impact and outcome levels despite the many years of affirmative action is a source of concern for intervention packaging
- Scaling and sustaining access to life long treatments to increasing numbers of the infected especially in the context of an expanding population might not be feasible without heavy dependence on external support

Several challenges specific to young people programming have also been identified:

- The celebrated achievement of reducing incidence and prevalence rates among young people might result in a shift of attention to adults especially due to resource constraints

- Comprehensive OVC support is still constrained due to prevailing poverty conditions in communities.
- Packaging of information especially through the common mass media enhances coverage but presents challenges to heightening individual risk perception and internalization.
- Low comprehensive knowledge, low risk perception and normalization
- Limited access to HCT presents a unique challenge to those who inevitably have to transit from abstinence to being faithful in long term sexual relationship.
- Addressing conflicting info from trusted sources e.g. from peers, adults, teachers etc
- Managing sexuality and reproduction issues for healthy infected adolescents and youths
- Universal comprehensive and sustainable coverage for all the diverse young people groups with appropriate information and services and ensure adequate follow-up requires unachievable resources levels
- Most young people lack appropriate skills to engage in the management and implementation of the response by and for themselves.

4.7 Emerging issues and opportunities

The NHSBS 2004-5 and the various reviews conducted on the dynamics of the epidemic and effectiveness of prevention interventions revealed factors that require priority focus to achieve significant reduction in new HIV infections. Similarly, the recently concluded national strategic planning process established cost effective and cost saving interventions that need to be prioritized to achieve 40% reduction in infections by 2012. Specifically for young people the following emerging issues and opportunities are worth highlighting:

- Universal secondary education will provide opportunity to the many adolescents who have been dropping out of school due to school fees to enroll. The education system provides strategies opportunities for delivering HIV/AIDS services with a multiplier effect as the students interact with community members from informed perspectives. It is envisaged that with improved transition ratios from primary to secondary education, there will be increase of young people in tertiary and vocational facilities. This will in the long term enhance the skills base among young people to participate in development generally and the nation AIDS response
- The new government development programme (Boona bagaggawale) should be optimally exploited to address poverty levels among young people & communities
- Full integration of HIV in SRH interventions and in HIV care and treatment
- Intensifying prevention with positives
- Male circumcision is a potential addition to HIV prevention that can also serve as a strategic entry point for delivering male SRH services. It is however acknowledged that if not well packaged it can potentially erode past gains especially through behavioural dis-inhibition
- Universal ART coverage should be viewed beyond a treatment programme to assess benefits to prevention and impact mitigation. It is for example projected that universal ART coverage would prevent 356,600 children from becoming orphaned by 2010
- Young people are a target for diverse programmes from different sectors. Limited mainstreaming of HIV/AIDS in such programmes is a missed opportunity for enhancing contextual interventions, wider coverage and optimal resource utilization

4.8 Way forward

Future strategies for enhancing young people's health from the perspective of intensifying HIV/AIDS responses need to be considered from global and national obligations generally and specifically from the roles and responsibilities of young people themselves.

At global level, the UNGASS Declaration 2001 highlighted the following key targets:

- Ensure that at least 95% of young people have the information and access the services they need to reduce vulnerability to HIV
- Ensure that at least 95% of young people have access to the skills they need to reduce their vulnerability to HIV
- Develop and strengthen strategies, policies & programmes which reduce the vulnerability of children and young people

At national and sector levels, it is acknowledged that HIV/AIDS is a key determinant of health and social development among young people. Their vulnerability to HIV infection and its impacts is influenced by many factors addressed by different sectors. This demands for a multifaceted and coordinated response by stakeholders from the health, social and economic sectors. Mainstreaming in development programs generally and young people focused programmes should take priority. Specific HIV/AIDS programming should be viewed as catalytic.

The Road Map towards Accelerated HIV Prevention in Uganda and the recently concluded National Strategic Framework for HIV/AIDS Activities 207/8-2011/12 highlight priorities, approaches and targets that should be exploited to intensify the HIV/AIDS response among young people as part of national development generally. Key highlights include:

- Prevention is the mainstay of the response targeting 40% reduction in new HIV infections by 2012,
- Behavioural interventions are prioritized through ABC+ delivered primarily through communication for individual and social behaviour change. *ABC+ is defined as a behavioural intervention taking into account the social, cultural and economic environments around the individual that influence behaviours and linking to other prevention and care interventions to enhance risk perception and internalization, and life skills building to support individuals to adopt and sustain positive behaviours of abstinence, mutual faithfulness to a partner of known status, and correct consistent condom use at every high risk sexual encounter.*
- Address drivers of the epidemic, major sources of new infections and causes of vulnerability. This includes focus on social, cultural and economic circumstances that render people vulnerable
- Provision of integrated HIV/AIDS prevention, treatment and care also as part of national development efforts
- Promote prevention with those who are HIV positive to avoid re-infection and transmission, and provide basic tertiary prevention care services to delay progression from HIV to AIDS stage.
- Expand and sustain access to antiretroviral therapy (ART) targeting 57-73% coverage for those eligible.
- Increase social support to the infected and affected
- Mainstream HIV/AIDS in all sector plans and budgets
- Ensure evidence-based programming to address contexts and ensure responsive interventions
- Develop systems and infrastructure to support universal equitable and quality services delivery

Specifically for young people, the following strategies and approaches are emphasized:

- Create of social spaces for young people

- Integrate HIV/AIDS young people issues into socio-cultural, economic services Linking to ASRH, treatment and care services
- Focus on causes of vulnerability to enhance positive behaviour formation and change
- Address gender contexts that cause vulnerability and impede service uptake
- Enhance focus on high risk sex
- Enhance innovation through packaging interventions, services/products to match development trends that appeal to young people and influence their behaviours
- Enhance community involvement and adult-support approaches targeting creating supportive environments and social change
- Involve young people in HIV/AIDS programming and implementation, and service delivery

4.8 Roles and responsibilities of young people

Achieving and sustaining health and HIV/AIDS targets among young people largely depends on their active involvement and individual commitment to access services and adopt positive behaviours. While acknowledging their rights, they should also seriously take on their roles and responsibilities. Young people are expected individually and collectively to respond to the epidemic, and specifically to:

- Develop AIDS Competence i.e. understand the dynamics, magnitude and impacts of the problem and particularly how it affects them in the short and long term.
- Translate this information into comprehensive knowledge on HIV/AIDS to improve risk perception and internalization
- Develop and apply life and vocational skills
- Participate in management and coordination of the response at different levels and especially through the Uganda HIV/AIDS Partnership and district coordination structures
- Develop and apply leadership skills in mobilizing young people to engage in the national response and development generally
- Young people leaders are specifically called upon to proactively participate and inspire action from other young people. As a priority, they should gather evidence on status and gaps and advocate for the response generally and young people issues specifically:
    - Advocate for policy and systems change for universal access to quality services:
    - Lobby for action at policy, programme and service delivery levels and for community and individual AIDS competence
    - Advocate for mainstreaming HIV and AIDS in all development programming & youth targeted programmes
    - Participate in capacity development of young people to take on appropriate roles and responsibilities
    - Initiate young people driven programmes with adequate competences and adult support

5.0 Conclusions

The dynamics of the HIV/AIDS epidemic among young people pose the biggest barrier to attainment of quality of health and their development and contribution to national development generally. Meeting global and national targets for young people development will hinge on integrated diverse actions from various sectors and at different levels to enhance scope and equity in service coverage. Programming and service delivery should take into account the social, cultural, economic, religious and political dimensions of issues the render young people vulnerable to HIV infection and hinder adoption of positive and uptake of services.

There is need to minimize young people generalization considering the variety of situations so as to design innovative and responsive age, gender and local context specific interventions. This requires an emphasis on developing programmes based on evidence to enhance cost effectiveness, and conducting on ongoing evaluations to demonstrate impact. Involvement of young people in the design and implementation of programmes that target them is crucial to build on and sustain past achievements.

Uganda has demonstrated that the HIV/AIDS epidemic can be addressed utilizing the right mix of approaches and commitment at various levels. The country has invested in research to establish the drivers of the epidemic and response, which has been the basis for new 5-year planning framework. With the involvement of all key stakeholders and young people themselves, it envisaged that country will achieve its targets.

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