

# THE Health Digest

Issue 08 | June 2016

## Sexual and Reproductive Health Rights for Youth and Adolescents

Youth-friendly corners boost uptake of sexual and reproductive health services

End Forced Sterilization of Women Living with HIV

Writing Women's Reproductive Health: A Uganda Study



HEALTH Journalists  
NETWORK IN UGANDA

*"Improving public discourse on emerging health issues"*



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## Editor's Message

Dear readers,

Of Uganda's 36 million people, about a third are young people (10-24 years). They carry the highest challenges concerning Sexual Reproductive Health (SRH). It is prudent for all of us to team up and offer solutions to their challenges.

This issue of the Health Digest focuses on Sexual Reproductive Health Rights (SRHR) for adolescents and the youth. The articles here present a portrait of health facilities that offer youth-friendly services, how they do it, and how much youth enjoy or hate them.

There is no doubt that the Uganda Government through the Ministry of health is trying to enhance access to SRH services to young people. The problem, in part, is that there is limited funding for the model that the youth prefer to what the Government can afford.

We have a map compiled by Reach A Hand, one of the organisations that work in this space, that shows where these youth friendly services are available.

There is also good news. Women may finally have a self-initiated HIV prevention product. Uganda alongside other countries participated in two large phase III trials that have shown promise of protecting women from HIV infection by 27-31 percent.

Unfortunately, the young women who participated in the study didn't use it. And in more disturbing news, women living with HIV are being sterilized without their consent. Their rights are being violated by health workers who should know better.

We have a story about a young woman who is living with HIV but has hope and is spreading information about living positively and with hope like she is doing.

The Health Digest has this time been written by volunteers and HEJNU staff. We are truly grateful for your contributions. Although we tried to look around for funding for this issue, we failed. But all the same here it is and ready for you to enjoy.

This edition is our eighth issue. You can read the others on our website: [www.hejnu.ug](http://www.hejnu.ug). We welcome your feedback.

Enjoy your reading,  
Edris Kisambira.  
Editor

# Media Reporting on Sexual Reproductive Health Rights Rated Fair

In mid January 2016, the focus of our monthly science Café was Sexual Reproductive Health Rights (SRHR) for adolescents and youth. For the first time, we had another sponsor for this Café, the Uganda Network of AIDS Service Organisations (UNASO).

Joshua Wamboga, Executive Director, UNASO thought the topic was relevant and timely as “the mass media have excellent potential to promote good sexual and reproductive health outcomes.”

However, he faulted the Ugandan media for often failing to prioritize and report accurately on SRHR. “Media coverage of SRHR is just fair,” he concluded. Joshua has been an advocate for these issues long enough so I believe him.

The Health Journalists Network in Uganda (HEJNU) once every month, usually on a Wednesday afternoon, from 3-5 pm holds a science or media café. HEJNU is an association dedicated to increasing understanding of health care issues and improving health literacy among Africans.

The science cafés we have held have almost exclusively been sponsored by AVAC, a global non-profit organisation that works to accelerate the ethical development and global delivery of HIV prevention options. Thankfully, more sponsors are coming on board.

Generally, science cafés are an innovation that present a platform for engagement on science issues that are pertinent but may be rather isolated from the general public including the media.

Uganda’s adolescents and youth have been wretched in terms of SRHR. But with more than half of the country’s 36 million people below 30 years, its important to know that these young people prefer health facilities with services tailor-made for them.

At the January Café we discussed SRHR issues extensively and here are the highlights of each speaker to whom we are profoundly grateful for having taken time to speak to us.

Godfrey Walakira, training and development manager, Straight Talk Uganda, explained that young people should know about their SRH rights. This requires that journalists are knowledgeable to inform the public and report objectively.

Uganda is a signatory to several international treaties on the rights and wellbeing of young people but as with other policies, it has flops at implementation.

Patrick Mwesigye Sewa, founder and CEO, Uganda Youth and Adolescents Health Forum, said many young people do not know what SRH services they are entitled to and where to access them.

Bakshi Asuman, programs manager Reach A Hand, also discussed the challenges of work-ing with the media to create awareness on SRH issues for young people. He said the media does not understand and appreciate SRHR issues and urged journalists to increase their coverage so as to draw more attention to them from policy makers and other stakeholders.

In this edition of the Health Digest we have a map produced by Reach a Hand where these services are provided.

Ministry of Health officials were available to tell us what the government is doing about it. Dr. Wilberforce Mugwanya from the Reproductive Health Division of the Ministry said they are aware that the health-seeking behaviour of adolescents and youth need to be addressed if more are to seek SRH services.

Therefore, there are efforts for all health facilities to have youth-friendly services. Different models are being explored and the one that the youth prefer unfortunately is unaffordable to government.

Olivia Kiconco an official from the same department said the Ministry of Health in partner-ship with UNFPA is developing a mobile App that will make it easier for young people to access SRH information.

Since most young people have smart phones, putting information online is a wise decision and also crucial to increase access to SRH services.

Lastly, Primah Kwagala from the Centre for Health, Human Rights and Development, said young people have the right to access SRH information and services like safe, legal abortion and contraceptives.

Hopefully, the media can sustainably increase coverage of SRHR to create more awareness. I thank all our writers who volunteered their time. A big thank you all.

We hope our contribution is helpful. Hopefully more organisations also realise the need and urgency of SRHR and play their part. Enjoy.

*Esther Nakkazi*  
*President HEJNU*  
*Freelance Journalist*

# Youth-friendly corners boost uptake of sexual and reproductive health services

*By Esther Nakkazi*

The ambience in the waiting room is upbeat. There is a huge, loud TV screening a drama on sexual and reproductive issues. Young people watch attentively, eyes glued to the screen. Others are chatting and laughing loudly.

Asia Babirye, a young woman, looks around. She can't believe what she's seeing. There are many young people in the waiting room.

The walls are covered with colourful posters of teenagers. The text is mostly in dialogue, the people in the posters are dressed casually and use 'cool' words commonly heard in school. There are also leaflets, condoms and a suggestion box.

Babirye picks up one of the leaflets - a Straight Talk pull-out. It tells her about the discussions young people have about teenage pregnancy. It has so many visuals, illustrations and the language is something she can relate to.

According to the Ministry of Health, 25 percent of Ugandan teenagers become pregnant by the age of 19. About 49 percent are married before their 18th birthday and they start getting babies until their mid 40s.

"I didn't know that," she thinks to herself.

"The discussions and themes in our pull-outs are decided by the young people," says Martha Akello, the mass media manager, Straight Talk Foundation. Staff go to the field and get information from the young people, which is what is printed and so readers can relate with it.

Akello also says the pictures and illustrations used express hope, so that whatever problem young people go through, she knows they will overcome it. The messages are also kept as simple as possible.

Seated at Naguru Teenage Information and Health Centre (NTIHC), Babirye says she likes reading these stories.

Most hospitals in Uganda don't look like this. For a start, they're filled with much older people.

"Adolescents constitute the highest demographic segment in Uganda, yet sexual and reproductive information and health services to meet their needs are still limited," says Ruth Aceng, the Minister of Health.

More than half of Uganda's population is below 15 years of age, according to the State of Uganda Population Report 2014.



*Photo by Esther Nakkazi*

The teenage Centre runs parallel to a health facility serving adults, the Kiswa health centre IV. Even though the two facilities are located in the same compound, they're in separate buildings. The staff at Naguru are assisted by peer educators who are on vacation from school.

### **Challenges for youth accessing SRHR:**

Young people in Uganda face health challenges similar to those faced by others elsewhere in the rest of the world: early or unwanted pregnancies; unsafe abortions; sexually transmitted infections, HIV and Aids and sexual abuse.

The teenage centre's Deputy director, Denis Lewis Bukunya, says young people in Uganda need to be handled in a sensitive way, because they're often too uncomfortable to talk about reproductive health issues.

"They come in and say they have a headache when in actual fact they have a sore penis," says Bukunya.

Bukunya says it takes between 45 minutes to one and half hours to serve a young person. Staff receive special training to deal with adolescents.

It is one of the reasons Babirye prefers this

clinic to the youth corners in public hospitals.

"They are not rude and do not judge me," says Babirye. "Every time I come I get what I want easily. Even medication is free."

This mostly doesn't happen at other health facilities. When young people turn to public health services, they face long queues, a lack of privacy, and confidentiality, and staff may be rude and judgemental towards them.

According to Nixon Ochatre, the founder Amani Initiative, an organization that works with youth, some health facilities without special consideration for adolescent health issues make teenage mothers feel judged and 'left out' when they need to be empowered with adequate information and support.

Babirye and her peers prefer the teenage information centre to the youth corners in public hospitals because it's in a separate building and has staff specially dedicated to the youth.

According to Dr. Wilberforce Mugwanya of the Ministry of Health's reproductive health division, creating parallel facilities such as the Naguru teenage centre is costly and too expensive to maintain.

Mugwanya says a full health service unit with comprehensive structures, including buildings, equipment and staff, implies would require doubling the cost of using a hospital or health centre.

“Most of these can only be supported by non-governmental organisations and donor funding, which poses sustainability questions,” he says.

Therefore, the Uganda Government has created youth corners, also referred to as youth-friendly centres, a response to the finding that youth shy away from seeking reproductive health services offered in open-to-all clinics for fear of being seen by parents or people who know them.

But youth corners in public hospitals serve the youth on a single day of the week, and they have no staff dedicated to young people’s needs as they serve adults alongside young people.

These facilities are also supposed to offer pre- and post-natal care for young women, post-abortion care, immunisation, clinical care for sexually abused young people, and they inform young people of their health rights.

But at many public health facilities outside Kampala these guidelines are not adhered to.

Organisations like the youth empowerment and reproductive health advocacy group Reach A Hand Uganda (RAHU) have mapped out the hospitals with youth friendly centres so that young people can be referred to them.

RAHU’s founder, Humphrey Nabimanya, says youth friendly corners bring together the type of services young people want. “Such services must be accessible, acceptable and appropriate for all young people,” says Nabimanya

In these corners, young people meet to play and also learn about their health. They are equipped with infrastructure that appeals to young people such as video and TV screens, CD players and games such as ludo, pool tables, volleyball and football.

Many young people feel they can easily run into their relatives who might find out that they have

come to collect contraceptives or access other reproductive health services when they opt to use the Youth Corners in the main hospitals.

Yet at teenage information centres they only see their peers and the staff hired are younger and less judgmental.

“Young people want to be able to go and test for, say, HIV without the health worker going to tell their parents,” says Godfrey Walakira from Straight Talk Foundation.

“Young people need to be reached with adolescent-friendly services to mitigate multiple health challenges and behavioral risks that they are faced with,” says Nabimanya.

Gaps in service delivery at health facilities include: long time spent at facility, lack of privacy, limited counselling, negative attitudes of health workers, no communication between schools and health facilities as well as training gaps.

Naguru teenage centre staff are trying to help establish and strengthen youth friendly services in various public health facilities around the country by offering training and mentorship.

Besides NTHIC, which has a stand-alone model and operates like a non-government organization funded by donors, other youth corners are visible only in the Kampala Capital City Authority health facilities, of which there are less than 10.

### **Costing Comparison for the two Models**

At NTHIC, 28,746, 32,196 and 33,662 young people were attended to in 2013, 2014 and 2015 respectively.

On average, \$15 is spent on drugs, counselling and clinical services for every young person who goes to the facility. In a month, a facility like Naguru teenage centre attends to about 100 young people. If you do the math for a month, the bill comes up to \$45,000 for every 30 days.

Founded in 1994, NTHIC is funded by SIDA, Kampala Capital City Authority (KCCA) and the Ministry of Health.



Photo by Esther Nakkazizi

The centre employs 35 staff including 9 program managers, 10 medical personnel, 7 in the counselling unit, 7 peer educators and data entry staff, 2 drivers and 2 support staff (cleaners).

Dr. Sabrina Bakeera-Kitaka, an adolescent health specialist, heads the Makerere/Mulago Columbia Adolescent Clinic (MMCA) found at Mulago referral hospital that can be described as a youth corner.

Opened for patient care in May 2013, MMCA provides holistic adolescent health care for teens aged 10-19 years within the environment of a tertiary and university teaching hospital. It is not funded by development partners and the adolescents' clinic runs only once a week on Friday whereas the Naguru teenage centre runs 24/7.

In general, the youth corners that have been integrated into hospitals have indigenous problems like lack of staff, poor pay, low funding and poorly motivated staff.

Asked how the one she heads compares to the Naguru teenage centre, she says: "I cannot answer

how effective the model is because we have never done a study to compare the two."

"It is not like we would like ours to be cheap but we do not have the funding. If we had all the services at Naguru available in our clinic, it would be equally expensive," says Dr. Kitaka.

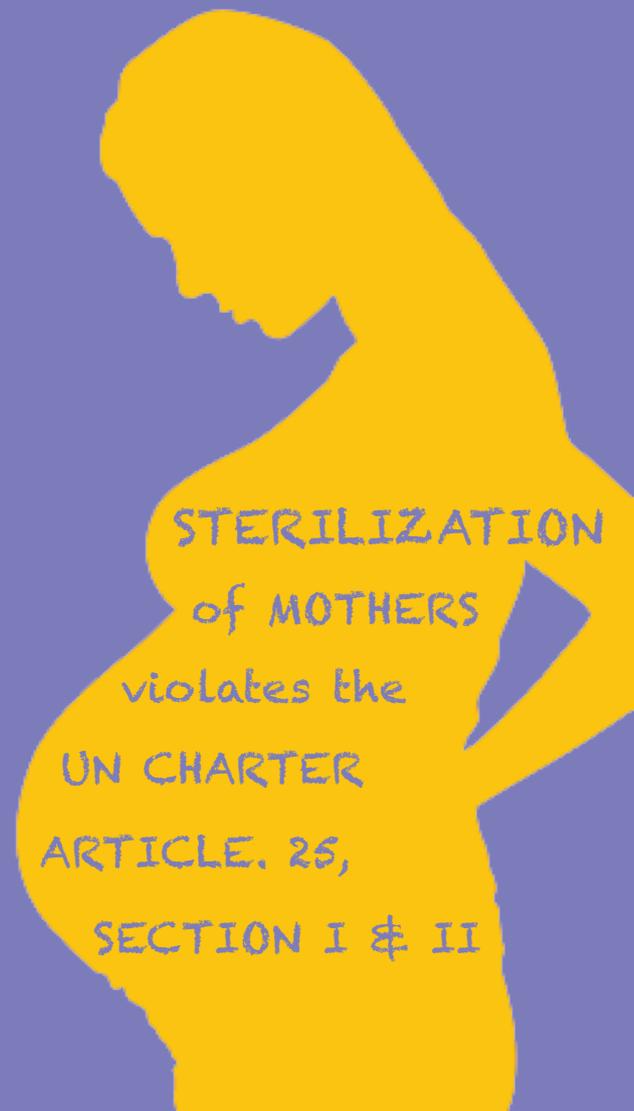
Mugwanya says as a poor country, Uganda can only afford the model where youth friendly services are integrated within a health facility. He reasons that after all, while some of the health needs of adolescents may be unique, some are similar to the rest of the population.

Says Mugwanya; "We are going to work within the structures we have. The whole idea is to improve access to services and information to adolescents and the youth in a friendly manner and environment."

But Bukenya is not convinced. He says that will never be effective, as health workers will be overwhelmed.

*An edited version of this article was first published by the Bhekisisa centre for health journalism of the South African based Mail & Guardian.*

# End Forced Sterilization of Women Living with HIV



*By Brenda Banura*

“My husband passed on just before I gave birth to our first child. Unknown to me then, that would be the last time to go to the labour ward as a mother to be,” says Sandra Kalema\* (Not real name) with tears.

“After giving birth by caesarean, the doctor took it upon himself to sterilize me. I discovered this a while later when I got into a loving relationship and tried to get pregnant but failed.”

“I went for a thorough check up in an attempt to find out why I was not getting pregnant. Years later, it still hurts like I have just found out. I do not know what I would do to the doctor who did this to me if I ever got to know him.”

That is just one of the stories of women living with HIV who are forced and coerced into sterilization. It is an injustice that some medical practitioners practice. It is a violation of their rights.

Kalema’s case is not an isolated one. A study conducted in Uganda and released by The International Community of Women Living with HIV Eastern Africa (ICWEA) about violations of Sexual and Reproductive Health and Rights of women living with HIV found that women living with HIV experience a wide range of violations in clinical settings, their homes and communities.

This study was carried out in nine districts of Uganda including Arua, Gulu, Hoima, Kabale, Kampala, Masaka, Mbale, Mbarara and Soroti in 2014.

The field survey targeted 744 women living with HIV of whom 72 of them at an average age of 29 years reported cases of sterilizations. Furthermore, out of these 20 women had been coerced and forced to undergo this irreversible operation. The study points out many more examples of these violations. A couple of women narrate that

they were told that their fallopian tubes were going to be “tied” (translated directly in the local dialect). To these women this would be a temporary condition and once they wanted to resume they would be “untied”. They actually never knew the full implications of the procedure because it was not thoroughly explained.

Most of the cases happened within government hospitals especially when the women in question gave birth by caesarean section. Consent was given by health workers and the women’s relatives.

### **What should be done to end sterilisation;**

Even with initiatives like Elimination of Mother to Child Transmission (eMTCT), some health workers and members of society still believe that women living with HIV should not give birth.

The medical fraternity, government and the entire community need to be made aware that HIV positive women are sterilized against their consent when they give birth especially by caesarean section and steps need to be taken to end it.

This should start with reaching out to women living with HIV, communities, health workers and men and educating them about women’s rights and the fact that forced and coerced sterilization is illegal.

Information on Sexual Reproductive Health Rights (SRHR) should also be integrated in the current HIV/AIDS programmes and services. Tubal ligation protocols need to be developed and should be communicated during antenatal clinic visits.

The current HIV and Sexual Reproductive Health policies also need to be reviewed, taking into account SRHR violations.

Health workers also need to be trained in offering professional care without violating women’s rights, ensuring that informed consent processes are of high quality.

For the women that have experienced these violations, counselling services at the community level are necessary to offer psychosocial support.

Women who have experienced these violations should be offered legal support to sue. The women need to know that a win in court is possible.

This has happened in Kenya where the High Court is currently is handling a case of forced sterilization of HIV-positive women after a report titled “Robbed of Choice” was published.

A High Court in Namibia in 2014 ruled that medical personnel at public hospitals violated the rights of three HIV-positive women when they sterilized them without their consent.

As these changes are being made, everyone needs to understand and know that Kalema and other women living with HIV like any other women who are not HIV-positive share similar sexual and reproductive health rights including the right to get pregnant and determine how many children to have. This should be respected by everyone.

*Brenda Banura*

*Communications Officer*

*The International Community of Women Living with HIV Eastern Africa (ICWEA)*



# HIV Positive Teenagers Grapple with Stigma in Boarding Schools

*By Esther Nakkazi*

It was time for Jordana Nankya\* to be cleared by the school matron. Escorted by her mother, as Nankya queued outside the matron's office, she quickly whispered to her mother to put the 'lollipops' away.

"Mum put the lollipops in your bag," she said as she held a white tin that had no label. The plastic, opaque tin originally contained painkillers but the labels were removed and it was washed thoroughly.

'Lollipops' is the password for the Anti-Retroviral (ARV) pills that the family uses to remind or check if Nankya has taken her medication. Most families address this problem with some password to keep the issue private.

Nankya's mother, Mrs. Jacqueline Mubiru could not have emphasised enough to her daughter to pack the 'lollipops' in the suitcase before anything else. She crosschecked with Nankya loudly just as they were driving out of the home headed for the first day at school.

A fortnight ago, they had counted out the pills, one per day, to last for one and half months, and repacked them into the plastic container. The mother promised to visit her daughter after a month to check on her health and refill the medication.

At twelve years, Nankya represents the group with the highest HIV prevalence rate in Uganda and the world over. Adolescents in Uganda also have the highest mortality rate for HIV, said Dr. Adeodata Kekitiinwa, Executive Director, Baylor Uganda.

At Baylor-Uganda, the largest paediatric HIV care and treatment clinic and service provider, 67 percent of their clients attend day school.

Children aged 13 to 19 constitute the highest number of persons living with HIV/AIDS in

Uganda. The prevalence among girls is 1.5 times higher than it is among boys.

Adolescents are a difficult group to treat and the key problem is adherence, said Dr. Andrew Kambugu, head of research at the Infectious Diseases Institute (IDI) College of health sciences, Makerere University.

It is because they are at that stage in life where hormones are disturbing them, explained Kambugu. Yet the medication has to be taken religiously daily.

Kambugu explained that adolescents who have acquired HIV through mother-to-child transmission grow up only to find themselves different from their peers which disturbs them a lot during the adolescent years – some become rebellious, others angry or depressed.

Prof Vinand Nantulya, the Chairman of the Uganda Aids Commission (UAC) said the vulnerability of young women is getting worse. Yet adolescents fall in this age group.

An estimated 190,000 children under the age of 15 are living with HIV/AIDS in Uganda according to UNAIDS. Of these, 110,000 children need to start anti-retroviral therapy immediately but only 33 percent have access to care and treatment.

Studies have documented adolescents stopping to take their medication citing reasons like 'they want to see what will happen to them' and 'they want to feel normal' or 'just because they can' or because of stigma and to 'keep it a secret'.

A paper by Kavuma R et al 'Children will always be Children' published in PubMed, a service of the US National Library of Medicine, said HIV-positive children and young people may face substantial social barriers to maintaining appropriate levels of adherence to antiretroviral therapy

(ART) during childhood and adolescence.

The paper draws on retrospective self-reports of 26 children living with HIV, taking ART and attending a clinic in central Uganda. It examined the reasons for non-adherence to ART among children and why they may not report when they miss their treatment.

“Children are aware of the stigma that surrounds their condition and respond to adults who stress the importance of keeping their condition secret,” the study published in 2014 says.

It cites the causes of non-adherence as not necessarily due to forgetting, but because of concerns about secrecy and children deliberately avoiding being seen taking their treatment, for example, to avoid identification.

If taking anti-retroviral drugs for adolescents is a challenge, it is even harder for those attending boarding school; they are particularly traumatised said Kekitiinwa at the Cross Community Advisory Board (CAB) meeting in Makerere held last year.

Unlike students attending day school who will return home and take their pill in the comfort of their homes, there is no privacy and confidentiality in boarding schools.

“Children in boarding carry out most activities at the same time and in the same space. So it is difficult to hide the fact that they are taking drugs everyday and at the same time,” said a matron at a boarding school.

But service providers at Baylor-Uganda advise that parents who have HIV positive school going adolescents try and take them to day schools although obviously not all of them can manage the rigours of balancing work and picking a child from school everyday.



*Photo by Esther Nakkaazi*

For those in boarding schools, the Baylor staff advise that the schools take the school nurse or matron for training and the parents or guardians alert the nurse about the condition.

In the training, the nurses are taught to help the children adhere, by helping the children to take their medication on time and to monitor them.

Dr. Kekitiinwa reasons that this should be easy after all, it is not only these children that take chronic medication and that they will go to the school nurse or matron with other children suffering from diseases like Asthma or Diabetes.

But there is another big hurdle. Uganda has no policy or programme for training of teachers and school nurses supporting children who are taking HIV medicines.

“I prefer my daughter’s status to remain confidential,” says Mrs. Mubiru.

Daughter and mother are determined to keep it that way. “Repackaging of the anti-retroviral pills keeps school administrators from getting suspicious.”

Dr. Kekitiinwa said this is not a problem as long as they put them in a container that is airtight.

“If other students find out about Nankya’s condition she will be stigmatised and even fail to lead a normal school life,” concludes Mrs. Mubiru. Nankya agrees with her mother.

# Is the Vaginal Ring the future

*By Flavia Matovu Kiweewa*

Of the 37 million people living with HIV globally, more than half are women. They account for nearly 60 percent of adults with HIV in sub-Saharan Africa, where unprotected heterosexual sex is the primary driver of the epidemic.

Young women are especially vulnerable. Those aged 15 to 24 are twice as likely as young men to have HIV.



Efforts to promote abstinence, monogamy and the use of male condoms have neither done enough to stop the HIV epidemic nor are they realistic methods in many settings.

Vaginal microbicides are HIV prevention products being developed for women to help reduce their risk of HIV infection through vaginal sex. To date, clinical trials have primarily focused on microbicides formulated as vaginal gels.

In 2010, the CAPRISA 004 study showed that tenofovir vaginal gel reduced women's risk of HIV infection by 39 percent when used before and after sex. Subsequent studies did not confirm these results.

In 2013, the VOICE trial did not find the gel effective when used on a daily basis, likely due to low adherence.

More recently, the FACTS 001 trial (2015) found the gel, when used before and after sex, also was not effective for the same reason.

These findings underscore the need for self-initiated products that women, especially young women, can and will use consistently. Yet women lack practical and discreet tools they can use to protect themselves from HIV infection.

The dapivirine ring, which women insert and leave in place for one month, is the first long-acting ARV-based product to enter efficacy testing and the first involving an ARV other than tenofovir or a tenofovir combination.

The Ring Study and ASPIRE were the first large-scale clinical trials of a vaginal ring for HIV prevention and represent a major step toward new, self-initiated HIV prevention options for women.

Both were Phase III trials designed to evaluate whether the dapivirine ring is safe and effective when used for one month at a time.

ASPIRE, led by the Microbicide Trials Network (MTN), enrolled 2,629 women at 15 sites in Malawi, South Africa, Uganda and Zimbabwe.

All women received condoms and other HIV prevention tools, and then randomly assigned to one of two groups: one used the active ring, with dapivirine; the other received a placebo ring containing no drug.



# Why a vaginal ring for HIV prevention?



<p><b>Longer Acting:</b></p> <p>Used monthly or longer - sustained release of drug</p> <p>May help with consistent use Higher adherence → increased effectiveness</p>	<p><b>Ease of Use:</b></p> <p>Flexible ring – women insert and remove the ring themselves</p> <p>Little or no impact on sexual activity</p>
<p><b>Safety:</b></p> <p>Studies have shown the ring is safe to use and has very few side effects</p>	<p><b>Privacy:</b></p> <p>Vaginal rings can be inserted and removed in private</p> <p>Rarely felt by women or male partners</p>



Vaginal rings are used in the US and Europe to deliver contraception



Women replaced the ring once a month. Twenty-seven percent fewer women in the dapivirine ring group acquired HIV than in the placebo group. The Ring study showed similar results.

The Ring Study, led by the International Partnership for Microbicides (which developed the dapivirine ring), enrolled 1,959 women at 7 sites in South Africa and Uganda. HIV incidence was 31% lower with the dapivirine ring compared to placebo, and women.

Adherence and age were key to HIV prevention. In ASPIRE, HIV incidence was cut by more than half – by 56% among women 21 and older. As a group, women over 21 appeared also to use the ring most consistently. The ring was not effective in women ages 18 to 21, who also had the lowest adherence.

Although this is an age group we know has difficulty adhering to ARV treatment and contraception, there could be biological or other factors at play. Clearly, more research is needed in this very vulnerable age group.

Stopping HIV will require a variety of effective

products. This is because existing HIV prevention options work for some but not all women. Condom use can be difficult for many women to negotiate. Research has shown that PrEP can be an effective prevention method for women, although continued research is needed on its feasibility for young women.

This is why it is important to investigate different and complementary HIV prevention strategies that match women’s individual needs and fit within the context of their lives such as studies of long-acting injectable ARVs which are non-user dependent as well as combination rings which a woman can use a single product for preventing HIV, other STIs and unintended pregnancy.

Could these next generation products be the future of young women in Africa at highest risk of HIV acquisition?

*Dr. Flavia Matovu Kiveeva, was the Principal Investigations of the Ring Study which was hosted by Makerere University - Johns Hopkins University Research Collaboration in Mulago*



UNFPA file photo

# Time to Act is Now

*By Nicholas Niwagaba*

Imagine a place with a young, vibrant, educated, healthy population positively contributing to society – that is the Africa we want to be a part of!

There are 1.8 billion young people in the world today. It is the largest group of young people ever in history and many of them are in Africa. Despite this we are still not reaching our ultimate potential. Uganda has the youngest population in Africa.

In sub-Saharan Africa 7 million young girls are married before the age of 18. Adolescents (10-19 years) and young people are disproportionately affected by HIV. Adolescents are also the only age group in which AIDS deaths have risen between 2001 and 2013. These statistics remain disturbing.

In order to revert this situation we need to scale up comprehensive sexuality education for young people and access to quality reproductive health services.

It is also clear that young people are sexually active therefore youth friendly services should be provided and brought closer to them. This is how it can be done.

We for instance can have a mobile clinics that could be parked near schools or a youth centres for easy accessibility. These should play very loud music in them, have youthful health care workers, games, open at hours that are convenient for their clients, offer free services and generally be a one stop centre for sexual and reproductive health services.

The government should also create an enabling legal and policy environment where young people can access services with no barriers most importantly by considering sexual reproductive health as a human right.

There should be meaningful engagement of young people especially those from the marginalized society. Generally, young people should not be considered merely as ‘beneficiaries’ of public policies, but as active participants, implementing partners who are fully consulted and informed.

To achieve this it is necessary that voices of young people are heard and respected equally with those of adults. Ultimately, involving young people in developing, implementing, and evaluating programs can help ensure that their needs are met.



UNFPA file photo

Also gender norms within the community that negatively affect access to reproductive health knowledge, information and services and that promote risky behaviours among both sexes need to be changed.

We know for sure that a country's gender norms often affect people's reproductive health and the dynamics of sexual behavior; like who initiates sex, who can refuse, how contraceptive use is negotiated, and the gender role.

Changing existing gender norms can improve the quality of reproductive health care, particularly for young adults. Adults need to understand how gender stereotypes place girls and boys at risk, and young people need to know how reproductive health issues affect them.

Creation of a multi sectoral framework to strengthen adolescent young people policies and programming is also key. In this, all sectors within the country need to work together for a common goal.

We also need a strong political leadership and commitment to mobilise resources locally, own the responses and work towards increasing access to quality sexual reproductive health services for all young people in order to achieve the right to health for all.

Indeed, while we call upon all stakeholders; Governments, United Nations, bilateral and regional

partners, civil society organizations, the private sectors to take action, we also have to commit ourselves as young people to TAKE ACTION!

So go ahead young people, translate the knowledge and information you have about sexual and reproductive health and rights in order to take control of your own health and well-being.

This will help us understand the responsibility of our rights and exercise them fully, take up services that are provided to us, work with fellow peers linking them to services and providing them with information we have acquired and also participate and engage meaningfully in all youth programmes to encourage accountability.

Nicholas Niwagaba is a 22-year-old peer educator and advocate who is passionate about creating enabling environments for people living with HIV. He has identified the need for increased access for SRHR/HIV services and information among young people in his community, and he dreams of helping his fellow youth in Uganda overcome these challenges through the power of dialogue.

*Nicholas was a youth video contest winner and Youth pre-Conference moderator at the January, 2016 International Conference on Family Planning (ICFP) in Nusa Dua, Indonesia one of the largest family planning conferences to date, convening family planning advocates, high-level delegates, researchers, and young leaders from around the globe*



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# Young Males in Kampala reluctant to attend KCCA youth friendly corners

*By Dr. Mulungi Mariam Nantambi*

Michael Ssesanga is a 19-year old, a conductor on one of the taxis to the city centre. Ssesanga like many youth his age with a job that earns them over a dollar a day is busy from 6am until 10pm.

From work he has to find fast food usually a 'rolax' and then proceeds home takes a shower and goes to bed. He sleeps for five hours except during Sunday when he takes a half day off.

He hates his job but being uneducated and with the high unemployment among the youth he feels lucky to even be able to fend for himself and contribute to his extended family needs.

Like many other adolescents, Ssesanga is sexually active and as such has sexual and reproductive

health needs but he is reluctant to seek services.

In Uganda, 32 percent of the population is aged between 10-24 years and according to the 2011 Ministry of Health AIDS Indicator Survey, 3.7 percent of young people aged between 15 to 24 years are living with HIV.

Half a million residents of Kampala the capital of Uganda are aged 10-24 years. Youth in Kampala like elsewhere living in congested urban settings face reproductive health challenges further complicated by limited services.

These issues affect both male and female youth almost in equal measure but research has shown that male youth are not utilizing enough the available services for sexual and reproductive health.

For instance, data from the Naguru Teenage Information and Health Centre pre-sented last year showed that about 33 percent of the adolescents who attend their clinic are boys.

Supported by Naguru Teenage Centre, KCCA has set up youth-friendly-corners to provide care and support to young people. These offer a range of services like comprehensive HIV care and treatment, STI management, guidance and counsel-ling, family planning. Social groups such as youth drama groups also go out and disseminate health messages to communities.

To understand why male youth are not keen on attending their clinics, KCCA em-barked on a study with an aim to determine the factors that influence the percep-tion of young people towards sexual and reproductive health services at the youth corners in KCCA health units.

The study was also to determine factors that influence utilization and to describe the patterns of utilization of sexual and reproductive health services at the youth corners at the KCCA health centers.

The study was done by KCCA in early 2016 and found that unlike young females, the male are normally engaged in some sort of casual labour and find it hard to leave work to visit the hospital.

The young men also cited long waiting time and absence of the services they were seeking, which wasted their time. Health workers acknowledged that many times they experience stock outs of medicine and supplies like condoms, which disap-oints their clients.

While the young females would return for a service that was previously unavaila-ble the male would not.

Most male respondents did not even know of the existence of youth-friendly ser-vices. Only 7 per-cent of the male youths that attend the KCCA clinics received in-formation about sexual and reproductive health from their parents, 11 per-cent from their teachers and the rest from their friends.

### **What needs to be done about male youth;**

There is need to reschedule visiting hours to cater

for working youth like Ssesanga. The ideal time the study established is weekends and evenings. The male youth also want youth-friendly-services to be taken closer to their work places. Overall, there is also need to strengthen peer to peer ed-ucation as well as increasing parent and teacher involvement in young people's sexual and repro-duc-tive issues.

Particularly for the male youth, they should be engaged from when they are young boys through adolescence.

The study concluded that there is urgent need to re-assess the 'friendliness' of the youth-friendly-corners in order to attract the young men for whom in many cases the onset of sexual behav-iour during adolescence serves as a rite of pas-sage into manhood but doesn't trigger thinking about preventive behaviour related to the conse-quences of risky sexual behavior.

*UNFPA file photo*





UNFPA file photo

# Policy guidelines on sexual and reproductive health are not helping

By Jackson Oyugi

Grace Ederu, 17 from Adumi sub-county in Arua is among many youth who suffer with sexual and reproductive health challenges in Uganda – having difficulty accessing services as well as information on issues like sexually-transmitted infections, HIV/AIDS and early pregnancy.

Ederu's challenge is in part due to lack of youth friendly health services particularly in rural areas.

Policies put in place by the government to ensure access to these services are not adequately implemented as health workers at grassroots levels are largely unaware of these guidelines.

A large information gap also exists due to the fact that information on sexual and reproductive health is mostly packaged to target urban youth who make up a very small percentage of the total young population.

According to the Uganda Demographic and Health Survey 2011, the youth in Uganda contribute significantly to the number of morbidity and mortality cases.

Adolescent females account for a significant proportion of maternal deaths, which are largely due to preventable causes like malnutrition, infections and haemorrhage coupled with inadequate health care and supportive services, particularly in the rural areas.

Ezekiel Kyasesa, a village health team coordinator in Kasese district says the reasons for this continued state of affairs is that adolescents and young people do not go to health facilities with their concerns until it is too late and yet the health workers do not make it easier for the youth.

“The health workers are not youth friendly. Instead of listening to the young people and help-

ing them with their problems, in most cases they simply judge and condemn them for irresponsible behaviour. The young people fear to be embarrassed, so they stay away and engage in risky behavior like unsafe abortions,” Kyasesa says.

The Ugandan government has created and attempted to adopt policies that create an environment supportive of the delivery of services in relation to adolescent sexual and reproductive health.

For example, the 1996 National AIDS Control Policy addresses adolescent sexual and reproductive health as well as access to voluntary testing and counseling (VCT).

The 1999 National Youth Policy commits the government to fulfill youth development goals as spelled out at the 1994 International Conference on Population and Development in Cairo.

The 2000 National Health Policy specifically addresses the sexual and reproductive health needs of youth.

The National Adolescent Health Policy aspires to mainstream adolescent health concerns in the national development process to improve the quality of life, participation and standard of living in young people

Other relevant policies are the Reproductive Health Policy, which promotes increased availability and accessibility of services and the National Policy on Young People and HIV/AIDS, which addresses rates of HIV transmission passed from teenage mothers to their infants.

Despite these policies having clauses that clearly pertain to adolescent sexual and reproductive health, they rarely inform programs or services that are aimed at addressing the needs of adolescents and young people.

Nakitto Erina, a senior midwife at Namirembe Hospital in Mukono wears a puzzled look on her face when asked if she is aware of the existence of these policy guidelines put in place by the government.

“Policy? No. We just try to do a good job,” she

says. A random survey among her colleagues at the hospital shows that the grassroots health workers that interface with adolescents and youth are largely unaware of the existence of these policies.

Jane Okello, a nurse says ‘they make their documents and keep them there’. Asked what needs to be done to make sure medical workers have access to these policies, nurse Okello says that it is the role of the government to make sure the policies reach the relevant implementers otherwise they are just printed documents in some office that don’t benefit anyone.

Due to this gap between policy makers and health workers, the sexual and reproductive health needs and access to information of adolescents and young people remain inadequately met.

All is not lost however; and a lot of work is being done by various stakeholders to address the sexual and reproductive health needs of adolescents and young people.

The School Health Education Project aims to integrate HIV prevention into school curricula and build capacity of teachers to handle HIV/AIDS-related topics. An example of this is the Keep it Real project at Old Kampala Senior Secondary School.

Mr. Moses Ddumba, a teacher trainer of trainees in the school says that the main purpose of the project is to cause self awareness among the students, raise their self esteem and effectively communicate and sensitize them on their reproductive health and rights.

Vivian Zawedde, a student trainee with the project says that through the project, she has learnt important lessons on sexuality and been exposed to new facts that will help her make better decisions in future.

Another key initiative is the Presidential Initiative on Aids Strategy for Communication to the Youth (PIASCY). This is a strategy put in place by the Ministry of Education and Sports to curb the increasing levels of infection among the youth.

Vincent Kyeyune, a coordinator for PIASCY at St. Michael Senior Secondary School Sonde says that the program has gone a long way in enhancing awareness of responsible sexuality and reproductive health among the youth.

“For a long time there has been a conspiracy of silence and fear among parents, teachers and the adolescents on matters concerning HIV/AIDS yet there is an overwhelming rise in the infection levels among young people,” he says.

He points out that when the teachers’ skills in guidance and counseling and other major skills are in place through the PIASCY training, the adolescents in their care will have their psychosocial needs met by a knowledgeable person.

“These young people have a lot of information, however they lack guidance and this program helps us to guide them better,” says Kyeyune. These services and others like them have opened up avenues for the delivery of sexual and reproductive health information to many adolescents; however, most of these services are located in urban areas.

Additionally, health services targeting adolescents are often based in schools and therefore do

not reach vulnerable out of school adolescents. Rural adolescents and young people, who comprise approximately 80% of all teenagers, are still largely under-served.

A medical officer at Hoima Referral Hospital recently revealed that they receive up to 90 girls seeking post abortion treatment every month.

Policies alone, without a clear and collaborative implementation plans are not enough. Systematic measurement of the risk and protective behaviors of Ugandan adolescents and young people over time is necessary to assess how well the country is meeting the sexual and reproductive health needs of the next generation.

There is a lack of information about the implementation, monitoring and, most importantly, evaluation of interventions aimed at improving the sexual and reproductive health of Ugandan adolescents and young people.

Without this information, it is difficult to know which interventions are most effective and worth supporting, and this will continue to leave the sexual and reproductive health needs of a large proportion of Uganda’s adolescents and young people inadequately met.





UNFPA file photo

# Is delivering quality adolescent services and rights in Uganda Myth or Reality?

By Ibrahim Batambuze

Patience (not her real name) is eighteen years old. She approached a health center after having unprotected sex seeking to get emergency contraceptive pills.

To her greatest shock and embarrassment, a nurse in her 40's chased her away calling her a prostitute yet Patience claims she was told by a friend that she can seek help from the hospital as an adolescent.

Three fundamental questions need to be asked and answered here;

- Is she an adolescent?
- What are her rights and were they violated?
- Does she then have any responsibilities?

To start with, an adolescent according to the Adolescent Health Policy of Uganda, is defined as a person aged 10-19 years while a young person according to the same policy, is a person aged between 20 - 24 years.

Adolescence on the other hand as a stage, is a period of transition from childhood to adulthood, and is characterized by physical, psychological, social and behavior change. Outrightly, she is an adolescent.

As an adolescent, Patience is among the large population of young people in Uganda who contribute to about 13.1 million of Uganda's total population aged 10-24, according to the 2014 United Nations Population Fund (UNFPA) report.

Young people make up to more than 52.7% of the total population. To put this into perspective, this means that one in every four Ugandans (23.3%), is an adolescent and one in every three (37.4%) is a young person.

After having established that she is an adolescent and giving a status quo analysis of adolescents, it's now prudent to turn our campus in the direction of human rights.

Simply put, human rights according to the UN, are fundamental entitlements, especially those believed to belong to an individual and in whose exercise a government, person or any other individual may not interfere, as the rights to speak, associate and request among others.

Human rights are not just an issue of adolescents. They are universal. The preamble to the Universal Declaration of Human Rights proclaims that the

foundation of rights is the “recognition of the inherent dignity and of the equal and inalienable freedoms of all members of the human family.”

In Uganda, the 1995 Constitution which is the grand norm and supreme law of the land, has a full chapter (four) dedicated to human rights and freedoms accruing to all individuals whether, female, male, young and old acknowledging the fact that they are inherent and not granted by the state.

This means that, every person working in any government agency or otherwise be it in a hospital, school or any facility, must observe such rights of a person because they are entitled to them as persons not as citizens being governed.

Specifically, the Adolescent Health Policy, lays down the rights of adolescents, their entitlements when it comes to getting services from health services providers and at the same time responsibilities laid down on page 11 of the policy.

For example, the policy emphasizes that an adolescent is entitled to go to any health center that accommodates her as an adolescent where there must be specifically trained non-judgmental, positive attitude centered staff available and accessible at all times who respect their sexual and reproductive health rights and finally have adequate time for provider interaction as well ensuring presence of peer counselors.

Consequently, human rights (or in this case adolescent rights) are not a construct of Western civilization, health service providers or government. They are not a privilege that any adolescent must think that the government or parents are just extending an olive branch to them.

The Uganda Performance Monitoring and Accountability 2020 Detailed Indicator Report 2014 on page 24, indicates that 22.2% of all women aged 15 to 49 and 27.3% of women currently married or in union at the time of the survey reported that they or their partner were using a contraceptive method.

Patience who is an adolescent, falls in the first category where over 70% of women have no access to contraceptives.

Therefore, to settle the second question, Patience as

the Policy stipulates, has rights that can't be waived at any time.

The government does readily provide contraceptives for example condoms, IUDs (intrauterine devices) and Emergency Contraceptive Pills among others in public health centers and in other health centers at a subsidized price.

The responsibility of the government is to provide the contraceptives to health centers where the health service provider too, has a responsibility of ensuring that he or she provides them to the person seeking them when they approach them in a hospital.

Therefore, the nurse had a duty to ensure that Patience accessed the emergency contraceptive pills to help her overcome her reproductive health challenge which in this case was an unwanted pregnancy as an adolescent.

The nurse who was not a peer, was judgemental and not accessible by Patience which was a violation of her rights.

### **So then, does she have any responsibilities?**

Everyone has rights (Including adolescents) and yes, that, we have established. These rights however, also come with a set of important responsibilities and this can only work if they (people), remember these responsibilities.

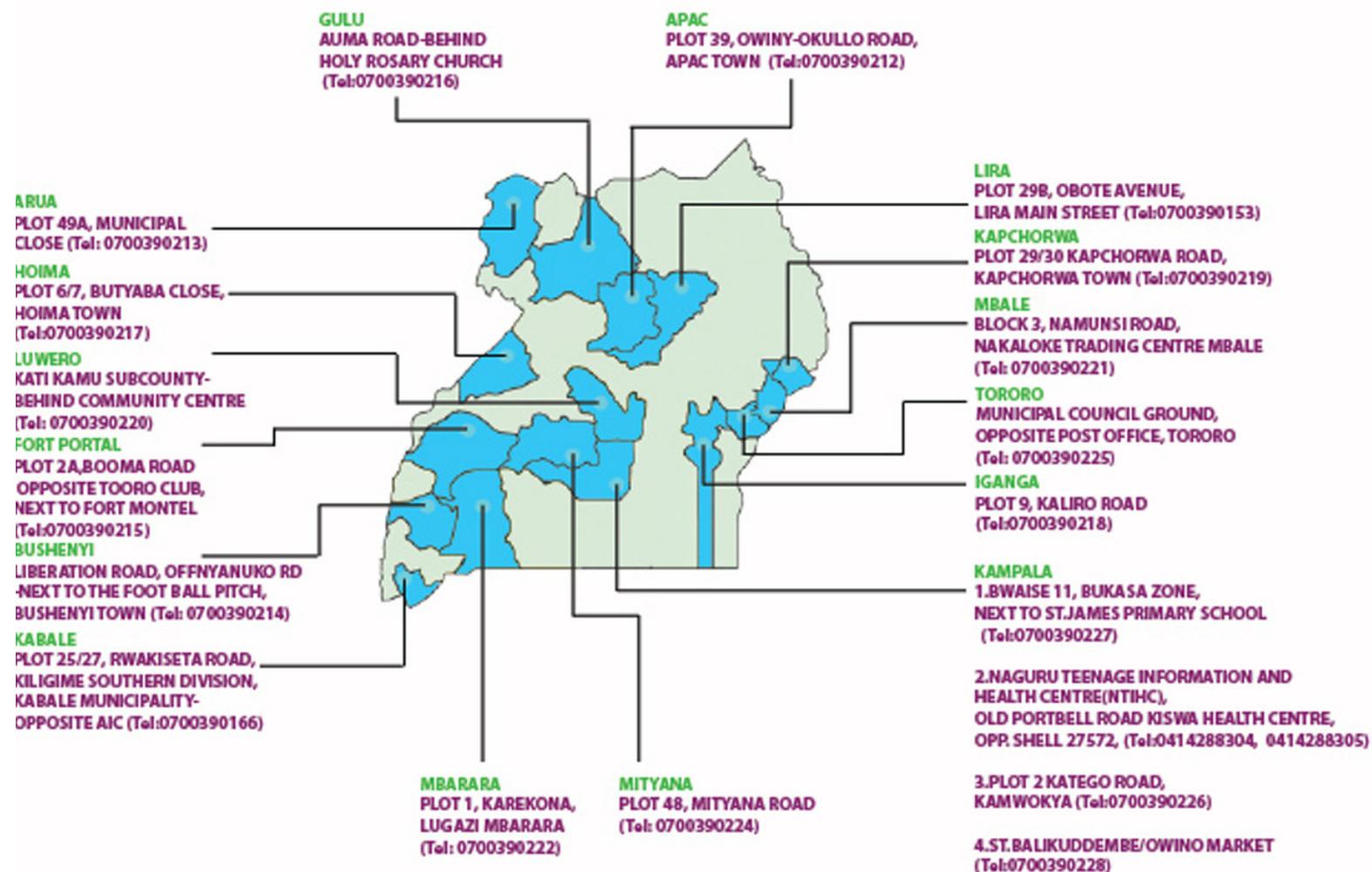
Every consenting adult has a right to have sex but it is his/ her responsibility to ensure that it is protected sex to help them overcome unwanted pregnancies, STI/HIV/AIDS and early childbearing.

Furthermore, it is your responsibility as a youth to take reasonable care of your own health and safety. Other people may not be responsible if you ignore instructions which might make you turn out to be careless in your behaviour.

However, Patience's position of not knowing her responsibilities like most adolescents and young people, can be attributed to lack of adequate and comprehensive sex education (CSE).

Research by Guttmacher Institute has pointed out the great need for CSE in regards to Ugandan adolescents beyond just abstinence which has proved

## Sexual Reproductive Health Youth Friendly Service Clinics



to be inaccurate, ineffective and sometimes causes harm as curious young people end up taking chances.

This is because as the same study states, twenty percent of women aged 20–24 and 10% of men that age have had sexual intercourse by age 15. By age 18, 64% of young women and 50% of young men have become sexually experienced.

Twenty-three percent of females aged 15–19 have ever been in a union, and 26% have never been married but have had sex. By contrast, only 4% of males aged 15–19 have ever been in a union, and 45% have never been married but have had sex.

Therefore, to make adolescents aware of their responsibilities apart from having youth corners in

hospitals and improving access to contraceptives, substantial education regarding adolescents and sexuality must be widened and provided especially for young women.

Many adolescents are making uninformed decisions due to low levels of detailed knowledge about HIV/AIDS, unwanted pregnancies and clear information on the best forms of contraceptives.

CSE should be provided to youth in and out of school and also de-victimizing of pregnant adolescents to get back to school. Failure do this simply means, for Uganda's populations, it's more adolescents, more problems!

*Ibrahim Batambuzi is the Communications and Advocacy Officer, Reach A Hand, Uganda*

# E-Coupon redemption for sexual and reproductive health services

*By Esther Nakkazi*

Ideas42 is a non-profit that grew out of research programs in psychology and economics at top academic institutions, and its work draws on decades of experimental scientific research. They use the power of behavioural science insights to design scalable solutions to some of society's most difficult problems.

Karina Lorenzana the vice President, ideas42 based in Washington, DC spoke to the Health Digest about vouchers increased uptake of sexual and reproductive health (SRH) services:

## **How do vouchers improve SRH services uptake and public health outcomes?**

The e-coupons help clients, who have called into the sexual and reproductive health free hotline, follow through on their intention to seek out health services. The e-coupons subsidize the cost of the preliminary consultation for sexual and reproductive health services.

By getting more clients to follow through on seeking out health services, the e-coupons improve overall public health outcomes by reducing unmet need for contraceptive methods and ensuring that individuals who have needs for health services can fulfill them with a high-quality service provider.

The e-coupons contribute directly and indirectly to poverty alleviation and cost savings for users and health systems. Currently, the e-coupons subsidize the cost of consultation at Marie Stopes health centres, which amount to UGX 10,000. This is a direct benefit to users.

In the long-run, this benefits both users and health systems by bringing clients in for services they need -- both preventative and remedial, thereby reducing future costs associated with complications due to health conditions. For ex-

ample, by reducing unmet need among clients and providing contraceptive methods, the services reduce individual and health system costs of unwanted pregnancies.

## **How sustainable is the project in Uganda? And how can it be replicated in sub-Saharan Africa?**

The project is in Uganda, and was designed with an eye for scale and sustainability. By creating simple modifications to the existing mobile platform for text messaging clients, we have developed an intervention that is easily implemented and can be scaled not only across MSU programs, but to other mobile health platforms in Uganda and sub-Saharan Africa.

## **What behavioural interventions for the 'last mile' can we replicated?**

Depending on the findings of this experiment, we believe that there are a myriad of behavioural interventions that can be replicated to address last mile challenges in family planning and reproductive health.

It is, however, always important to understand the context for implementing an intervention to ensure that the right tools are being used. Thus, while there is potential to replicate different types of behavioral interventions, such as but not limited to implementation intention prompts, lotteries, peer comparison feedback, it's important to make sure the behavioral design matches the context.

*The Uganda vouchers project was presented at the January, 2016 International Conference on Family Planning (ICFP) in Nusa Dua, Indonesia one of the largest family planning conferences to date, convening family planning advocates, high-level delegates, researchers, and young leaders from around the globe.*



HEJNU file photo

# Uganda to benefit from 30m Euro maternal health project

By Emma Serwanga

Maternal mortality and Sexual and Reproductive Health Rights (SRHR) have been on the international agenda for many years, but the goal to reduce the maternal mortality ratio by 75 percent remains elusive.

A five-year 30 million Euro project that is being implemented at a global and regional level as well as country level in Uganda, Kenya and Zambia is hinging on this fact that now aims to reverse this trend.

The project focuses on strengthening the health system in order to realise a breakthrough, said Dr. Tim Reed from Health Action International.

According to the World Health Organisation (WHO), six interlinked and mutually reinforcing building blocks together make up the health system: human resources for health, health commodities, governance, financing, information and service delivery.

However, this project will focus on two building blocks; human resource for health, which entails increasing the availability and accessibility of skilled health workers. Human resource is essential in retaining equity and social justice.

The project will also enhance the availability of affordable medicines and family planning commodities to ensure that communities; women, girls and vulnerable groups have access to contraception and safe pregnancy, delivery and neonatal care.

“A multi-pronged approach is required to strengthen the perspective of availability and affordability of medicines,” said Dr. Emmanuel Higenyi from Joint Medical Stores.

The project will work through a partnership which comprises of Amref Health Africa, the African Center for Global Health and Social Transformation (ACHEST) and Health Action International (HAI).

# Issues to Consider

Other partners are Wemos Foundation, which is funded by the Danish Ministry for Foreign Trade and Development Cooperation as well as Health Promotion and Social Development (HEPS-Uganda).

The different partners will have diverse roles: Amref Health Africa will handle HRH and reproductive health commodities advocacy interventions at community or district level.

ACHEST will handle SRHR and health system governance advocacy aimed at national, regional and global levels. HEPS-Uganda will do advocacy around reproductive health commodities at national level.

The partnership will work to achieve outcomes by following two interconnected strategies that go beyond influencing policies and aim for sustainable social changes as well as changes in the entire SRH sector.

Patricia Vermeulen from Amref Health Africa says the overall goal of the project is to enable communities to realise their right to the highest attainable sexual and reproductive health impact.

Vermeulen said the project aims to contribute to achieving sexual and reproductive health rights by training and creating space for a civil society to engage effectively with governments, the private sector and other stakeholders accountable for health systems, deliver equitable, accessible and high quality SRHR services.

Dr. Jane Ruth Aceng, director general, Health Services at the Ministry of Health said it will be good for civil society to be trained so that they do not take government to court without real evidence.

She cited the case of when civil society took government to court because of a maternal death.

“We are excited it is building the capacity of civil society so that when they are lobbying they know how the government systems work,” said Aceng.

Dr. Francis Omaswa, the director ACHEST said Uganda has well designed health plans however, implementation still remains an issue. He said communities should be empowered to demand for services from the health sector.

He ended with his signature phrase ‘health is made at home and repaired in health facilities.’

*By Esther Nakkazi and Emma Sserwanga*

Some major issues need to be considered during research among HIV positive adolescents who are termed as a ‘difficult group’ because of a key problem unique to them, adherence to medication.

Adeodata Kekitiinwa, the Executive Director, Baylor Uganda explains that there is an urgent need to research into HIV in adolescents. “More studies will be coming up, but how do you safe guard this vulnerable group from undue research risks and at the same time manage their expectations?” she poses.

In Uganda, HIV positive adolescents aged 10 to 19 years, have the highest mortality rate, dying from AIDS related illnesses and with the greatest risk of contracting HIV, according to the Uganda Aids Commission.

This was one of the discussions at the cross-CAB (Community Advisory Board) network forum held in Kampala, Uganda, last year (12-14 November).

Kekitiinwa explains that with research among adolescents, budding and curious, there is a lot of exploitation by the adults, and human rights, location of study site and their consent are some of the key issues.

Globally, over 120,000 adolescents died from AIDS related illnesses in 2013, translating to more than 300 per day according to UNAIDS.

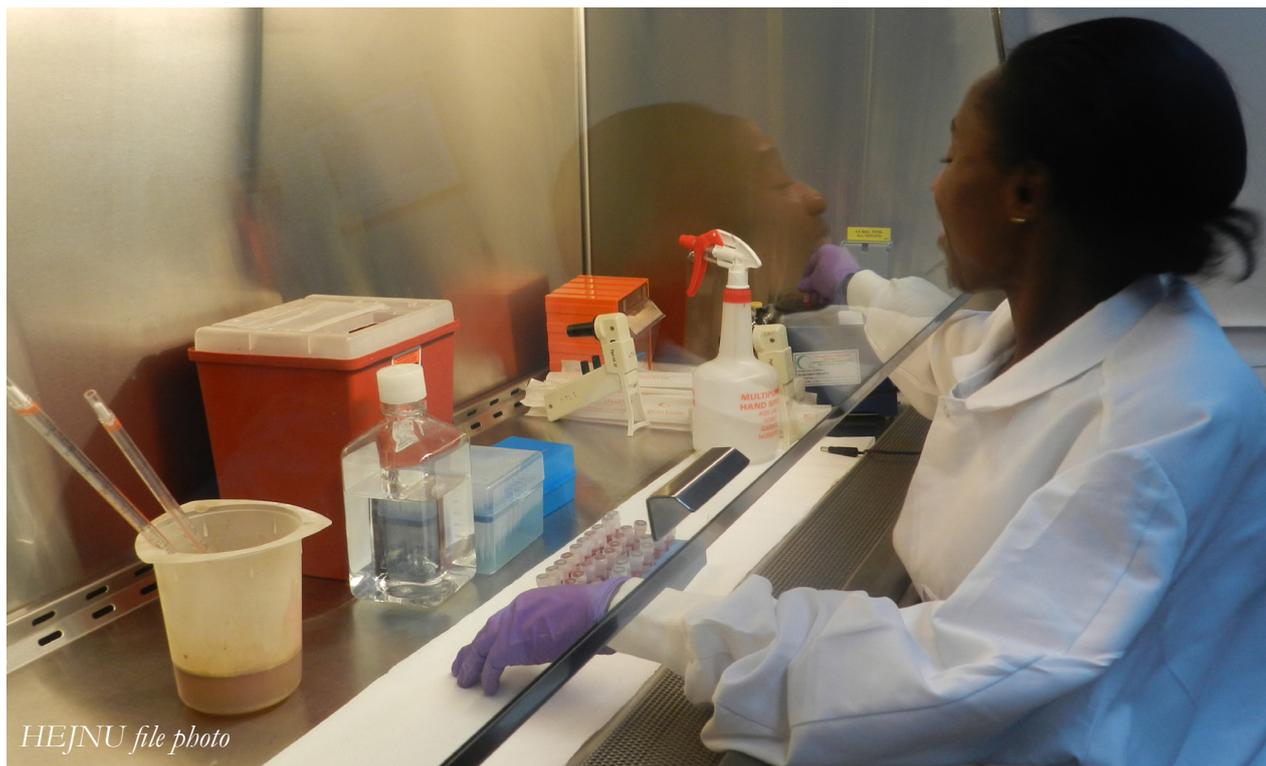
In Uganda, 110,000 adolescents aged 10 to 19 years are known to be HIV positive of the estimated 1.5 million Ugandans who are so. Children aged 13 to 19 constitute the highest number of persons living with HIV/AIDS in Uganda according to the Uganda Aids Commission (UAC).

It is, therefore, inevitable that research has to be done among adolescents. The Uganda National Council for Science and Technology (UNCST) is in charge, but with vulnerable groups like adolescents some research ‘actions might be legal but unethical’.

Line not clear in research



# in Adolescence HIV Research



HEJNU file photo

First of all, generally, the line is not clear in research, vulnerability is fluid and although research should have a benefit, mostly to advance science, volunteers ought to get something out of it but this too is not quantified. Research experts say ultimately the benefit should outweigh the risk.

Henry Tumwujukye, a research expert says issues of providing informed consent, maintaining confidentiality and privacy, weighing the risks versus benefits and paying attention to fairness are very important when working with vulnerable and stigmatised groups like HIV positive adolescents.

For instance, it is ethical and accepted by UNC-ST that all research volunteers are compensated for transport. In Kampala, study sites reimburse 20,000 Uganda shillings (\$7) for transport.

But with adolescents this could tantamount to closing one eye because this is a lot to them, says Kekintinwa. Ultimately, unlike adults, for adolescents this could be an excessive benefit because they look at what they can use the money for and it's plenty.

“In such instances their cognitive ability is to just have the transport refund meanwhile in that process researchers are jeopardising the human

rights of the adolescents,” says Kekintinwa. She explains that researchers dealing with adolescents have to tell them about the benefits and any intervention without mincing words.

For all the research that happens, volunteers have to sign consent forms, an indication of agreement to participate. Informed consent, as it is termed, in the case of children below 18 years is a shared responsibility between them and their guardians.

Adequate informed consent is a key aspect as emphasised by Joseph Ochieng, head of the anatomy department at Makerere University College of Health Sciences.

“The benefits can come in later. Community representative should bring out the salient aspects of risks to the volunteers. You cannot eliminate all risks so the best way is to put everything on the table, all the harms,” he says.

But sometimes it gets complicated. Many children aged below 18 years head households but this does not put them in a position to consent to research. Legally it is unacceptable. However, they can ascent.

Consent is legal while ascent or agreeing to par-

ticipate in research by children is not regulated by law.

If such a child asents, they are also at liberty to decide on which family member to be involved with them in the research process. Culturally this is very 'unAfrican' as adults make decisions for children here. It has also been observed that children who do not ascent are judged harshly by adults, said Kekintiinwa.

In countries with no proper adoption procedures like Uganda, an adult will usually 'suggest' the adult they think will participate with the adolescent in research.

Adolescents consent is crucial

"In this case an adult judgement cannot override the decision of the child. If an adolescent says no, research should stop and not be judgemental, because that keeps them away from research permanently," says Kekintiinwa.

According to the UNCST research guidelines volunteers should decide whether to participate in the research or not and withdraw at any time with-

out penalty. They should also report any abuses of one's rights and welfare to the Principal Investigator or the Institutional Review Committee (IRC), to UNCST or any other relevant legal authority.

Volunteers should have privacy and confidentiality during and after the research. Therefore, institutions doing research among adolescents must be able to have the sensitivity, privacy and an acceptable ambience. But that happens in very few institutions, according to Kekintiinwa.

Here is what will keep adolescents away. Long waiting hours and insensitive to them. Most of them dress 'funnily' are rude and with an 'I don't care attitude'.

Ultimately, when they feel like they are being treated badly they just quit the research which then raises the issue of retention of adolescents in research.

"At Baylor we have had 97 percent retention rate. If we were not retaining they would not allow us to do research," says Kekintiinwa, who adds, that comes with all the issues researchers have to put in mind to do research among HIV adolescents.



# Retracing Family Planning Commitments Using Technology

*By Esther Nakkazi*

Often times, government officials and leaders attend global conferences and make commitments towards causes they never honour because there is no mechanisms to make them accountable.

Samasha Medical Foundation has developed an innovation, the Motion Tracker, that can monitor if the commitments are not only honoured but also translated into implementable activities.

The project was a proof of concept translating reproductive health global commitments into action at a country level, said Dr. Moses Muwonge the director Samasha, a non-governmental organisation dedicated to advocating for improved health.

"It is an evidence based tool that has been very good for us to know how our resources are expended and has helped us to coordinate with all the stakeholders working on reproductive health issues," said Dinah Nakiganda, the assistant commissioner reproductive health at the Ministry of Health.

It has been successful and will be adopted by Burkina Faso and Zambia.

The Motion Tracker is an evidence based online monitoring tool based on the WHO health systems Framework monitoring service delivery,

# Preferred Family Planning Methods Missing

By HEJNU reporter

Many Ugandans try to obtain their preferred family planning method at health facilities but find that they are not available.

“There is a problem of limited choice. When you don’t find the method of your choice, it is akin to a stock out,” said Prima Kazoora, the head of training and capacity building at HEPS-Uganda.

The conclusion follows an opinion poll carried out by Coalition for Health Promotion and Social Development (HEPS-Uganda) which found that 79 percent of the 6,096 respondents wanted to be availed with a wide range of family planning methods at all health centers.

51 percent respondents said that the times they have tried to obtain family planning their preferred method was not available.

“Access and availability of family planning is still a big challenge due to delays in delivery of commodities,” said Kazoora.

The opinion poll was carried out during live interactive radio text messaging (SMS) dubbed ‘TRAC FM’ in Mbarara, Isingiro, Kiboga and Kamuli between December 2015 to January 2016, that showed lower availability and access of family planning services than demand.

The poll was part of the twin projects ‘Voices for Health’ and ‘Empowering communities to combat contraceptive stock outs and expand contraceptive choice’ implemented by HEPS.

HEPS officials said despite government efforts, Sexual Reproductive Health (SRH) indicators remain weak with high infant and maternal mortality rates; high rates of fertility and teenage pregnancies; unsafe abortions as well as low uptake of contraceptives.

They explained that the main reasons for this are a widespread disempowerment of youth and women, myths and misconceptions on family planning methods. There is also a lack of awareness of Sexual Reproductive Health Rights (SRHR) due to cultural determinants that bring about silence,



UNFPA file photo

stigma and discrimination.

Civil Society Organizations under their umbrella body, HEPS-Uganda want the government to fix the mess in the distribution channel of family planning commodities in order to stop their rampant stock outs.

“We want government to put mechanisms in place that will ensure timely delivery and efficient distribution of these commodities including a responsive and effective supply chain management system,” said Kazoora.

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HEJNU file photo

*From page 28*

health workforce, information, medicines, financing and governance.

It can track the progress made towards achievement of commitments made. The Government of Uganda made reproductive health related commitments at various global fora; in 2011 at Every Woman Every Child (EWEC), 2012 at the London Family Planning Conference –FP 2020 and in 2013 at the UN Commission on Life Saving Commodities (UNCoLSC).

#### **How it works:**

Samasha working with Reproductive Health Supplies Coalition (RHSC) developed a Commitments Compendium, which has a compilation of explicit and implicit statements from the Commitments made by Uganda, which were deconstructed into implementable activities that can be monitored, said Dr. Muwonge.

The Motion Tracker was then used to monitor progress towards these commitments.

In the project methodology, selected individuals from organisations that contribute to reproductive health related commitments were selected basing on a stakeholder mapping matrix.

Primary data was collected using a partner contribution questionnaire and secondary data was collected through review of various documents like policy statements, newspaper articles. Data was also collected from key informant interviews, desk reviews, email correspondences, meetings one-on-one meetings and phone calls.

Cornelia Asimwe, the program officer at Samasha explained that they and Plan International trained 64 local civil society organisations officials to track the commitments who would voluntarily input data used to monitor progress.

At the time the project ended after about a year, the percentage of returning users to the Samasha website had grown and they were spending more time. “At first they were spending just about a minute now they take 3 minutes and more,” said Asimwe.

After about a year now, the Motion Tracker has shown that the different commitments are either on track or have been or not achieved in regards to reproductive health commitments in the areas of finance, policy, service delivery, supply chain and technology said Asimwe.

It tracks the financial commitments made and the places that are underserved.

Since it tracks the money it helps policy makers devote money to areas where it is needed most, said Dr. Nakiganda.

Espilidon Tumukurate an adviser for Jhpiego, said this is one of Uganda’s success stories for this innovation that is an export.

He however said that Samasha needs to get more funding and take the tool to the lower level, at the district, and also track how the money is helping deliver services.

# Trained clinical officers increase access to surgical contraceptive services

By *Esther Nakkazi*

Thirty-one year old Hasfa Logose has a choice. She has six children, all girls and sells tomatoes in the market. She is in a polygamous marriage competing with six other women for one husband.

When she got pregnant for the sixth time she sighed and went around asking friends for the best way to stop it. She was tipped about the Marie Stopes clinic in Jinja, which offers free long-acting reversible contraceptives and permanent methods of contraception.

Today she is in line at the clinic holding her three months old child who is suckling on the breast while kicking tiny feet obviously enjoying the meal. “I did not want this child,” says Hasfa.

In Uganda, 34 percent of married women have an unmet need for family planning services including 14 percent who do not wish to have any more children.

Hasfa is going to have a tubal ligation, a permanent surgical contraception procedure in which a woman’s fallopian tubes are ‘tied.’

“My husband may not like it but it is what I want. I have been thinking about it for the last four years and today I have to do it,” says Hasfa with a determined voice of someone empowered and ready to make a reproductive health decision that will better her life.

Seated also in line at the Marie Stopes clinic is thirty-year old Rose Byogero a mother of eight, three boys and five girls. Even when Byogero tried to use the injectable family planning method, she was not comfortable with it.

“I used to bleed like a tap. My body could not contain it,” says Byogero who has now come for tubal ligation. Her other reason to have it is poverty.

“My husband is a farmer. We do not have enough resources. My eldest child is seventeen and its

shameful for me to continue having babies when my children are old,” says Byogero.

The two women’s procedures are to be done by a clinical officer not a physician. Tubal ligation is usually done immediately after birth or after six weeks, says Arafat Mugabe, a clinical officer at the clinic.

He says each operation will take him only 30 minutes. It involves making two small incisions and then to cut the tubes in the correct location.

Mugabe carries out tubal ligations on women and vasectomies on men, which are surgical procedures for male sterilization. He says most of his clients have one thing in common; they have more than five children.

While the clinic is now popular those who are hesitant are discouraged by myths like men becoming weak after vasectomy. But he disputes it. “Men maintain their sex drive and remain strong after vasectomy.”

What is happening at this clinic is task sharing meant to increase access to long-acting reversible contraceptives and permanent methods of family planning by mid-level health providers such as nurses, midwives and clinical officers.

Task sharing is therefore fundamental in increasing access to surgical contraceptive services in Uganda and Marie Stopes Uganda has piloted it using clinical officers, says Faith Kyateka, the communication manager, Marie Stopes Uganda.

Given the shortage of medical personnel especially in rural areas with ratios of 1 doctor, nurse or midwife per 1,818 people (Ministry of health 2010) this is necessary and the reason that the Ministry of Health requested for locally generated evidence to determine whether trained clinical officers can provide tubal ligations.

# Writing Women's

*By Rosanne Anholt*

Research shows that the decisions people make with regards to their health may be in part drawn from various mass media resources. As such, the media not only mirrors how health is understood within the society – it also shapes that society's health behaviours. The effect of any particular media message however, depends on the way the information is framed.

The idea of media frames is easy to grasp: if we read or hear about family planning methods that emphasise the dangers of the procedure or the possible negative consequences, we may hesitate to use them.

On the other hand, if articles about family planning methods focus on our right as women to decide whether, when, and how many children to have – we may very well consider using a method of family planning. Simply put, a media frame is a point of view on a given issue.

How an issue is framed, depends on many factors. Research, such as by Darrin Hodgetts in New Zealand, shows that the journalist (i.e. the writer) has a significant effect on the way an issue is framed. Professional factors specific to journalism may impact how an issue is presented, as well as the organisational milieu in which the media message was created.

Sources, whether particular persons, documents, or other, may also impact the point of view on any given issue, depending on the standpoint taken by the source.

Finally, any environmental issue – economic, or political – may also have an effect on the way in which an issue is presented in a media message. We can describe frame-building as the process in which media frames are created.

Together with the Health Journalist Network in Uganda (HEJNU) and under supervision of the Athena Institute at the Vrije Universiteit Amsterdam in the Netherlands, a study was carried out in order to analyse how women's reproductive health is framed in Ugandan media, and what factors influence the way in which Ugandan journalists construct these frames.

To answer the first question; how women's reproductive health is framed, an analysis of print media content was made, considering relative ease of analysing written content. Even though most Ugandans receive their news through the radio, local radio stations often review newspapers. Indeed, some community radio stations with no budgets to support reporters in the field read

To test it, Marie Stopes Uganda conducted an observational study between March and June, 2012 among trained clinical officers in mobile outreach teams of rural Uganda to determine if task sharing of tubal ligations is safe and acceptable to women.

The study assessed complications during and after the tubal ligation procedure, as well as the acceptability of the procedure performed by trained clinical officers. 518 women were recruited and they were followed up three, seven and 45 days after the procedure.

The overall complication rate (major adverse events) for the study was 1.5 percent, which is comparable to tubal ligation services provided by physicians in other settings. Nearly all women who had the procedure reported having either a good or very good experience and said they would recommend the health services to a friend.

The study found it to be safe, acceptable and highly satisfactory. It was also found benefits like cost-effectiveness as medical education, training and salaries for clinical officers require less time and monetary investment than for physicians.

Also mid-level health providers are more evenly distributed across rural and urban areas than physicians so offering them with training for specific tasks and procedures means that a rapid expansion of access to essential family planning methods can be made possible, said Kyateka.

This overcomes uneven health service distribution and it's true that clinical officers may be more willing to work in rural areas than physicians but it also frees up physicians' time.

Using this evidence, Marie Stopes Uganda has successfully advocated for permission that trained and supervised clinical officers at private not-for-profits organisations can provide safe and acceptable tubal ligations and also that a roll-out plan of training of tubal ligations for public clinical officers in five districts of Uganda is developed.

Based on the study findings, the Ministry of Health now permits all trained and supervised clinical officers at private not-for-profits organisations to provide safe and acceptable tubal ligations in Uganda, concluded Kyateka.

*Additional reporting by Emma Serwanga*

# Reproductive Health; A Uganda Study



the stories from the newspapers as news items. This makes print media, despite its relatively low coverage, an important communication channel fit for analysis.

A total of 204 articles on women's reproductive health were collected from four national newspapers published between 1 May 2015 and 31 May 2015.

To answer the second question; what factors influence journalists' frame-building, 19 in-depth semi-structured interviews were done with journalist in and around Kampala. The sample consisted of eight men (42%) and 11 women (58%), from both print and broadcast media (both television and radio), with an average of 7.5 years of experience.

On July 22 2015, HEJNU organised a research dissemination seminar, which was attended by 20 people. Other attendees included a medical doctor who gave a presentation on the social determinants of health and human rights, HEJNU staff, a media researcher, and the writer.

Firstly, the content analysis showed that half of all articles on women's reproductive health addressed maternal health topics, such as pregnancy, childbirth, and the midwifery profession. Pregnancy was primarily understood as a dangerous 'condition' from which 'vulnerable' women 'suffer' or die.

The International Day of the Midwife on May 5 and the events that surrounded this day noticeably influenced articles, highlighting Uganda's lack of midwives and the dangers associated with (unassisted) childbirth.

The main treatment recommendation for the country's lack of midwives was recruitment schemes and 're-branding' of the profession – in other words, giving the profession a new, positive image that will draw students to choosing midwifery as a career. Other maternal healthcare services were understood in terms of missteps made by individual healthcare workers, or successes gained by government or NGO projects.

Twenty-five percent of the articles were about sexual violence, understood primarily as arrests or case proceedings from (gang) rape and defilement cases, although harmful traditional practices such as female genital mutilation/cutting (FGM/C) were also addressed.

The national high profile defilement case of police athletics coach Peter Wemali in particular received much media attention. In general, sexual violence was very much approached from a criminal justice perspective, placing the individual perpetrator at the centre – sometimes literally, with their full names exposed. This perpetrator-focused point of view was similarly evident in punishment being advocated as the primary solution to sexual violence.

Thirteen percent of articles addressed various health conditions, including reproductive tract infections (RTIs), STIs, HIV/AIDS, HPV and cervical cancer, and obstetric fistula. What was especially noteworthy about these articles was that conditions of these infections was predominantly blamed on women's own behaviour.

For example, HPV infection was attributed to girls' early onset of sexual activity, and subsequent

cervical cancer was attributed to women not going for regular health check-ups. Obstetric fistula on the other hand, was primarily attributed to medical causes. Also notable, solutions for obstetric fistula cases focused on what NGO projects can achieve, rather than seeking treatment or behaviour change.

Other topics (12%) included family planning, menstruation, and abortion. Family planning was understood primarily in terms of the possible adverse consequences of family planning methods, and in the light of women not using family planning – attributed to men's resistance to family planning.

When women experience any issues that may relate to their use of family planning, they are encouraged to 'visit their doctor and get treatment' – without any consideration of their ability to actually carry out that advice.

Menstruation was addressed in the light of Menstrual Hygiene Day on May 28 and advocacy around national programmes targeting the improvement of menstrual hygiene practices in schools, in order to combat girls' high dropout rates.

Abortion, although hardly covered, was primarily understood as a dangerous procedure with debilitating consequences – moreover, it is against the law and religion. The primary 'solution' for abortion focused on the individual: instead of aborting one should rather focus on pregnancy prevention.

Similar to previous studies on how women in Ugandan media are portrayed, this study shows that in articles on women's reproductive health, women themselves were portrayed predominantly as victims: vulnerable to suffering and dying.

Also, but considerably less, women were described as passive recipients of healthcare services or mothers saved from death by skilled birth assistants. Women were also portrayed as being responsible for their adverse health outcomes: their own behaviour caused health conditions such as STIs and cervical cancer – leaving social determinants of health, such as poverty, unchallenged.

The fourth and final way in which women were portrayed in stories about women's reproductive health was what we may call a 'passive agent'. In this type of portrayal women were given advice of what to do in cases of health conditions: when you experience constant vaginal bleeding, you have to visit your doctor and get treatment.

At first glance, it seems that this advice enables women to exercise their power over their own health. After all, these stories give them the information on what to do – sometimes even providing a step-by-step approach.

At the same time however, it is not only assumed that women do not know they have to visit a doctor when they experience health problems, also, the woman's personal, cultural, or economic barriers in accessing that care, are dismissed. If they cannot even afford the transport fee to the hospital, is 'advice' that tells them to visit a doctor even useful to them?

Secondly, the interviews with Ugandan journalists showed that various factors on the personal, professional, organisational, source-related, and environmental level influence the way these media frames are constructed.

On a personal level, having an in-depth understanding of women's reproductive health has a significant effect on how issues are presented in the media. For example, if a journalist understands women's right to health, she or he may be more likely to take a human rights-based approach to the topic they are writing about.

On the other hand, if a media professional fails to grasp the social, cultural, and economic causes of certain reproductive health outcomes, she or he may blame the individual for her illness – as we have seen in the identified frames. In this study, interviewees emphasised that you have to understand an issue first, before you can explain it to others.

Training media professionals on (women's) reproductive health could advance their understanding, results however, showed that training is primarily a personal initiative. This means that attending a training depends greatly on the individual journalist's ability to access information about potential training opportunities – resulting in unequal opportunities.

Likewise, it depends on journalists' media houses. Some media houses may be neglected by trainees because their impact on the community is considered insignificant – thereby significantly crippling talent development. Although this was not directly examined, training opportunities may depend on the type of media; print media journalists may be far more likely to go for training than radio or TV journalists.

On a professional level, journalists understood their work in terms of disseminating information,

acting as a link between the public and policymakers, and as playing the role of watchdog, critically interrogating government policies. In the articles, the role of ‘educator’ or ‘provider of information’ was much more evident than advocacy and accountability.

One way in which this showed was journalists’ self-expressed need for quoting official sources in their stories, such as government officials or medical professionals. Interviewees shared that this is not only ‘good journalism’, it also ensures the information you have is correct.

On an organisational level, an important finding was the challenging work environment: media houses’ lack of resources simply bars journalists from pursuing stories if it means they have to make costs, such as travel expenses. In addition, low pay causes many journalists to be unsatisfied with their job, using journalism as a ‘stepping stone’ to other jobs, such as with an NGO. This also means a high turnover of staff in journalism in general.

In addition, results showed that editors have a crucial role in whether and how a story eventually appears in the newspaper, highlighting the need to involve editors in any training initiative that addresses the importance of covering women’s reproductive health.

On the source-related level, the low pay and lack of facilitation invites sources such as (international) NGOs to step in and provide travel reimbursements, accommodation, food, and sometimes even a per diem. Interviewees expressed their concern that this practice may bias journalists’ objectivity. Some articles used clear NGO language, summing up the strides made by a particular organisation as the necessary steps towards addressing Uganda’s reproductive health issues.

Finally, on an environmental level, the politics of the season and media houses’ commercialism influenced if and how health stories in general made it to the newspapers. In the light of the upcoming presidential elections of 2016, the space for health-related news is increasingly less, in order to make room for political stories, since these are the ‘stories that sell’. One interviewee recommended that health journalists have to learn how to navigate these challenges cleverly, by for example reporting on presidential candidates’ health policies – yet none such articles appeared during the study period.

So what do these results mean? For women in Uganda, it means that they are currently not sup-

ported through an empowering media discourse. This is in line with previous studies on the way women are portrayed in Ugandan media.

The results point out that there are many opportunities for journalists and other stakeholders to improve the practice of health reporting in a way that will allow the media to more clearly play the advocacy and watchdog role. This may also require Ugandan journalists to proactively communicate their needs. Strong journalists’ associations may be able to leverage their power to demand better working conditions.

For NGOs, the results of this study highlight that (international) organisations must be aware of their influence on the media through practices such as providing facilitation where journalists’ own media houses cannot. This calls for the inclusion of ethical media practices based on respect and integrity into existing policies – or the development of comprehensive media collaboration policies.

The results reinforce previous studies’ recommendations that media development initiatives should be needs-driven instead of driven by the wishes of international donors, emphasising the importance of local ownership.

Training should be independent from (inter)national NGOs’ agendas, which highlights the importance of grassroots media organisations, such as HEJNU and other national journalists’ associations. Media development should be led by Ugandan journalists and Ugandan researchers from Ugandan institutions, who have in-depth knowledge of not only the needs, but also the local context.

For government, the results of this study point to the severe lack of resources that Ugandan media houses suffer from. In order to use media as a vehicle for women’s (health) empowerment and social justice, the government should support the media rather than restrict them, not only financially but also through a conducive legal environment.

In conclusion, media is shaped by society and has a significant effect on the shaping of that society. In Uganda, this study shows that there are ample opportunities for media, civil society organisations, local experts, and government to work together to improve the current practice of health reporting for a more empowered, more socially just society.

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# A Personal Experience

*By Catherine Nakidde*

I was born on 18th April 1995 to now the late Edward Kalyango and his wife Annet Nantege. Both my parents died of AIDS and I was born HIV positive since Prevention-of- Mother-to-Child (PCMTc) was not available at the time.



*Above: Children play at The Mildmay Centre*

I was raised by my paternal auntie and my big brother since I was a baby. I attended Lake Victoria school for my primary education before joining Entebbe Secondary School where I finished my senior six in 2015.

*Below: Noah's Ark centre at Mildmay*

*Photos by: Morgan Mbabazi*

It has not been a smooth ride coming this far battling HIV related complications but it has also not been as rough as I had imagined when I was a little girl.

At some point, I was stricken by AIDS, which put me down for two good years and I even had to pause school. Every time, I was repeatedly diag-



nosed with a new infection or illness, which weakened my immunity and made me look like death in the face. At that point I was so young and only had hope in God.

During my sickness, I was introduced to Mildmay Uganda, where I became a member of Jajja's home, which is well known for taking care of orphans and vulnerable children infected with HIV and Aids.

At Mildmay, I got the best care and treatment any HIV positive person anywhere in the world would require and this helped me recover faster than usual. I was treated for pneumonia, which I acquired in spite of being enrolled on anti-retroviral therapy.

When I recovered I joined the Mildmay Children's choir. We sang inspiring songs that were giving hope and encouraging positive living. In the choir, I was certain of sharing my positive living experience with the world.

Through this new found activity, I have gained social recognition and have travelled to various places including England, South Africa and Kenya. I also attended the International children's conference on HIV and AIDS in Sierra Leone in 2010.

God has lifted me higher and higher. My self confidence and high self esteem is not only helpful to me, but to others as well, because I am now a role model to my peers and their mentor.

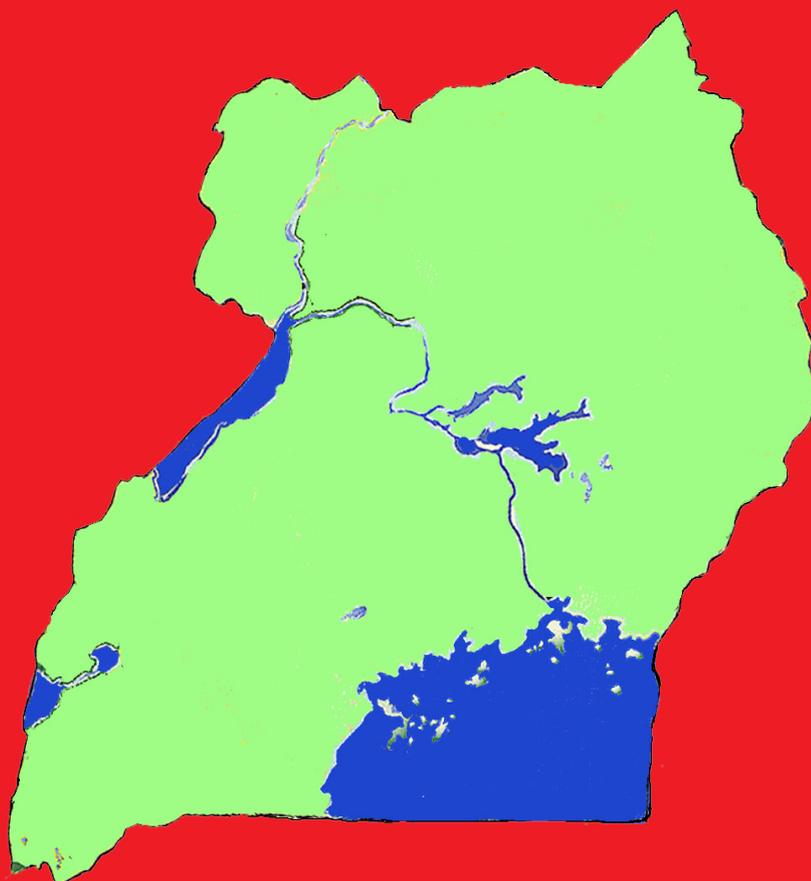
I have engaged in many advocacy activities most especially in my community and I stand tall and strong to be a voice for the many HIV positive young people out there who are silent.

Currently, my viral load is undetected and one day I know I will be HIV free. It is the same prayer I say every night for the world to get to zero HIV. I do not want my children and grand children to ever get to know about the HIV epidemic.

I have promised myself that I will always come out to speak and educate the world at every opportunity. I know that I have a lot of potential and I always say Ebenezer for the LORD almighty who has brought me this far but it is still is a tremendous journey.



**Sexual & Reproductive  
Health Rights for  
Youth & Adolescents**



**THE Health Digest**

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