



**2011 -
2015**

The National Adolescent Health-Strategy

TABLE OF CONTENTS

| | |
|---|-------------|
| FOREWORD | III |
| ACKNOWLEDGEMENT | IV |
| ACRONYMS AND ABBREVIATIONS | V |
| GLOSSARY OF TERMS | VI |
| EXECUTIVE SUMMARY | VIII |
| CHAPTER ONE: BACKGROUND | 1 |
| 1.1. INTRODUCTION..... | 1 |
| 1.2. POLICY ENVIRONMENT AND LEGAL FRAMEWORK | 4 |
| 1.4. RATIONALE AND PURPOSE..... | 18 |
| 1.5. VISION | 18 |
| 1.6. MISSION | 18 |
| 1.7. GOAL | 18 |
| 1.8. OBJECTIVES..... | 19 |
| 1.9. THE GUIDING PRINCIPLES..... | 19 |
| 1.10. TARGET GROUPS..... | 19 |
| 1.11. PRIORITY AREAS AND COMPONENTS | 20 |
| 1.12. OUTPUTS..... | 20 |
| CHAPTER TWO: STRATEGIC DIRECTIONS | 22 |
| Strategy 1: Advocacy for resources and provide an enabling environment for adolescent health programs and interventions | 23 |
| Strategy 2: Sensitization and mobilization of adolescents, communities, policy-makers and other stakeholders on adolescent needs and concerns..... | 24 |
| Strategy 4: Coordination, networking and partnerships for management of adolescent health with an emphasis on sexual reproductive health programs. | 26 |
| Strategy 5: Capacity building for delivery of quality adolescent health services at all relevant levels. | 26 |
| Strategy 6: Improvement of access to adolescent-friendly health services with an emphasis on sexual and reproductive health. | 27 |
| Strategy 7: Research on Adolescent Health | 27 |
| Strategy 8: Supervision, Monitoring and evaluation of adolescent health programmes | 28 |
| Strategy 9: Ensure a Multi-sectoral approach to attainment of adolescent health for all adolescents and young people | 28 |
| CHAPTER THREE: INSTITUTIONAL/IMPLEMENTATION FRAMEWORK | 29 |
| CHAPTER FOUR: IMPLEMENTATION PLAN | 38 |
| CHAPTER FIVE: INDICATORS FOR ADOLESCENT-FRIENDLY SERVICE PROVISION | 47 |

FOREWORD

Adolescence, which broadly means the teenage years, has many manifestations. It refers to the development period between childhood and adulthood during which a number of dramatic physical changes and important emotional and social developments take place. This period can be difficult and confusing, and can therefore create a lot of fear and anxiety to the adolescent, parent and the community. These circumstances make adolescents vulnerable with regard to making reasonable decisions about their life, values and sexuality. The ability to make rational decisions and act on them is critical to healthy adolescent development.

With this background in mind, one of the most important commitments a country can make for future economic, social and political progress and stability is to address issues and concerns of its young people. The Adolescent Health and Development Strategy is therefore, a major step in the right direction. It provides an excellent opportunity for planners and key implementers of adolescent interventions at different levels to reassess their structural and functional approaches with the aim of improving their capability in addressing adolescent health and development issues.

The goal of this strategy is to improve the quality of life and well-being of young people in Uganda. This will be achieved by creating an enabling policy environment and legal framework that will facilitate adolescent health and development programmes. The attainment of the goal will also be achieved by increasing young peoples' access, participation and utilization of innovative, integrated, high-quality services and programmes. Promotion of positive attitudes and behaviour change in communities and among parents and young people will be encouraged.

The strategy is providing a sound framework on which to streamline multi-sectoral efforts, in an integrated manner, for the development and implementation of policies and programmes for promoting and protecting the health and development of adolescents.

It is my sincere hope that this document will serve as a reference tool to guide the Government, NGOs, the private sector, young people themselves, parents and development partners and other stake holders in the implementation of programmes over the next five-year period .

Thank you.

Dr Jane Ruth Aceng
Director General, Health Services
MINISTRY OF HEALTH.

ACKNOWLEDGEMENT

The successful completion of the Adolescent Health and Development Strategy is an indication of the dedication and commitment of various institutions and individuals to which the Government will remain indebted.

Sincere thanks and appreciation are hereby extended to the following: Ministry of Labour, Gender and Social Development, Ministry of Health, Ministry of Education and Sports, Ministry of Finance and Economic Development, Ministry of Justice and Constitutional Affairs, FIDA-Uganda, Director of Public Prosecution, Uganda AIDS Commission, Department of Obstetrics and Gynaecology (Makerere University), Reproductive Health Uganda, Kawempe Adolescent Centre, Naguru Teenage Centre.

Special thanks are extended to WHO, UNFPA, UNICEF for their continuing technical and financial support. Their financial support made it possible to cover costs for data collection, formulation and completion of this document. Likewise, their technical support that was provided by the country teams was a very valuable input in the development of the strategy document. The contribution of the donor community in the development process of this strategy is highly appreciated. Sincere thanks are extended to PATHFINDER and USAID for their valuable contributions at different stages of the strategy development.

Appreciation also goes to the various stakeholders including the District Health Teams and adolescents who shared their views, perceptions and experiences on the development of the strategy. The Ministry of Health staff is commended for their tireless efforts in not only co-coordinating activities but also giving their technical inputs that led to the completion of the document.

There are many people who put long hours to ensure the successful completion of this document; their valuable contributions are highly appreciated.

Dr. Anthony K. Mbonye
Commissioner for Health Services, Community Health
Ministry of Health

ACRONYMS AND ABBREVIATIONS

| | |
|--------|--|
| AFHS | Adolescent Friendly Health Services |
| AIDS | Acquired Immuno Deficiency Syndrome |
| AYA | African Youth Alliance |
| BCG | Behaviour Change Communication |
| CBO | Community Based Organizations |
| CDP | Child Development Policy |
| CEDAW | Convention on the Elimination of all forms of Discrimination Against Women |
| CORP | Community Own Resource Persons |
| CRC | Convention on the Right of the Child |
| DHO | District Health Officer |
| DHT | District Health Team |
| DLG | District Local Government |
| FGM | Female Genital Mutilation |
| HCT | HIV Counselling and Testing |
| HIV | Human-Immuno Virus |
| HPV | Human Papilloma Virus |
| ICPD | International Conference on Population and Development |
| IEC | Information, Education and Communication |
| M&E | Monitoring and Evaluation |
| MOES | Ministry of Education and Sports |
| MOFPED | Ministry of Finance, Planning and Economic Development |
| MOGLSD | Ministry of Gender Labour and Social Development |
| MOH | Ministry of Health |
| MOJCA | Ministry of Justice and Constitutional Affairs |
| MOLG | Ministry of Local Government |
| MP | Members of Parliament |
| NGO | Non-Governmental Organizations |
| NMS | National Medical Store |
| RHS | Reproductive Health Section |
| SDPs | Service Delivery Points |
| SRH | Sexual Reproductive Health |
| STIs | Sexual Transmitted Infections |
| TFR | Total Fertility Rate |
| TR | Terms of Reference |
| TOT | Train of Trainers |
| UBOS | Uganda Bureau of Statistics |
| URCHS | Uganda Reproductive and Child Health Survey |
| VCT | Voluntary Counselling and Testing |
| VHT | Village Health Team |
| WHO | World Health Organization |
| YFS | Youth Friendly Services |
| YSO | Youth Serving Organizations |

GLOSSARY OF TERMS

- Abuse** This refers to pathological pattern of use causing impairment in social, physical or occupational functioning.
- Adolescent** An adolescent is defined as a person aged 10-19 years.
- Capacity for adolescent health** Examples infrastructure, skills, equipment and supplies, recreation facilities etc.
- Defilement** Unlawful sexual intercourse with a girl under 18 years of age is a period of transition from childhood to adulthood, and is characterised by physical, psychological and social changes. The family environment is the best place to address the basic needs and rights of adolescents, which include shelter, food, education, health care, social and economic support, spiritual development and overall well-being.
- Drug** Any natural or synthetic substance which, when taken into a living organism may modify its function.
- Gender** Refers to what a person, society, or legal system defines as “female” or “male”.
- Gender role** Describes the set of socially or culturally defined attitudes, behaviours, expectations, rights and responsibilities that are considered for women and men.
- Gender based violence** is any act that results into physical, sexual or psychological harm or suffering to women, men and children. This includes threats of such acts as coercion or arbitrary deprivation of freedom whether occurring in private or in public.
- Sexual abuse** refers to all forms of sexual coercion (emotional, physical and economic) against an individual. It may or may not include rape. Other forms of sexual abuse include defilement, rape, incest, sexual assault, sexual harassment and sexual exploitation.
- Hygiene** is a practice of keeping the body clean (including oral hygiene) in order to prevent infection, bacteria, infestations and diseases

from occurring in individuals and communities..

Incest: Sexual relationships occurring between members of the same family.

Indecent assault: Is the sexual harassment or unwanted sexual advances/sexually motivated physical contact or verbal communication of sexual nature.

Misuse of a drug: This refers to a non-medical or inappropriate use of psycho-active drugs.

Prostitution: Involvement of girls/boys/women/men in sexual activities for monetary or material gains.

Rape: The use of physical and/or emotional coercion or threats to use coercion in order to penetrate a child, adolescent or adult vaginally, orally, anally against her/his wishes.

Sexual abuse: Any type of unwanted sexual contact.

Sexual Violence: Being forced to have sexual intercourse or perform any other sexual acts against one's will.

Stakeholders: Examples public and private institutions, NGOs, development partners, adolescent/ young people themselves, and civil society organizations

Substance: A product taken in the body and affects the way we feel, think, see, taste, smell, hear, walk or behave. It can be a medicine such as morphine or it can be an industrial product such as glue and petroleum. Some substances are legal like approved medicines and cigarettes and others are illegal like heroine, cannabis

Use: Use of a substance means the individual in control, not compromising physical health or damaging family life, social activities or work abilities.

Unsafe abortion is defined as *'the termination of a pregnancy carried out by someone without the skills or training to perform the procedure safely, or in a place that does not meet minimal medical standards, or both'*. (WHO).

Young person A young person is defined as being between 10-24 years of age (UNBOS 2002).

Youth According to the Uganda constitution, youth are 18 – 30 years.

EXECUTIVE SUMMARY

Uganda has a predominantly young population with 52.4% being under 15 years. While adolescents (10-19 years of age) comprise of 23.3 %, the percentage for young people (10-24 years of age) amounts to 37.4.3 %.

Adolescence is a period of transition from childhood to adulthood during which one undergoes dramatic physical, physiological, psychological and social changes. The rapid development and growth in this age group points to a potential that can contribute positively to the socio economic development of the individual and the country.

However, young people are also prone to all kinds of accidents by virtue of their level of activity, willingness to take risks and limited information. Limited employment opportunities for the young people can force and subject them to inhuman conditions of work in both the formal and informal sectors. In addition, they face a multitude of challenges including reproductive health problems such as early/unwanted pregnancy, unsafe abortion, STIs/HIV/AIDS, and psychosocial problems such as substance abuse, delinquency, truancy, sexual abuse etc.

Income generating activities for adolescents through livelihood skills development present one of the avenues of dealing with some of the above issues. Retention of young people in both primary and secondary school contributes to improvement in their sexual and reproductive health. Provision of accurate knowledge and information can greatly assist adolescents in making informed decisions which contribute to behaviour formation, maintenance and change. Encouragement of participation and involvement of adolescents in programmes aimed at enhancing their health and development will focus interventions based on needs of adolescents and promote ownership and sustainability.

This National Adolescent Health Strategy has been designed as a tool to improve health services targeting this particular group of young persons in Uganda.

Description of the strategy

This Strategy describes factors that promote and those that pose risks to health and development of adolescents/young people. The strategy further highlights strengths, weaknesses, opportunities and threats in the implementation of the interventions to meet requirements of the young people. It also describes outputs and activities to be implemented at national, district and community levels in order to meet the strategic objectives. It identifies the operational targets, indicators, implementation framework including proposed implementing partners and institutions during the five-year timeframe.

CHAPTER ONE: BACKGROUND

1.1. INTRODUCTION

The rapid increase in the numbers of adolescents/young people points to the potential to contribute positively to the socio-economic and political development of the country. However, if not well directed it can lead to consequences that may be harmful to the health status of the entire population.

Young people are vulnerable to all kinds of health challenges by virtue of their level of activity, willingness to take risks, and limited information. These include reproductive health problems such as STIs/HIV/AIDS, early or unwanted pregnancy, unsafe abortion, and psychosocial problems such as substance abuse, delinquency, truancy, sexual abuse etc. Factors that predispose them to vulnerability include economic issues such as poverty, over dependence on adults, or lack of employment opportunities. The majority of these young people are engaged in subsistence agriculture or petty trade in the informal sector. This situation is worsened by lack of adequate social services, characterised by low access to information, low demand and utilization of reproductive health services, high school drop outs and an un-conducive teaching and learning environment in schools and health facilities. **(include statistics for enrolment for Secondary education vis-a-vis primary for both girls and boys; teenage pregnancy rate is 25%(UDHS 2006).**

According to the UDHS 2006, teenage pregnancy rate was estimated at 25%. By the age of 15, 23 % of females have had sexual intercourse and this figure rises to 67% by 18 years and by 18 years 53% of girls are already married. Despite early onset of sexual intercourse among adolescents, contraceptive use is low. This sometimes leads to unplanned/unwanted pregnancies, unsafe abortions and related complications sometimes resulting into disproportionately high maternal mortality and morbidity. Maternal mortality is 2 to 5 times higher for

Uganda has a predominately large young population. Fifty two point seven (52.7%) % of the population is under 15 years of age. About one in every four Ugandans (25 %) is an adolescent and one in every three (37.4%) (34 %) is a young person.

An adolescent is defined as a person aged 10-19 years while a young person is defined as being between 10-24 years of age (UNBOS 2002). According to the Uganda constitution, youth are 18 – 30 years. For the purpose of this strategy, the health sector programming focuses on the adolescents 10 – 19 years but services will cover up to individuals of 24 years.

under 18 compared to older women. Utilisation of antenatal, delivery and postnatal care service by adolescents is poorer than in the adult group and yet they are at a greater risk of obstetric complications. Children born to adolescents are generally prone to higher morbidity and mortality due to poor prenatal and improper childcare practices (Infant mortality among adolescent mothers in Uganda is 105/1000 live births compared to a national average of 77/1000 live births).

There's scanty data about the prevalence of STIs amongst this age group. However, HIV/AIDS and HPV are rampant in this age group.

The Uganda HIV Sero-prevalence and behavioural survey of 2004/5 estimated that for every HIV positive male, there are 4 to 6 girls in the same age group while the ratio in adults is 1:1. The HIV prevalence among men and women aged 15-24 years is 4.9%. Fifty percent (50 %) or more of all HIV/AIDS cases occur in the ages 15-24 years¹. After 15 years of age there is a sharp rise in HIV/AIDS prevalence indicating that there is early sex and infection.

Adolescents and young people need to be reached with Adolescent-Friendly Services (AFS) to mitigate the multiple health challenges and behavioral risks that they are faced with. This has to be in a manner that ensures availability and accessibility by all young people including those in conflict and hard to reach environments

Substance abuse is common in Uganda and is on the increase. Few studies conducted so far have focused on street children and urban secondary schools. The most commonly abused substances are tobacco and alcohol. The use of narcotic (hard) drugs is on the increase as reported in some print media. The use of cannabis sativa (marijuana), Khat (mairungi) or miira, has its roots in some traditions, but has now obtained commercial proportion. It is also a practice for some young people to sniff various substances such as petrol, aviation fuel glue, etc.

Studies elsewhere have documented the close relationship between drug abuse, crime, violence and risky sexual behaviour with consequences of unwanted pregnancies, STI's and HIV/AIDS. Habituation and drug addiction problems have multiple devastating impacts on the young people, their health and social structure. Rehabilitation of drug addicts is a difficult and expensive undertaking.

Adolescents need nutritious food for proper growth and development, energy to play, work, study, fight infection. The common nutrition problems among adolescents are poor growth, anaemia and micronutrient deficiencies especially vitamin A, iodine and iron. Poor feeding habits are becoming common in both boys and girls. This is further complicated by declining food supplies in the country, poor processing and preservation, wrong preparation methods and poor storage facilities.

Uganda is currently experiencing outbreak of hygiene related diseases. Many of these are attributed to poor water and sanitation facilities as well as poor personal hygiene practices. It is assumed that personal hygiene habits should have been imparted into the young adolescents at an earlier stage since the family environment

¹ Uganda HIV Sero-prevalence and Behavioural Survey, 2004/2005

is the best place to address the needs of young people. Uganda introduced a comprehensive school health program many years ago to prevent and control diseases that occur among school-going children and promote personal hygiene. However coverage is still low.

Gender biases cause the girl and boy child to live in different worlds hence a difference in access to several resources. In some communities boys are left to enjoy educational and other social privileges while the girl child is left to take over domestic chores. This contributes to the apparent diverse differences in literacy, health status and access to health care.

Measures have been taken to reduce gender biases and promote equal opportunities for both boys and girls to education, sports, skills acquisition and gainful employment. Affirmative action has increased girls enrolment in educational institutions at all levels. As adolescent health programmes are designed, the above gender concerns should be considered and addressed.

Some traditional practices are harmful to adolescent health. The practice of marrying off under-age girls (minors) is rampant² indicating poor or inadequate sensitisation and law enforcement. Other practices include female genital mutilation (FGM) and rituals surrounding male circumcision commonly performed in adolescence, together with spousal sharing and inheritance. These infringe on adolescents' rights and result into poor health especially sexual and reproductive health (unsafe abortion, difficult deliveries, high risk of acquiring STIs/HIV/AIDS and death.)

According to the UDHS 2006, 21.3% of females aged 15-19 and 40.9% of those between 20-24 years had experienced some form of sexual violence. Whereas sexual violence in males was registered as 7.4% in those aged 15-19 and 9.1% for those aged 20-24. This is strong evidence to show that young boys should be targeted with SGBV programs especially in various institutions such as schools, remand homes, prisons etc.

On a good note, some religious institutions in Uganda have put in place a policy of marrying couples at the constitutional age of 18. A policy on sexual and gender-based violence is in place and training of various service providers has been accelerated. FGM has been outlawed in Uganda. The sexual offence Bill categorises rape, defilement as capital offences.

Poverty is both a cause and an effect of poor adolescent health status particularly in the area of sexual and reproductive health. It plays a significant role in increasing chances of early sexual involvement and marriage. Some adolescents both girls and boys, do exchange sex in anticipation of material gains. Families in poverty are less likely to provide for the basic needs of adolescents thereby predisposing them to several vulnerability such as prostitution, child labour, etc.

Among adolescents, there are categories of adolescents that have special needs. These vulnerable groups of adolescents exist and comprise of adolescent orphans, street children, out-of-school children, incarcerated adolescents, refugees or

²UDHS, 2006

displaced persons, child parents, adolescents with physical and mental challenges, child soldiers, adolescents and young people involved in transactional sex/commercial sex/cross generational (sexual exploitation), house-girls and house-boys.

Providing accurate knowledge and information can greatly assist adolescents in making informed decisions which contribute to behaviour formation, maintenance and change.

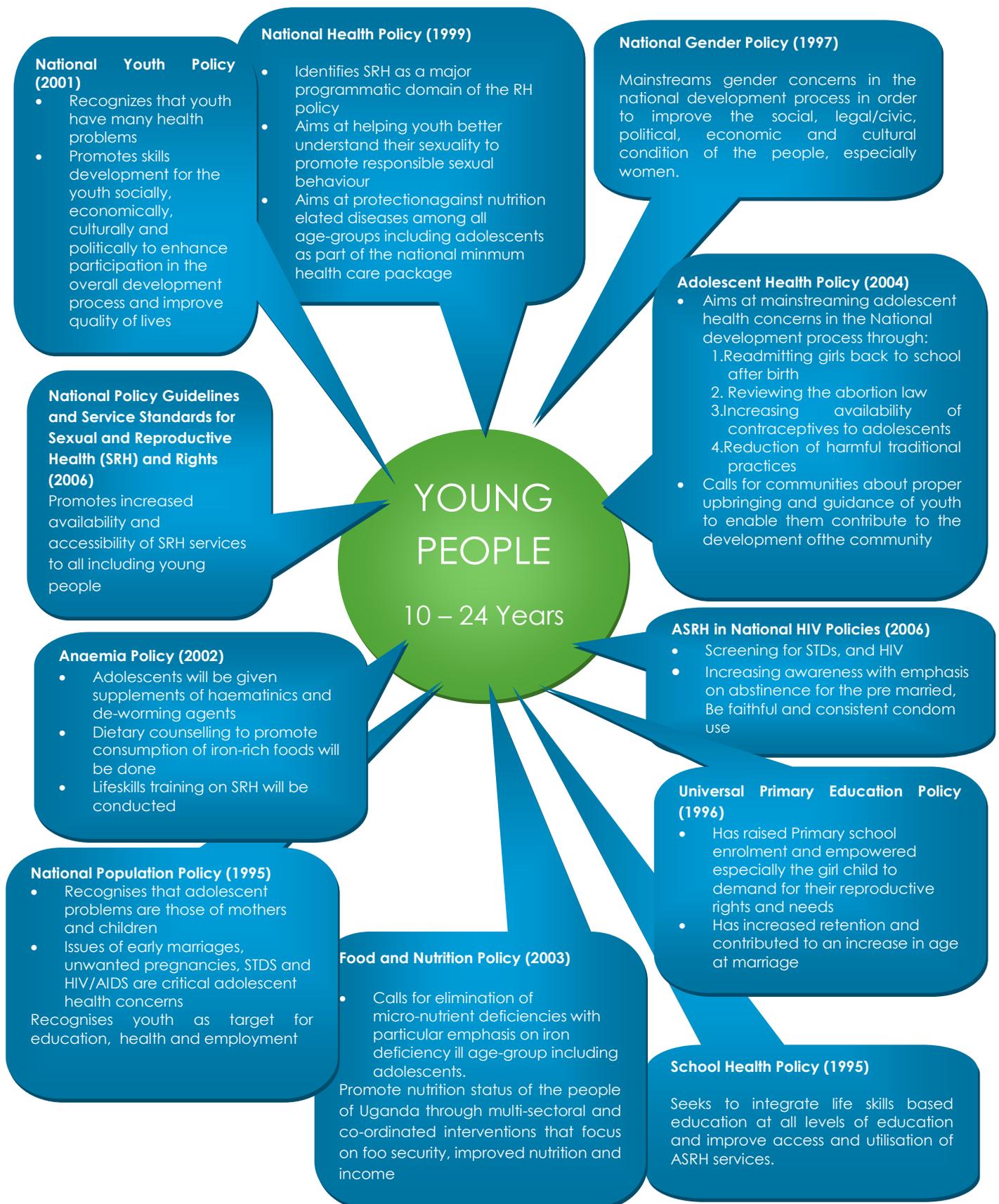
1.2. POLICY ENVIRONMENT AND LEGAL FRAMEWORK

Following the 1994 International Conference on Population and Development, held in Cairo, a number of policies, backed by law in support of adolescent health and development, were discussed. Many policies have been developed within this context, by different line ministries. These include:

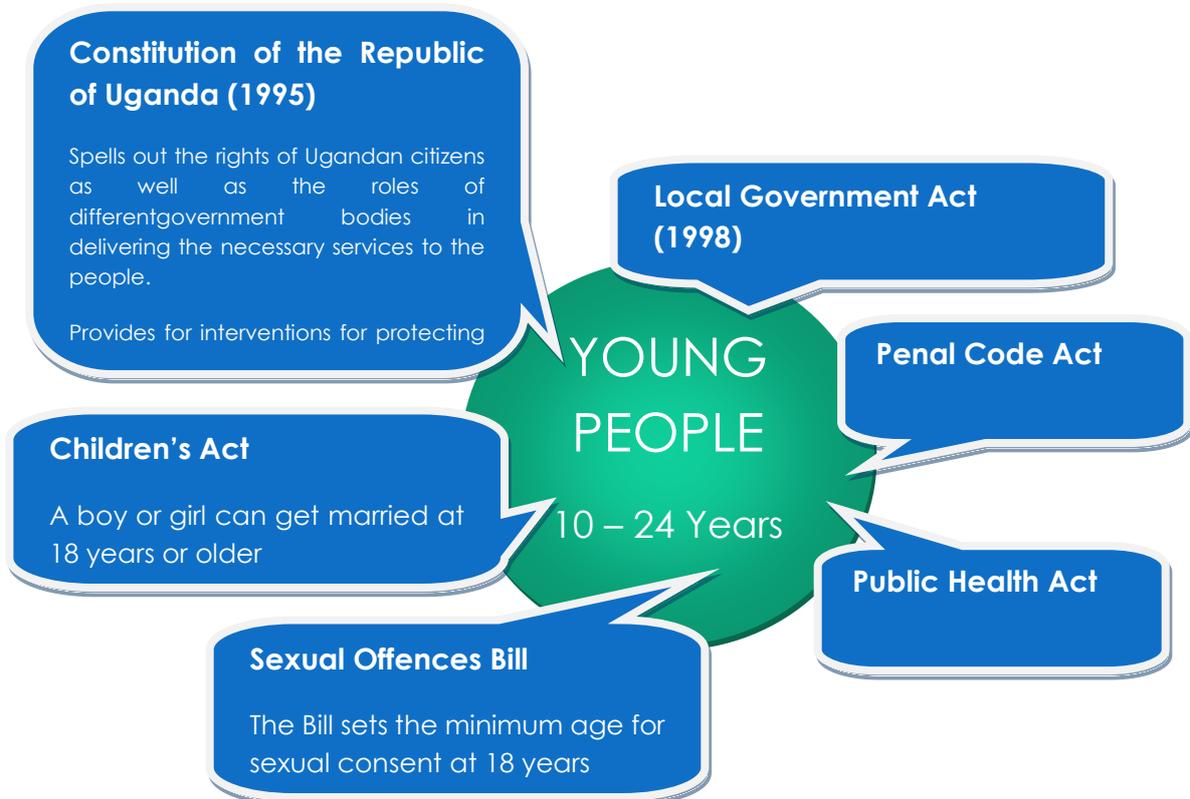
- Constitution of the Republic of Uganda 1995.
- The National Youth Policy 2001;
- The National Population policy 2008
- The National Gender policy 2007
- The National Policy on Young People and HIV/AIDS.....;
- National Sexual and Reproductive Health Policy 2006.
- The Adolescent Sexual and Reproductive Health Policy 2004.
- The Sexual and Reproductive Health Minimum Package 2005
- Article 31 and 32 of the Constitution of Uganda 1995 (Affirmative Action) ,
- The Decentralisation Act 1997
- The Sexual Offences Bill, a policy setting the minimum age for sexual consent at 18 years
- The Universal Primary Education Policy (1997???)

However, full implementation of these initiatives is lacking and hampered by resource difficulties. As a result the task has often been assigned to internationally funded youth programs developed by non-governmental organizations, which are not sustainable in the long run. While local pilot projects involved in many of these areas abound, coordination of youth services at the national level is still weak.

UGANDAN POLICIES THAT INFLUENCE YOUNG PEOPLE'S HEALTH AND DEVELOPMENT



THE LAWS THAT INFLUENCE YOUNG PEOPLE'S HEALTH AND DEVELOPMENT



THE LEGAL FRAMEWORK

Introduction

The legal framework in Uganda promotes adolescent and young people's health through laws that provide for protection of this category of people from physical and mental abuse, as well as ensuring that they live and grow in an environment that is conducive to good health and development.

The Constitution:

The Constitution as the supreme law of the land provides the broad legal framework for the protection and promotion of human and property rights, and outlaws discrimination. It lays the foundation for most of the laws that promote adolescent and young people's health. It provides for Protection of right to life; respect for human dignity and protection from inhuman treatment; protection from slavery, servitude and forced labour; Right to education; Protection from laws, cultures, customs and traditions which are against the dignity, welfare or interest of women or any other marginalized group; Rights of Women, including taking into account their unique status and natural maternal functions in society; rights of children and the right to a clean and healthy environment.³

The Penal Code Act

The Penal Code Act creates many sexual offences that are intended to protect vulnerable people like children and young people from sexual abuse, which is harmful to their health and development. They are termed 'Offences Against Morality'⁴:

- Defilement – Unlawful sexual acts with children below 18 years
- Rape – Unlawful sexual intercourse with a woman or girl without her consent
- Abduction – Taking or detaining a person for marriage or sexual intercourse against his or her will; or unlawfully taking a child out of the custody of the parents.
- Defilement of idiots or imbeciles –Unlawful sexual intercourse with a woman or girl known to be an idiot or imbecile.
- Procuration – Procuring a girl or woman to have unlawful carnal connection or to become a prostitute.
- Procuring defilement by treats – Procuration with threats, intimidation, false pretences or representations, administering drugs to stupefy or overpower, etc.

³ Articles 22, 24, 25, 30, 32(2), 33, 34 and 39 of the Constitution

⁴ Chapter XIV of the Penal Code Act

- Permitting defilement – Owner or manager of premises inducing or keeping a girl below 18 years for sexual intercourse by a man.
- Detention with sexual intent – unlawfully detaining a person for the purpose for sexual intercourse.
- Indecent assault – Unlawfully and indecently assaulting a woman or girl; uttering words, making sounds or gestures or intruding on the privacy of a woman or girl with intent to insult her modesty.
- Unnatural offences – having sex intercourse against the order of nature, or with an animal or permitting a male person to do it on another against the order of nature.
- Abortion – carrying it out on oneself, another person or supplying drugs/substances for the purpose
- Incest – having sexual intercourse with a person within the prohibited degrees of consanguinity (kinship)
- Prostitution – Practicing or engaging in prostitution
- Living on the earnings of prostitution – knowingly living wholly or in part on the earnings of prostitution
- Operating a brothel – Keeping a house or room for purposes of prostitution.

Here below are details and analysis of some of the offences:

Defilement:

The law on defilement is intended to protect children and adolescents from sexual acts before they are mature enough to appreciate and take important decisions regarding their reproductive health rights and welfare. Thus the law prohibits engaging them in sexual acts as this amounts to abuse and is harmful to their health and morals. Defilement results into serious injuries (sometimes permanent) to the mental, physical or reproductive health of a child.

The defilement law punishes many forms of undesirable sexual acts that may be committed against children, be they boys or girls, and defines a sexual act as “penetration of the vagina, mouth or anus however slight, of any person by a sexual organ” or “the unlawful use of any object or organ by a person on another person’s sexual organ”.⁵ Therefore, mere touching or otherwise coming contact with the sexual organ of a child unlawfully amounts to defilement; and lesbianism, masturbation or oral sex with a child may constitute defilement. Women and girls can also defile male or female children. The law also provides for compensation to victims of defilement for physical, sexual and psychological harm caused by the offence. However, where the offender is below 12 years, or where two children defile each

⁵*Ibid* section 129

other the law provides for less formal procedures for them, which aim more at rehabilitating the children, than punishing them.⁶

The law creates two categories of the defilement offence; simple and aggravated defilement. Simple defilement is triable by a chief magistrate and punishable by life imprisonment, while aggravated defilement is only triable by the High Court and carries a maximum sentence of death. Simple defilement means ordinarily performing a sexual act with a person below 18 years, while aggravated defilement refers to the following cases:

- Where the victim is aged below 14 years;
- Where the offender is infected with HIV;
- Where the offender is a parent, guardian or person in authority over the victim;
- Where the victim is a disabled person; or
- Where the offender is a serial offender.

Prostitution:

The law prohibits prostitution and punishes those who practice it, those who promote it as well as those who earn from the practice.⁷ The aim of the law is to protect persons especially adolescents and young people who happen to form a big percentage of prostitutes, from the harmful effects of the practice on their health and development, and also on their morals. The policy compliments this cause by making provision for ways of assisting adolescents and young people understand and appreciate the risks that prostitution exposes to their health. It also aims at assisting those who have engaged in it with treatment and counseling to recover from its effects and to desist from further practicing it.

Abortion:

The law prohibits abortion. The Constitution of Uganda guarantees the right to life, including that of an unborn child – “No person has the right to terminate the life of an unborn child except as may be authorized by law”.⁸ This provision guarantees the right to life of an unborn child except as may be authorized by law. From the wording of the provision it appears that the framers of the Constitution were aware of the laws prohibiting abortion and terminating the life of an unborn child, but anticipated that some law(s) would probably be enacted, which authorize such acts. However, to date no laws have been made specifically legalizing or decriminalizing abortion or authorizing termination of the life of an unborn child in Uganda.

⁶ *Ibid* section 129A

⁷ *Ibid* sections 136 - 139

⁸ Article 22(2) of the Constitution

The penal code specifically creates offences and punishes females who willfully undergo abortion, those who facilitate it as well as those who carry it out on women.⁹ However, section 224 provides a general defence for the offences endangering life or health where death or injury occurred as a result of a surgical operation, which could be applicable to some abortion cases:

“A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case”.

Since Ugandan law severely restricts abortion, the girls and women who wish to have abortions resort to the other available choice of unsafe abortion, which endangers their health. Unsafe abortion is one of the avoidable causes of increased women morbidity and mortality rates in Uganda. Due to the nature and illegality of the act again these women fear to go for proper Post Abortion Care in medical facilities at the right time, and in many cases seek medical attention at a late stage, with severe consequences to their health, including death. This could be one of the causes of the high numbers of maternal deaths and complications resulting from unsafe abortions. Unsafe abortions constitute between 20 – 30% of maternal deaths in Uganda.¹⁰ It is for this reason that abortion is increasingly becoming a subject of concern as an aspect of reproductive health of girls and women in Uganda, which greatly impacts on maternal mortality rates.

There has been debate on whether or not to decriminalize/legalise abortion in selected cases, with the advocates for this change arguing that it would be an effective way of protecting girls' and women's lives because it would be carried out safely in deserving cases, thereby minimizing deaths and complications that would normally result from unsafe abortions.

Uganda needs to address the issue of the high maternal mortality rate, and one way of doing this is by taking measures to reduce deaths caused by unsafe abortions, which could be avoided. This policy contributes by making provision for family planning services, adolescent and young people's post abortion care and support. The provision to adolescents and young people with awareness and motivation to adopt safe adolescent reproductive behavior, and provision of friendly adolescent sexual reproductive health information and services to improve the health of this category of people need not be over-emphasised.

⁹ Sections 141 – 143 of the Penal Code Act

¹⁰ Abortion Situational Analysis Report, August 24, 2008: By Association of Obstetricians and Gynaecologists of Uganda, and FIGO (ASAR)

The Magistrate's Courts Act:

The Magistrates' Courts Act requires a magistrate trying a case of defilement to consider hearing the case in private for reasons of morality and protection of the victim of defilement¹¹. This law however, covers only a portion of defilement cases which are tried by magistrates (defilement of children above 14 years). Cases of aggravated defilement are not accorded this protection. However, the Sexual Offences Bill seeks to provide this privacy in all trials of sexual offences under the Act,¹² and to require courts to always act in accordance with the best interests of the child in cases where the victim is a child. This bill if passed into law will therefore enhance protection of victims of sexual violence/abuse, and there is room for more innovation in this area.

The Sexual Offences Bill, 2011

The Sexual Offences Bill, 2011 seeks to revise and consolidate various laws relating to sexual offences in order to effectively combat sexual violence, and to protect victims of sexual abuse during trial of their cases. While it adopts all the sexual offences provided under the Penal Code Act listed above, it also intends to change the definition of 'Sexual Act' which constitutes defilement and rape offences to:

- a) Direct or indirect contact with the anus, breasts, penis, buttocks or vagina of one person and any other part of the body of another person; or
- b) Exposure or display of the genital organs of one person to another person;
- c) The insertion of any part of the body of a person or of any part of the body of an animal or any object into the vagina or penis or anus of another person; or
- d) Cunnilingus; fellatio or any other form of genital stimulation"

Where the offender is infected with HIV or suffering from AIDS or a sexually transmitted disease, the offence would be aggravated and carry a more severe sentence. The bill also proposes that marriage is not a defence in cases of forceful sexual intercourse under certain circumstances, thereby introducing marital rape in Ugandan law.

The bill is a departure from the current law which still defines rape as unlawful penetrative sex without the consent of the girl or woman. It would broaden the definition of rape and defilement offences for better protection against sexual violence.

¹¹ Section 40(1A) of the Magistrates' Courts Act

¹² Section 28 of the Sexual Offences Bill

The Prohibition of Female Genital Mutilation (FGM) Act

The Constitution prohibits "laws, cultures, customs and traditions which are against the dignity, welfare or interest of women or any other marginalized group".¹³ This provision lays basis for laws like section 7 of the Children Act which prohibits subjecting a child to social or customary practices that are harmful to the child's health, and the Prohibition of Female Genital Mutilation (FGM) Act. The Prohibition for FGM Act prohibits FGM because it is against the dignity of girls and women, is harmful to their general health, and a violation of their sexual and reproductive health rights. Female adolescents and young women have been the main target for FGM, a harmful cultural practice done in some parts of Uganda. Hence the Act creates the offence of FGM in two categories; simple and aggravated FGM, with a maximum sentence of life imprisonment for cases of aggravated FGM.¹⁴ Aggravated FGM refers to situations where:

- "a) death occurs as a result of FGM
- b) the offender is a parent, guardian or person having authority or control over the victim;
- c) the victim suffers disability;
- d) the victim is infected with HIV as a result of the act of FGM; or
- e) FGM is done by a health worker"

The FGM Act also punishes related activities like attempting or procuring FGM, and participating in events leading to FGM. Discrimination and stigmatization of females who have not undergone FGM is punishable, and there is provision for compensation to victims of offences under the Act.

The prevention of Trafficking in Persons (PTIP) Act.

Adolescents and young people are the key victims of human trafficking, a growing but harmful practice, and a violation of the victims' rights. The exploitative situations/methods applied to the victims of trafficking like sexual exploitation, forced and harmful labour cause them physical and emotional harm, which affects their health and development.

Human trafficking is defined as:

"The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or

¹³*Supra 1*

¹⁴ Sections 2 & 3 of the FGM Act

receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation".¹⁵

The Uganda PTIP Act adopted the above definition of the Palermo Protocol. The Act defines exploitation to include at a minimum "sexual exploitation, forced marriage, child marriage, forced labour, harmful child labour, use of a child in armed conflict, use of a person in illegal activities, debt bondage, slavery or practices similar to slavery or servitude, human sacrifice, the removal of organs or body parts for sake or for purposes of witchcraft, harmful rituals or practices."

The PTIP Act protects adolescents and young people's health through prohibiting human trafficking, creating offences and penalties for it, offences related to it and those that promote it. It punishes trafficking in children (people below 18 years) with a maximum sentence of death. It also punishes engaging the labour or services of victims of trafficking, and provides measures for protection, assistance and support for victims. Restitution and compensation to victims by the perpetrators is provided too. The services provided for in this policy would help adolescents and young people who are high risk groups for human trafficking to avoid it, while those who have fallen victims would be assisted to recover from its effects.

The Children Act

The Children Act was enacted in line with international standards¹⁶, and the Constitution of Uganda. These make provision for the children's right to know and be cared for by their parents or those entitled by law to bring them up, basic education, medical treatment, protection from social or economic exploitation and work that is likely to be hazardous or to interfere with their education or to be harmful to their health or physical, mental, spiritual, moral or social development. The Children Act therefore contains detailed provisions for the protection of children against all forms of physical and psychological abuse, and the right to good health and development.

The Act emphasizes a child's right to stay with parents or guardians, and the duty of a parent or guardian to provide education and guidance, immunization, adequate diet, clothing, shelter and medical attention; and to protect the child from discrimination, violence, abuse and neglect. Indeed desertion of children below 14 years without means of support, and neglect to provide the necessities of life to a child of tender years are criminal offences under the Penal Code Act.¹⁷ In addition to harmful social or customary practices, the Children Act also prohibits employing or

¹⁵ Article 3 of the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the UN Convention Against Transnational Organised Crime (Palermo Protocol)

¹⁶ The United Nations Convention on the Rights of the Child

¹⁷ Sections 156 & 157 of the Penal Code Act

engaging a child in any activity that may be harmful to his or her health, education or mental, physical or moral development. It further tasks members of the community to report infringement of a child's rights or refusal/neglect to provide necessities to the child.¹⁸

The Children Act establishes the Family and Children Court (FCC) to try the majority of criminal cases against children and all matters relating to child care and protection. The court is informal in nature and follows laid down rules regarded suitable in children matters, which were specially made for it. Detailed provisions are made for the care, supervision, adoption and fostering of children, while children accused of committing crimes are treated different from adults. The Act also gives Local Councils power to try cases of children including selected criminal cases, and to make appropriate orders.

In the case of child offenders the Act provides child friendly laws and procedures intended to protect and divert children from the formal criminal justice system which could be harmful to their development, and emphasise the need to reform and rehabilitate children, rather than punish them. Under the Act the age of criminal responsibility is 12 years, but bail to a child offender is automatic unless there is a serious danger to the child. Where the child has to be detained pending trial it must be for a limited period, and in a remand home rather than a prison. Most criminal cases of children are triable by the FCC and have a time limitation/duration at all stages, and the Act emphasizes non-custodial rather than custodial orders (sentences) for children against whom offences have been proved. Where a custodial order has to be made the child will only be detained in a rehabilitation centre and for a short period. Contravention of any of the provisions of the Children Act is an offence.

The process of amending the Act is currently ongoing, to improve on its provisions.

The National Drug Policy and Authority Act

This law protects adolescent and young people's health and development by prohibiting and punishing possession of narcotic drugs and psychotropic substances under international control. It specifically punishes smoking of opium, frequenting premises where it is smoked, owner permitting premises to be used for that purpose, and possession of utensils used for smoking it. Cultivation any plant from which a narcotic drug can be extracted is also an offence.¹⁹ However, the current law is lacking in some aspects and a bill to amend the law is in place.²⁰ Adolescents and young people often fall prey to temptations of using narcotic and psychotropic

¹⁸ Section 11(7) of the Children Act

¹⁹ Sections 47 – 49 of The National Drug Police and Authority Act

²⁰ The Narcotic Drugs and Psychotropic Substances (control) Bill, 2007

substances and related practices. It is important therefore, that they are assisted to avoid committing those offences for their own safety and for the good of their health. Those who have practiced or been addicted to the practice must be assisted to easily access counseling or treatment services. This policy contributes by providing for easy access to those services by adolescents and young people.

The HIV and AIDS Prevention and Control Bill, 2010

The HIV and AIDS Prevention and Control Bill, 2010 would if enacted into law contribute to promotion of adolescents and young people's health through its proposed provisions that relate to prevention and treatment of HIV and AIDS. Provisions like those on voluntary HIV testing, efficiency in testing, confidentiality of test results, pre-test and post-test counseling, continuous counseling, testing of donated blood, licensing of HIV and AIDS testing places, responsibilities of the state, agencies and organisations in HIV and AIDS, will support the policy objectives on ensuring access of adolescents and young people to services that promote their safety and treatment in cases of HIV and AIDS.

The Domestic Violence Act:

Adolescents and young people are among the people offered protection under the Domestic Violence Act that was enacted in 2010. They are included as victims in the definition of 'domestic relationships' under section 3(1): "...where..

- a) The perpetrator and the victim are family members related by consanguinity, affinity or kinship;
- b) The perpetrator and the victim share or shared the same residence;
- c) The victim is employed by the perpetrator as a domestic worker or house servant and the victim does or does not reside with the perpetrator..."

The Act prohibits and punishes domestic violence (acts which threaten, injure or cause harm, whether physical or mental to victims) to people in domestic relationships with imprisonment, fines and orders for compensation and restitution among others. It also provides for protection orders to be issued by courts for the protection of victims from impending or continued violence from the perpetrators; harm, discomfort or inconvenience as a result of domestic violence. These provisions help to protect the health of adolescents and young people in domestic relationships.

The Liquor Act

This law seeks to protect children, adolescents and some young people from the harmful effects of liquor on their health and development, through restrictions and penalties on owners and dealers in liquor. It restricts the issue or transfer of liquor trading licenses to persons below 21 years. It prohibits licensees from allowing persons below 18 years to be in a bar or licensed premises during the sale or consumption of

liquor, the sale of intoxicating liquor to children, and their employment for purposes of selling or otherwise handling issues of liquor.²¹ However, enforcement of this law is very poor. Notable also is the fact that the law does not prohibit adolescents and young people from visiting bars, buying or consuming liquor. The policy however, makes provision for services that can help these people avoid or remove from alcoholism.

The Employment Act:

This Act puts restrictions on employment of children to protect them from employment that may be hazardous to their health, welfare or development. Employment of children below twelve years is illegal. Children below fourteen years can be employed for light work carried out under supervision of an adult, if it does not affect the child's education. The Act prohibits employment of a child for work which is injurious to his or her health, dangerous or hazardous or otherwise unsuitable, or employment for night duty.²² Furthermore there are provisions which establish a complaints procedure for addressing sexual harassment at work, and require employers to have in place measures to prevent sexual harassment.²³ This protection is important especially for adolescents and young employees, who are at high risk of such practices from their superiors, which would expose their health to sexually transmitted infections and reproductive health hazards through possible unwanted sexual acts.

The Public Health Act

The Public Health (School Building) Rules made under the Public Health Act require schools to ensure that pupils/students live, study and play in a healthy environment. The rules provide for proper lighting and ventilation, and appropriate classroom dimensions. They also provide the minimum space for pupil in a dormitory, as well as spacing of beds. Water supply, latrine, accommodation, drinking water and a playground of sufficient size are also a must.²⁴ These provisions are intended to protect the health of school going persons many of whom happen to be adolescents and young people, through enforcement of a study and living environment that is conducive to good health and development.

The Local Government Act

The second schedule to the Local Government Act provides for the functions and duties of the District Councils to implement Government policies. The listed services include education from nursery to primary, secondary, special education and

²¹ Section 19 of the Liquor Act

²² Section 32 of the Employment Act

²³ *Ibid* section 7(4)

²⁴ Section 5 – 14 of Statutory Instrument 281 – 20 made under the Public Health Act

technical education; medical and health services including maternity and child welfare services, control communication diseases like HIV/AIDS, health education, environmental and sanitation. Among the decentralized services required of these councils are social rehabilitation; labour matters; probation and welfare; street children and orphans; women in development; community development; youth affairs; and cultural affairs.²⁵ Many of these services are critical for protection of adolescents and young people's health.

International and Regional Instruments:

Uganda is a signatory to various international and regional instruments which require states to ensure respect and protection of children, women, girls' and young people's human rights, including their sexual and reproductive rights, and oblige them to enact laws in line with those standards and expectations. These include The United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), The Convention on the Rights of the Child, The United Nations Protocol to Prevent, Suppress and Punish Trafficking in persons, Especially Women and Children, supplementing The Convention Against Transnational Organised Crime' (Palermo Protocol), The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), The Continental Policy Framework on Sexual and Reproductive Health and Rights, The Plan of Action for 2007 – 2010), The Barcelona Declaration, and The Regional Strategic Plan on Sexual and Reproductive Health and Rights in East Africa. Some of the laws in Uganda are therefore enacted in conformity with these instruments.

Conclusion:

Adolescents and young people a critical resource in a country's development. Matters of their health should always be given special consideration, not only in the law making process but also in other Government programmes and policies.

JUSTIFICATION

Adolescent health issues are increasingly being seen as critical areas of action at global, national and community levels. The 1994 International Conference on Population and Development, Cairo (quote relevant chp); The 1995 Fourth World Conference on Women, Beijing; World summit for Social Development, 1995 Copenhagen; highlighted issues concerning young people. Declarations from these conferences are interrelated and underline the need to address the glaring gap in SRH and rights of young people.

The **School Health Program** initially employed in schools to teach on sexual and reproductive health by health care providers has declined. In addition, the

²⁵ Part 2 of the second schedule to the Local Government Act

traditional practice by family members and community to groom adolescents into responsible adults has weakened. There are efforts by Ministry of Education and Sports to integrate ASRH into the main stream curriculum. This intervention has been piloted in 5 primary schools of 5 districts and needs to be rolled out in the whole country through the Pre-service training (place in chapter 1 alongside interventions)

Young people face numerous health, gender, social challenges that require focused multi-sectoral approaches. In addition, given the need to meet the rights of young people in regard to their Sexual and Reproductive Health a strategy that clearly outlines priority interventions for implementation is necessary. The National Strategy on Adolescent Sexual and Reproductive Health will address the young peoples' challenges in order to improve on adolescent health. It spells out priority cost-effective interventions, resource mobilization processes and coordination mechanisms. The strategy will also guide the appropriate monitoring and evaluation of adolescent sexual and reproductive health activities in the country.

1.3. RATIONALE AND PURPOSE

While the majority of young people remain healthy and become productive adults, a large number face different health and development challenges. Many of their decisions, behaviour and relationships impact on their future health and development. This has major implications for individual, as well as public health. Therefore, one of the most important commitments a country can make towards its development is to address issues and concerns of its young people. Additionally, current global initiatives support the need to have a strategy that addresses young people's health issues.

The Adolescent Health Strategy aims at providing a viable and comprehensive framework to address the needs and problems of young people on health and development in Uganda. This framework will serve as a reference tool to guide government, NGOs, the private sector, communities, collaborating agencies and different institutions in the implementation and support of programmes over a five-year period (2009 - 2014).

1.4. VISION

A healthy and productive adolescent population.

1.5. MISSION

To facilitate the attainment of a good standard of health by all adolescents in Uganda in order to promote health and productive life for development.

1.6. GOAL

To provide strategic directions to government, NGOs and all collaborating agencies and institutions for planning and implementation of adolescent health programmes in Uganda.

1.8. OBJECTIVES

1. To create an enabling policy, socio-cultural environment and legal framework that promotes the rights and facilitates the implementation of health and development programmes for adolescents.
2. Increase resources for adolescent health programmes.
3. Increase access to quality adolescent health friendly services and programmes from ...% to ...% by 2015.
4. Promote the generation and use of information about adolescents through research, monitoring and evaluation.
5. Promote and strengthen coordination, collaboration, partnerships and networking among stakeholders that are involved in the support or delivery of adolescent programs and services.
6. Increase awareness, appreciation and respect of young people's needs and rights.
7. Provide information, services and facilitate life skills development for positive behavioural change amongst adolescents and young people.
8. Promote meaningful participation of adolescents/young people in adolescent programmes.

1.9. THE GUIDING PRINCIPLES

This document has been developed on the basis of the following principles:

1. Respect for adolescents rights.
2. Gender responsiveness.
3. Meaningful participation and involvement of adolescents.
4. Parental and community involvement and support.
5. Integrated and sustained delivery of adolescent friendly services
6. Partnerships.

1.10. TARGET GROUPS

The **target groups**, for this strategy will include:

- Ministries that include; MOH, MOPPED, MOGLSD, MOES,MOJCA,MOAFN
- Policy makers and planners
- Donors and Development partners
- Local governments
- NGOs and Civil Society Organisations
- Schools and Training Institutions
- Research Institutions
- Community Leaders
- Cultural and Faith Leaders
- Parents/Guardian and Adolescents
- Peers
- ADH Service providers

Primary Users include:

- Programme implementers

1.11. PRIORITY AREAS AND COMPONENTS

This strategy will focus on the following priority areas:

- Policy and legal framework
- Coordination, networking and partnerships
- School Health
- Adolescent Friendly Services
- Sexual Abuse and gender based violence
- Psychosocial services for Adolescents
- STI/HIV/AIDS and Adolescents
- Harmful traditional/cultural practices
- Advocacy, Research ,Monitoring and Evaluation
- Capacity building for adolescent health programmes and services.

1.12. OUTPUTS

The expected outputs are:

1. Service providers, policy and decision-makers in legal regulatory bodies supported in effecting government laws and policies relevant to the young people.
2. Minimum package for adolescent friendly services and service delivery standards developed.
3. Adolescent-friendly health services integrated in public, NGOs and private service delivery points and other settings.
4. ASRH services for vulnerable adolescents established.
5. Service providers trained on young people's health issues and adolescent friendly service delivery.
6. International conventions on health and development relevant to young people institutionalised in the policy and legal framework of the Government of Uganda. To lobby and advocate for government ratification of all international conventions in support of SRH of the young people.
7. Service delivery points provided with appropriately trained staff and relevant materials for provision of adolescent friendly services.
8. Young people knowledgeable on health and development, gender and SRH rights and equipped with lifeskills/Life Planning Skills for positive behavioural change.
9. Standardized comprehensive curriculum on Lifeskills/Life Planning Skills
10. Institutionalization of young people's participation in program designing, development, implementing, monitoring and evaluation for consistency and effectiveness.

11. Parents/ guardians and Influential community membersequipped with knowledge on adolescenthealth and development issues including interpersonal communication skills to foster healthy development of adolescents.
12. Counsellors equipped with skills to provide psycho-social support to young people.
13. Social marketing initiatives expanded to facilitate young peoples' adoption of safer health practices.
14. Young people equipped with livelihood skills
15. Livelihood initiatives for young people established.
16. Young people capable of soliciting and managing funds for their livelihood initiatives.
17. Standard procedures for effective adolescent health programme management including referral established in various settings at all levels.
18. Mechanisms for resources mobilisation and allocation to sustain and upscale adolescent programmes established.
19. An advocacy programme established to strengthen support for adolescent health and development.
20. A mechanism for formal and informal linkagesestablished between health services and non-health institutions and programmes to address young people's needs holistically.
21. Coordination structures and partnerships established for delivery of ASRH interventions.
22. Data from research, monitoring and evaluation of adolescent programmesutilised for programme improvement
23. An integrated ASRH education formal curricula for primary, secondary and tertiary institutions in place.
24. Alternative vocational skills in the educational curricula and for young people
25. Reduced teenage pregnancies/ abortions
26. Increased Family planning coverage

CHAPTER TWO: STRATEGIC DIRECTIONS

Broadly, the strategies shall include:

1. Advocacy for resources and an enabling environment for adolescent health programs and interventions.
2. Sensitization and mobilization of communities, policy-makers and other stakeholders on adolescent needs and concerns.
3. Involvement and participation of the community with special focus on young people in planning, implementing and monitoring of adolescent health programs
4. Coordination, networking and partnerships for management of adolescent health with an emphasis on sexual reproductive health programs.
5. Capacity building for delivery of quality adolescent health services at all relevant levels.
6. Improvement of access to adolescent-friendly health services with an emphasis on sexual and reproductive health.
7. Supervision, monitoring and evaluation of adolescent health programmes.
8. Research on Adolescent Health
9. Multi-sectoral approach

To achieve objectives of the strategy within the context of its guiding principles, Uganda will implement interventions at various relevant levels.

STRATEGY 1: ADVOCACY FOR RESOURCES AND PROVIDE AN ENABLING ENVIRONMENT FOR ADOLESCENT HEALTH PROGRAMS AND INTERVENTIONS

The main purpose of advocacy will be to influence legislation, policies, programmes and strategies to promote adolescent health and development. Successful advocacy outcomes will include increased allocation of resources, enabling environment and development of supportive policies to achieve programme objectives. Adolescent advocacy programmes will therefore:

- i) Explore options for securing dedicated funding for capital development, recurrent budget and operational funds to support pre- and in-service training, adolescent health programs and interventions. Sources of funds should originate from the central line ministries (Health, Gender, Education, Local Government, Justice, Internal Affairs, Agriculture, Finance), Local Government development partners, NGOs and communities.
- ii) Appropriately package information on adolescent health including SRH to create awareness among various service providers and users of the services including the adolescents, parents/guardians, teachers and families.
- iii) Use different media channels and settings extensively in a well coordinated manner to stimulate the necessary critical consciousness on young peoples' health issues, needs and concerns.
- iv) Influence the legal, medical and socio-economic environment to support and promote adolescent health and development programmes.
- v) Establish a system that addresses the growing concerns of smoking, drug and alcohol abuse among young people

STRATEGY 2: SENSITIZATION AND MOBILIZATION OF ADOLESCENTS, COMMUNITIES, POLICY-MAKERS AND OTHER STAKEHOLDERS ON ADOLESCENT NEEDS AND CONCERNS.

Adolescents are believed to be largely healthy and vibrant however adolescence is characterized by dramatic, physical, psychological and social changes not clearly understood by adolescents and adults. Accompanying this transition is the dilemma they face to adventure and experiment. These circumstances make adolescents vulnerable with regard to making reasonable decisions about their life, values and sexuality. Therefore:

- i) Communities should be educated on the features of normal growth and development, needs and concerns of adolescents/young people in a culturally sensitive manner however, without compromising the health of the young person.
- ii) Policy-makers and programme managers must be empowered with accurate and updated information about the needs and concerns of adolescents so as to enable them design appropriate interventions.
- iii) Schools should implement the school health programmes with an emphasis on water and sanitation, sexual and reproductive health, physical activities, nutrition and ensure participation of adolescents in these programmes.
- iv) Faith and traditional institutions should nurture adolescents/young people within their norms, values and standards taking special consideration not to promote those that might harm the health of adolescents/young people.
- v) NGOs are encouraged to implement adolescent education programmes that are sensitive to community needs and in line with the existing policies and guidelines.

STRATEGY 3: INVOLVEMENT AND PARTICIPATION OF THE COMMUNITY WITH SPECIAL FOCUS ON YOUNG PEOPLE IN PLANNING, IMPLEMENTING AND MONITORING OF ADOLESCENT PROGRAMS FOR BETTER OUTCOMES ON BEHAVIOUR AND COMMUNICATION.

As per the principle of involving the adolescents together with the community stipulated by the International Conventions, community participation will be encouraged during all stages of implementation namely, planning, implementation, monitoring and evaluation.

The main purpose of involving the community in Adolescent Health planning, implementation and monitoring is to increase the understanding of individuals on Adolescent Health as a subject; obtain their inputs for better results in attitudinal change, appreciation of beliefs, values and practices to promote adolescents'/young people's health. Behavioural Communication for Change (BCC) programmes on adolescent health will fall under this strategy and will therefore involve:

- i) Encouraging the participation of adolescents/young people, their families and community in the planning, implementation, monitoring and evaluation of BCC activities.
- ii) Using peer education on the premise that "like influences like"
- iii) Encourage the Village Health Teams (VHTs) to promote the participation of adolescents/young people in all VHT activities
- iv) Using relevant and effective communication channels and resource persons with emphasis on drama, debate, radio, television, music and print media with due consideration of reaching the target audience.
- v) Providing counselling, guidance and training on the development and implementation of programs on life skills to enhance behaviour change among the adolescents/young people.
- vi) Training and equipping service providers with competencies in BCC in order for them to carry out effective interventions.

STRATEGY 4: COORDINATION, NETWORKING AND PARTNERSHIPS FOR MANAGEMENT OF ADOLESCENT HEALTH WITH AN EMPHASIS ON SEXUAL REPRODUCTIVE HEALTH PROGRAMS.

Ministry of Health will take lead in co-ordination of Adolescent Health programs by various stakeholders at all levels through its representative structures in planning, implementation, monitoring and evaluation.

- i) The collaboration and partnerships will be strengthened through the establishment of mechanisms that support the country programs at all levels.
- ii) In its role to improve partnership and collaboration, the MoH will promote effective public-private partnerships through support of operations of partnerships organise regular meetings with the various stakeholders and receive reports on progress.
- iii) Young people in formal and informal organisations, shall be encouraged to participate as stakeholders and be mainstreamed into the coordination mechanisms at all levels to help capture issues of concern to them.
- iv) The Ministry of Health will lead the networking efforts through encouraging information sharing, on-line, through regular meetings and publications.

STRATEGY 5: CAPACITY BUILDING FOR DELIVERY OF QUALITY ADOLESCENT HEALTH SERVICES AT ALL RELEVANT LEVELS.

The provision of adolescent friendly health services is paramount to the demand and utilisation of the services by the young people. It is the desire of the government that capacity is built and the services focused to the needs of young people including those with disabilities and other disadvantaged groups. Capacity building will address:

- i) Availability of qualified service providers including young people for implementation of adolescent health at service delivery points
- ii) Human resources' technical needs for performance improvement,, coordination, management of Adolescent Health programs and resources.
- iii) Availability of, guidelines, relevant tools, equipment and medical supplies for provision of adolescent health services.
- iv) Infrastructural and material needs relevant for service provision

STRATEGY 6: IMPROVEMENT OF ACCESS TO ADOLESCENT-FRIENDLY HEALTH SERVICES WITH AN EMPHASIS ON SEXUAL AND REPRODUCTIVE HEALTH.

In order for adolescents to use the adolescent health services being provided, this strategy will ascertain that services provided are conducive to the young people. The service delivery point(public, private and Private-Non-Profit Facility, Community-based) shall:

- i) Be accessible, affordable, acceptable, attractive, private and confidential to meet the standards of quality health care for adolescents and young people.
- ii) Provide a minimum basic package for adolescent friendly services and ensure equity and quality.
- iii) Have facilities for recreation that will foster physical, emotional and social development of young people that are a requirement to adopting health-promoting behavior in and out of school.
- iv) Consider promoting technologies that are appropriate for age and sex of young people.

STRATEGY 7: RESEARCH ON ADOLESCENT HEALTH

Appropriate research is essential for determining cost-effective interventions and influence policy development for effective programme development and implementation.

- i) Carrying out research/studies on documented barriers to provision of adolescent friendly services: (accessibility, affordability, privacy and confidentiality, staffing including age and skills of service providers; availability of supplies; IEC materials for behavioural change; timing(days and hours of operation); community perception and support.)
- ii) Knowledge, attitudes, values, beliefs and practices) among specific target groups including adolescents/young people, teachers, health workers, parents etc in order to design appropriate interventions.
- iii) Disseminating research/study findings and use them to develop appropriate messages and materials on Adolescent Health.

These will be the priority areas of focus for operational research.

STRATEGY 8: SUPERVISION, MONITORING AND EVALUATION OF ADOLESCENT HEALTH PROGRAMMES

A monitoring and evaluation framework for Adolescent health programmes will be developed using appropriate indicators through a multi-sectoral approach. Data generated will be disaggregated (gender and age-specific) and used for planning, monitoring and programme evaluation. Regular monitoring, results of evaluation and best practices will be used to improve planning and implementation. The monitoring and evaluation programmes shall focus on the following:

- i) Capacity building, networking, coordination mechanisms, partnerships, quality of care, behavioural change, performance as well as resource mobilisation and utilisation.
- ii) The use of Standard guidelines and reporting formats by service providers.
- iii) Participatory monitoring and evaluation of Adolescent Health programmes.

STRATEGY 9: ENSURE A MULTI-SECTORAL APPROACH TO ATTAINMENT OF ADOLESCENT HEALTH FOR ALL ADOLESCENTS AND YOUNG PEOPLE

Young people's health needs cut across different sectors, have multi-dimensional consequences and therefore, call for the involvement of stakeholders. Different sectors based on technical competencies have definite roles and responsibilities in the implementation of Adolescent Health interventions. A multi-sectoral approach for adolescent health will, therefore, require that:

- i) Stakeholder mapping be done
- ii) ADH issues are mainstreamed within stakeholder operation plans
- iii) The role(s) and responsibilities of each stakeholder be clearly spelt out at all levels and sectors and agreed upon.
- iv) Functional steering committees be formed at each level and be facilitated to operate.
- v) There is adherence to the use of standard guidelines and report format(s).
- vi) Capacity is built at all levels to enhance utilisation of information derived from use of standard guidelines, reporting format(s) and other adolescent health related materials.
- vii) A multi-sectoral M&E framework be developed

CHAPTER THREE: INSTITUTIONAL/IMPLEMENTATION FRAMEWORK

COMMITTEES

THE NATIONAL STEERING COMMITTEE ON ADOLESCENT HEALTH

Membership:

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

| | |
|---|---|
| Government Ministries and Departments | Ministry of Health, Ministry of Gender Labour and Social Development, Ministry of Finance, Planning and Economic Development, Ministry of Education & Sports, Ministry of Planning, Ministry of Local Government, Ministry of Justice and Constitutional Affairs and Ministry of Agriculture. |
| Representative of RH, Inter-Agency co-ordination committee IACC (WHO, UNICEF, UNFPA, USAID) | 1 representative |
| Local NGOs | 2 representatives |
| Bilateral development partners | 1 representative |
| National Youth Council for Children | 1 representative |
| Parliamentary Committee on Social services | 1 representative |
| Chairperson Technical | 1 representative |

The Adolescent Health strategy will be implemented using the already existing structures of the line ministries, civil society at national, local government and community levels. These actors will be guided by the existing or developed guidelines.

| | |
|---|-------------------------------------|
| Advisory | |
| Committee on Adolescent Health | 1 representative |
| National Youth Council | 2 representatives (male and female) |
| Faith Based/Inter-religious organizations | 1 representative |
| Private Sector | 1 representative |

Membership shall be forwarded by the respective Ministries and Organisations.

This committee submits annual reports to the director general Ministry of Health.

Meetings

The Steering Committee shall meet at least bi-annually. Quorum shall be constituted by simple majority of membership with at least three sectoral ministries represented.

The Technical Committee for Adolescent Health (TACAH)

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

The Chairperson shall be selected by members and the secretariat shall be in the Ministry of Health (Reproductive Health Division).

Functions

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

- i. Assist the Steering Committee and relevant Ministries to determine, appropriate programmes, tasks and working links among Ministries, districts, agencies, NGOs and institutions working in adolescent health and related fields in the country and also assist to sustain the links so established.
- ii. Suggest, provide and review technical guidelines, which shall assist the Steering Committee and relevant Ministries, institutions and NGOs in carrying out their work efficiently in the field of Adolescent Health.
- iii. Advise the Steering Committee on key and relevant technical matters relating to the implementation of adolescent health and development of related programmes in the country.
- iv. Provide technical assistance to the steering committee towards the achievement of the objectives.

Membership

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

| | |
|------------------------------------|--|
| Ministries: | - Health (Reproductive Health) |
| | -Gender, Labour and Social Development |
| | - Education (School Health) |
| | - Planning (POPSEC - Family Health) |
| | - Local Government (Urban & Rural Health) |
| | -Justice (Law Reform commission) |
| | - Agriculture (Food and nutrition) |
| United Nation Agencies: | - WHO (Focal person for Adolescent Health) |
| | - UNICEF (Programme Officer) |
| | - UNFPA (programme officer) |
| Youth serving NGOs | - 1 representative |
| International NGOs | - 1 representative |
| Research Institutions | - 1 representative |
| Bilateral donors | - 1 representative |
| Youth Network | - 1 representative |
| Professional medical Body | - 1 representative |
| Local Youth Servicing Organisation | - 1 representative |

MEETINGS

The National Technical Committee shall meet at least quarterly and submits bi-annual report to the steering committee.

District Committee on Adolescent Health (DICAH)

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

FUNCTIONS

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

- i. Promotion, co-ordination, monitoring and evaluation of adolescent programmes and activities in the districts
- ii. Advocate for greater appreciation and focus on adolescent health within the district
- iii. Promote co-ordination
- iv. Ensure integration of adolescent health issues in district development plans
- v. Promote collaboration among departments and NGOs engaged in Adolescent Health Programmes and activities in the district
- vi. Initiate and facilitate the formulation and review of district Adolescent Health plans of action.
- vii. Advise the district Local Government on adequate resource mobilization and utilization for Adolescent health activities and monitor their utilization.

- viii. Link district adolescent health activities with national level programmes.
- ix. Compile bi-annual district situational reports on Adolescent health programmes, activities and submit to the national Technical Committee.

Composition

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

- i. The CAO in charge of health shall be the chairperson
- ii. DDHS - Secretariat
- iii. Maximum of 5 Heads of department responsible for Gender issues, Education, Childcare and protection, population and, youth issues. Where any of the officers above is not a member of the Committee they shall be co-opted to the Adolescent Health and Development Committee
- iv. Two members from relevant government NGOs operating in the district in the field of adolescent health
- v. Two youth representatives male and female of age less than 25 years.
- vi. The committee should meet quarterly and submit quarterly/annual report to the

ROLES OF THE MINISTRY OF HEALTH

Ministry of Health will take a lead in ensuring implementation of the strategy and will be responsible for the overall coordination. **In order to execute this important leadership role, the MoH will operationalize the** National steering committee on adolescent health (NASCAH) as enshrined within the adolescent health policy (ADHP)

The Ministry of Health will, therefore, strive to:

- i. Spearhead the overall coordination, networking and creation of partnerships of all stakeholders in Adolescent Health.

- ii. Take lead in initiating programme development in the Technical Advisory Committee on
 - iii. Set norms and standards for minimum package of Adolescent Health Services at all levels.
 - iv. Advocate for commitment from all stakeholders (government, civil society, development partners', community) to young people's health issues.
 - v. Mobilise resources to support implementation of adolescent health programs
 - vi. Develop/review/harmonize standard curriculum and training materials
 - vii. Disseminate materials on adolescent health to all structures and networks at all levels.
 - viii. Organize and conduct training and orientation on Adolescent Health care and services.
 - ix. Establish a management information system within the Ministry that will permit regular collection and provide relevant disaggregated data on young people's health.
 - x. Develop a monitoring and evaluation framework to assess the effectiveness of implementation of the Adolescent Health Policy and programmes.
 - xi. Ensure appropriate research, supervision, monitoring and evaluation to avoid duplication.
 - xii. Ensure multi-sectoral approach to young people's health that reflects commitment and participation of other stakeholders, including those responsible for education, community development, law enforcement, economic planning, technical and vocational skills development.
- i. area of adolescent health.
 - xii. Scale up implementation of Adolescent Health programmes and interventions.

ROLE OF OTHER SECTORS

The strategy provides guidance for other sectors to advocate for and reform legislation and policies affecting education, child labour, human rights and rights relevant to the health and development of adolescents. Each sector will apply relevant policies to support/integrate the national adolescent health strategy within their sector plans. Ultimately, sectors are expected to develop, implement, coordinate, monitor and evaluate youth health and development programs.

Ministry of Gender Labour and Social Development

- i) The Ministry of Gender labor and social development is inter-alia mandated to steer policy development, program design, implementation and coordination for young people's programmes targeting socio-cultural determinants. Specifically, the Ministry should; develop/review, widely disseminate, implement and monitor

policies and laws related to socio-cultural determinants of young people's health and development.

- ii) Mainstream gender issues in adolescent related policies and programs. This includes creation of public awareness on gender issues that affect young people's sexual and reproductive health rights and responsibilities of the community towards young people.
- iii) Build partnerships amongst stakeholders to support the mobilization and involvement of young people for successful implementation of youth health and development programs.
- iv) Support technical and institutional capacity building for effective implementation of adolescent development programmes.
- v) Mobilize and advocate for increased resource allocation for Youth programmes at all levels.
- vi) Establish a management information system that will enable regular data collection on young people and youth related development programmes as well as disseminate reports on the progress of the implementation of these programmes and related laws.
- vii) Initiate and advocate for the development of laws to protect and promote the rights of adolescents.
- viii) Empower communities to support youth programs.
- ix) Advocate for the elimination of social and cultural practices that affect the health of adolescents and violate their rights.
- x) Advocate and provide program technical assistance for the implementation of adolescent development programmes and policies for all adolescents with special consideration to vulnerable children and adolescent/young people.
- xi) Monitor the implementation of labour laws with reference to adolescents in various sectors of the economy and ensure elimination of child labour in collaboration with the Ministry of Justice.
- xii) Through the National Youth Council mobilize and coordinate youth groups and NGOs dealing in adolescent health to provide a forum for young people to express themselves on issues of adolescent health and development.

Ministry of Education and Sports.

The Ministry of Education and Sports' mandate is to facilitate acquisition of knowledge, skills and values for self-reliance and managing/coping with challenges within a family, community and wider society.

- (i) Integrate adolescent health responsive programmes in the school education system with respect to age and sex.

- (ii) Advocate for resource, mobilization and allocation for the school health programmes.
- (iii) Co-ordinate, monitor and evaluate implementation of programmes in schools related to Adolescent Health Policy and strategies, including safety and security in schools.
- (iv) Advocate, coordinate and monitor implementation of programmes for re-admission of adolescent mothers into school systems.
- (v) Foster linkages between children, teachers, parents, health workers and communities for the good health of the adolescents.

Ministry of Finance, Planning and Economic Development

- i) Allocate adequate resources for the implementation of adolescent health programmes.
- ii) Coordinate and monitor utilization of funds allocated to adolescent health and related Programmes.

Ministry of Justice and Constitutional Affairs

- i. Enact laws to protect adolescent health development, rights and needs.
- ii. Amend existing laws and formulate legislative measures designed to be instrumental in: Eradicating all harmful customary practices. Removing restrictions of adolescent development against enjoyment of civil rights such as access to information, education, employment, health services etc.
- iii. Ratify and incorporate international and regional instruments relevant to adolescent health into domestic law.

Ministry of Internal Affairs

- (i) Enforce laws that eliminate practices which affect the health of adolescents and violate their rights in collaboration with the MOGLSD and MOJCA.

Ministry of Agriculture, Animal Industry and Fisheries

- (i) Integrate adolescent health, economic development needs/concerns into agricultural programmes
- (ii) In collaboration with MoH educate young people on the importance of appropriate nutrition.
- (iii) Promote increased production and availability of nutritious foods.

Ministry of Local Government

- (ii) Develop assessment tools for and over see the implementation of adolescent programmes in the district
- (iii) Prioritise and monitor adolescent health and development programs

LOCAL GOVERNMENTS AND AUTHORITIES

The Local Governments and Authorities shall use relevant line departments to execute the following:

- (i) Support networks, expand coverage and scope of adolescent health service delivery through community based distribution and social marketing system offering adolescent services amongst others.
- (ii) Plan, coordinate, implement, monitor and evaluate adolescent health programmes at all levels in the district, including school health programs, hygiene, safety, security, IEC and community-based youth programs.
- (iii) Build capacity to implement adolescent friendly services
- (iv) Provide effective, committed and accountable leadership responsive to adolescent health programmes.
- (v) Mobilization and allocation of adequate gender and age proportionate resources for young people.
- (vi) Advocate for prioritisation of Adolescent health and development programmes.
- (vii) Integrate adolescent programmes in all relevant departments at operational level

DEVELOPMENT PARTNERS

- i) Provide technical and logistical support to the line ministries, institutions, Public, Private and Civil Society organisations implementing adolescent health programmes and activities.
- ii) Support policy dialogue and advocacy for adolescent health and development at national and international levels.
- iii) Co-ordinate development partner technical and logistical support for implementing adolescent health and development programmes.
- iv) Resource mobilisation for Adolescent Health services and programmes.

CIVIL SOCIETY ORGANISATIONS

- (i) Form a national network for promoting Adolescent Health and development.

- (ii) Integrate Adolescent Health concerns within the framework of other ongoing activities.
- (iii) Undertake operational research and disseminate information on Adolescent Health in collaboration with other stakeholders.
- (iv) Advocate for adolescent health development issues at local, national and international levels.
- (v) Mobilise resources for adolescent health programmes

RESEARCH INSTITUTIONS

- i) Carry out research in adolescent health and disseminate findings.
- ii) Provide technical assistance in assessments/surveys/evaluations related to adolescent health programmes.
- iii) Capacity building for research among institutions and with programmes of adolescent health.
- iv) Monitoring and evaluation of programmes related to adolescent health

MEMBERS OF PARLIAMENT

- i) Initiate debate and pass Bills supportive of adolescent health and development programmes
- ii) Advocate for adolescent health policies, programmes and budget allocation
- iii) Community mobilisation for adolescent health services

THE COMMUNITY

- i) Participate in ASRH programmes
- ii) Integrate ASRH into their activities
- iii) Advocate and uphold adolescent Health rights
- iv) Promote positive traditional/cultural practices related to adolescent health

CHAPTER FOUR: IMPLEMENTATION PLAN

| Objective 1: To create an enabling policy, socio-cultural environment and legal framework that promotes the rights and facilitates the implementation of health and development programmes for adolescents. | | | | | | | | | | |
|--|---|----------------|---------------------------|--------------------------|-------------|-------------|-------------|-------------|-------------|--------------|
| Activities | Indicators | Targets | Lead agency | Source of funding | YR 1 | YR 2 | YR 3 | YR 4 | YR 5 | TOTAL |
| Amend existing laws and formulate legislative measures | No. of laws amended/formulated | | MoJCA MPs | | | | | | | |
| Ratify and incorporate international and regional instruments relevant to adolescent health into domestic laws as well as disseminate and implement. | No. of laws domesticated, disseminated, and implemented | | MoJCA DLG | | | | | | | |
| Develop/review, disseminate and implement policies and standards related to young people's health and development | Policy and Standards in place Percentage of districts with ASRH Policy and Standards | 50% | MoGLS D MoH MoLG | | | | | | | |

| Objective 2: Increase resources for adolescent health programmes | | | | | | | | | |
|--|---|-----|---|--|--|--|--|--|--|
| Advocate for resource allocation, mobilisation for adolescent health programmes. | % of agencies with a budget item on ASRH | 50% | MoES MoH MoLG MoFPE D MoGLS D DLG NGOs MPs | | | | | | |
| Set up mechanisms for resource mobilisation for ASRH programmes | A mechanism for resource mobilisation in place. | | MoES MoH MoLG MoFPE D MoGLS D DLG NGOs MPs | | | | | | |

| Objective 3: Increase access to quality adolescent health friendly services and programmes from ...% to ...% by 2015. | | | | | | | | | | |
|---|--|-----|--|--|--|--|--|--|--|--|
| Mobilise and sensitise communities to participate in ASRH service delivery | Percentage of districts with communities sensitised on ASRH | | MoH DLG | | | | | | | |
| Design and implement adolescent health programmes that are sensitive to gender, age, culture and religion. | No. of adolescent health programmes with data desegregated for gender, age, culture and religion No. of ASRH programmes integrating gender, age, culture and religion concerns. | | MoLG MoH MoES MoGLS D Civil society | | | | | | | |
| Equip facilities to provide adolescent-friendly services | Percentage of facilities providing AFHS services | 30% | MoH | | | | | | | |
| Implement integrated ASRH interventions (ANC, FP, STIs/HIV/HPV HCT, PMTCT, Maternity, PNC, Nutrition, EmOC, Newborn care, Counselling, psycho-social support, Referral, mgt of SGBV, alcohol/substance abuse, etc.) | Percentage of service delivery points with integrated ASRH interventions | 30% | MoH DLG NGOs | | | | | | | |

| | | | | | | | | | | | |
|---|---|------------------|-----------------------------------|--|--|--|--|--|--|--|--|
| Support recreation activities in and out of school. | Percentage of districts with recreational activities for adolescents in place | 100% | MoH, MoES MoLG DLG | | | | | | | | |
| Form peer/youth groups/initiatives | % of planned peer/youth groups/initiatives formed | 100% | DLG NGOs MoGLS D MoES | | | | | | | | |
| Set up and support psycho-social services and rehabilitative centres at different levels of health care | Percentage of districts/SDPs with psycho-social and rehabilitative services | 30% | MoH MoES MoGLS D | | | | | | | | |
| Support and implement sanitation programmes and personal hygiene in schools and communities | Proportion of schools with sanitation/personal hygiene programmes % of adolescents with access to water and sanitation facilities. | 100% 100% | MoH DLG MoES MPs | | | | | | | | |

| Objective 4: Promote the generation and use of information about adolescents through research, monitoring and evaluation. | | | | | | | | | | |
|--|---|------------------|---|--|--|--|--|--|--|--|
| 1. Provide relevant desegregated data to all stakeholders. | Desegregated database available Percentage of stakeholders providing /provided with desegregated ASRH data | 60% | MoGLSD MoH MoFPED MoLG DLG Research Institutions | | | | | | | |
| 2. Provide technical assistance in management of desegregated data | No. of institutions receiving TA | | MoFPED MoH | | | | | | | |
| 3. Collect, analyse, interpret, disseminate and utilise desegregated data. | % of institutions with data management systems | 100% | DLG MoFPED MoH MoES MoGLSD MoLG NGOs | | | | | | | |
| 4. Conduct operational research on ASRH to influence policy | % of planned operational research projects conducted % of planned operational research for which findings are put to use | 100% 100% | MoH Research Institutions Academic institutions | | | | | | | |

| | | | | | | | | | | |
|---|--|------|-------------|--|--|--|--|--|--|--|
| Objective 5: Promote and strengthen coordination, collaboration, partnerships and networking among stakeholders that are involved in the support or delivery of adolescent programs and services. | | | | | | | | | | |
| | | | | | | | | | | |
| Co-ordinate planning, implementation and monitoring of ASRH activities with other partners | No. of stakeholders partnering with MoH | | MoH | | | | | | | |
| Co-ordinate facilitation of ASRH activities at all levels | Coordination mechanism on facilitation on ASRH activities in place | | MoH DLG | | | | | | | |
| Advocate, coordinate and monitor implementation of programmes for re-admission of mothers into school systems. | % of adolescent mothers re-admitted in schools. | 30% | MoES | | | | | | | |
| Coordinate ASRH activities by NGOs, private sector and line Ministries within the district | Percentage of districts with coordination mechanisms of ASRH | 100% | DHT | | | | | | | |
| Support activities that promote collaboration and linkages at all levels | % of budgeted funds for collaboration and linkages in ASRH allocated | 100% | MoH DLG. | | | | | | | |

| Objective 6: Increase awareness, appreciation and respect of young people's needs and rights | | | | | | | | | | |
|--|--|----|---|--|--|--|--|--|--|--|
| Mainstreaming programmes to support the development and integration of vulnerable young people | No. of programmes targeting vulnerable adolescents | 2 | MoGLSD MoH | | | | | | | |
| Promote and support adolescent focused initiatives to improve their livelihood skills in various fields. | No. of youth initiatives supported. | 30 | MoAAIF MoFPED MoES Private sector | | | | | | | |
| Support micro-financing of income generating activities for the young people | No. of youth initiatives supported. | 30 | MoFPED Private sector Corporate Banks | | | | | | | |

| Objective 7: Provide information, services and facilitate life skills development for positive behavioural change amongst adolescents and young people | | | | | | | | | | |
|---|---|------|---------------------------------------|--|--|--|--|--|--|--|
| Provide education and counselling in all service delivery points including the community. | % of service delivery points with education and counselling services | 100% | MoH MoES MoGLSD DLG | | | | | | | |
| Support and expand social marketing initiatives to facilitate young peoples' adoption of safer health practices. | No. of social marketing initiatives in place | | MoH MoGLSD Devt Partners | | | | | | | |
| Design, produce and disseminate IEC materials on ASRH | Proportion of service delivery points with ASRH IEC materials | 100% | MoH MoGLSD MoE MoFPED DLG | | | | | | | |
| Formulate and implement BCC activities on ASRH | No. of planned BCC activities implemented | 100% | MoH MoGLSD MoE | | | | | | | |
| | % of ASRH programmes with BCC component | 100% | MoFPED DLG | | | | | | | |
| Create awareness on the humanitarian, economic, social and cultural implications of negative traditional/cultural practices. | Percentage of communities with knowledge of negative traditional/cultural practices | 30% | MoGLSD MoJCA MoES | | | | | | | |

| | | | | | | | | | | |
|--|---|-----|---|--|--|--|--|--|--|--|
| Objective 8: Promote meaningful participation of adolescents/young people in adolescent programmes | | | | | | | | | | |
| Develop/review training curricula and materials | Training Curricula / materials in place | | MoH MoES | | | | | | | |
| Support community initiatives on ASRH | No. of community initiatives supported. | 30 | DLG MoH | | | | | | | |
| Train, monitor and supervise initiatives on ASRH including livelihood skills | Percentage of service providers trained/supervised. | 50% | MoH, MoES MoFPEDD LG MoGLSD NGOs Private sector | | | | | | | |

CHAPTER FIVE:

INDICATORS FOR ADOLESCENT-FRIENDLY SERVICE PROVISION

| | CHARACTERISTIC | INDICATOR | METHOD FOR MEASURING THE INDICATOR | TYPE OF INDICATOR |
|----|---|---|---|--------------------------|
| 1. | Age at first sexual intercourse for girls, boys | Percentage of girls who have had sex intercourse by specific exact age. | | |
| 2. | Contraceptive Prevalence Rate among adolescents (CPR) | Percentage of adolescents using modern contraceptives | | |
| 3. | Adolescent Pregnancy Rate | | | |
| 4. | Adolescent pregnancy among first ANC attendance. | | | |
| 5. | % of births amongst adolescents per 1000 live births. | | | |
| 6. | Abortion rate among adolescents | Proportion of abortions contributed by adolescents | | |
| 7. | % of MMR among adolescents | Proportion of maternal deaths contributed by adolescents | | |

| | CHARACTERISTIC | INDICATOR | METHOD FOR MEASURING THE INDICATOR | TYPE OF INDICATOR |
|-----|---|--|---|--------------------------|
| 8. | Girls to boys ratio for HIV prevalence. | Ratio of girls to boys infected with HIV/AIDS. | | |
| 9. | Proportion of Health facilities providing Adolescent Friendly Health Services (AFHS). | Percent of Health facilities providing Adolescent Friendly Health Services (AFHS). | | |
| 10. | % of parents who openly discuss sexuality with children | Proportion of parents who openly discuss sexuality with children. | | |
| 11. | Proportion of adolescents who have had discussions with parents. | | | |

SERVICE PROVIDER LEVEL

| CHARACTERISTIC | INDICATOR | METHOD FOR MEASURING THE INDICATOR | TYPE OF INDICATOR |
|---|---|---|-------------------|
| Technical competence: Specially trained staff | Proportion of staff who are up to date with current Youth Friendly Services protocols and guidelines. | Health facility survey Technical support supervision | Output indicator |
| | Proportion of health facilities with at least 2 health workers trained on Youth Friendly Services | Technical support supervision Records' review | Process indicator |
| Technical competence: Peer counselors available | Proportion of health facilities with at least 1 health worker providing peer counseling services to the youth | Health facility survey Technical support supervision | Output indicator |
| Positive attitude towards provision of services/ welcoming services | % of young people who felt comfortable/ satisfied with services provided to them at a facility | Exit Interviews with young clients | Outcome indicator |

FACILITY LEVEL

| CHARACTERISTIC | INDICATOR | METHOD FOR MEASURING THE INDICATOR | TYPE OF INDICATOR |
|--|--|--|-------------------|
| Privacy and confidentiality honored. | % of facilities with space set aside to provide health care to the youth. | Health facility survey Technical support supervisory visits | Process indicator |
| Access to services: Convenient hours | % of facilities with specific time set aside for youth clinic | Health facility survey Technical support supervisory visits | Process indicator |
| | Proportion of young people who feel that the waiting time is appropriate | Exit interviews | Outcome indicator |
| | Proportion of young people who feel that the time set aside for service is convenient for them. | Exit interviews | Outcome indicator |
| | Proportion of youth centres with a functional clinic for the youth | Technical support supervision | Output indicator |
| Client satisfaction | Proportion of facilities that registered a youth-specific client increase in the previous quarter | HMIS, Records' review Technical support supervision | Outcome indicator |
| Adequate space and sufficient privacy | Proportion of health facilities with an adolescent health corner | Health facility survey Technical support supervisory visits | Output indicator |
| Supplies & equipment are adequate & appropriate | Proportion of facilities with minimum supplies and Equipment for the range of services appropriate to youth. | Health facility survey Technical support supervisory visits | Input indicator |
| | Proportion of facilities with YFS guidelines | Health facility survey Technical support supervisory visits | Process indicator |
| Sufficient & appropriate IEC materials are available | Proportion of facilities with IEC materials appropriate to young people. | Health facility survey Technical support supervisory visits | Output indicator |
| | Proportion of facilities that provide information and education materials to youth | Health facility survey Technical support supervisory visits | Output indicator |
| | Proportion of facilities that have equipment, supplies and basic services necessary to deliver the essential care package to the youth | Health facility survey Technical support supervisory visits | Input indicator |

SERVICE PROVISION/ PROGRAM IMPLEMENTATION LEVEL

| CHARACTERISTIC | INDICATOR | METHOD FOR MEASURING THE INDICATOR | TYPE OF INDICATOR |
|---|--|--|--------------------------|
| Encourage youth involvement in design, implementation and continuing feedback | Proportion of districts with youth-targeted programs/ activities incorporating youth in the implementation | Technical support supervisory visits, Reports' review | Output indicator |
| | % of adolescents informed about service provision to youth and their rights | Community surveys, Household surveys | Outcome indicator |
| | Percentage attendance by youth at the health facility | Records' review | Outcome indicator |
| Involvement of peer service providers | Proportion of plans in which peer providers participated in the development | Reports' review | Process indicator |
| | Proportion of peer providers who are participating in decision making and planning | Reports review, Minutes review | Process indicator |
| Parent/family/community support | Number of parents participating in ASRH activities and allowing young people to participate | Community surveys, Household surveys | Outcome indicator |
| Display of services and hours of service available | Number of health facilities displaying services offered | Technical support supervisory visits | Output indicator |
| | Numbers of health facilities displaying hours of service | Technical support supervisory visits | Output indicator |
| Display of guidelines and standards, including rights | Number of health facilities with Sexual Reproductive Health Rights displayed | Technical support supervisory visits | Output indicator |
| No overcrowding | Proportion of facilities with sufficient waiting space | Technical support supervisory visits, Health facility survey | Input indicator |

| | | | |
|--|--|---|-------------------|
| Short waiting time for patients/ clients | Average time spent before being attended to | Technical support supervisory visits | Input indicator |
| Affordable services/fees | Proportion of clients who feel the service is within their means. | Community surveys, Household surveys | Outcome indicator |
| | Proportion of young people seeking the service | Records' review | Outcome indicator |
| Publicity that inform and reassure youth | Proportion of community members and young people that are aware of where to access YFS | Community surveys, Household surveys | Output indicator |
| | Proportion of health facilities that have created awareness about YFS offered | Technical support supervisory visits, Health facility survey | Output indicator |
| Wide range of services available | Proportion of facilities that have a minimum required YFS package provided | Technical support supervisory visits, Health facility survey | Output indicator |
| | Proportion of facilities that have a minimum required YFS package being displayed | Technical support supervisory visits | Output indicator |
| Functional referral system/mechanism available | Proportion of facilities with a functional referral system for youth in place | Technical support supervisory visits, Health facility survey | Output indicator |
| Follow-up mechanisms in place | Proportion of clients who were followed up after first contact | Records' review | Output indicator |
| | Proportion of planned technical supervisory visits conducted by the DHT on YFS provision | Reports' review | Output indicator |

| | | | |
|---|---|-------------------------------------|------------------|
| | Proportion of planned outreaches conducted by the DHT on adolescent health service provision | Reports' review | Output indicator |
| Alternative ways to access information, counseling and services | Proportion of districts with alternative approaches to accessing information for youth other than the health sector | Technical support supervisory visit | Output indicator |
| | Proportion of services in the district (health, non-health based) with YFS integrated within. | Technical support supervisory visit | Output indicator |
| | Proportion of districts with alternative approaches to accessing counseling for youth other than the health sector | Technical support supervisory visit | Output indicator |