

Delivering an Integrated Package of Rights

Linking Sexual and Reproductive Health with HIV prevention and Gender Based Violence services

Benefits of SRH/HIV & SGBV integration



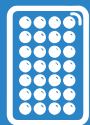
Improves access to and uptake of key HIV/SRH and SGBV services



Reduces HIV-related stigma and discrimination



Promotes better utilization of scarce human resources for health



Supports dual protection against unintended pregnancies and STIs including HIV



Decreases duplication of effort and competition for scarce resources



Improves quality of care



Promotes better understanding and protection of individuals' rights



Enhances programme effectiveness and efficiency



Background: A young population, complex challenges

Linked together in a complex cycle of causes and consequences, sexual and reproductive ill health including HIV/AIDS and Sexual and Gender Based Violence (SGBV) remain major public health concerns for Uganda. With one of the world's highest total fertility rates (TFR) at 5.4, Uganda has one of the youngest and most rapidly growing populations¹. Almost half (48.7%) of the population is under the age of 15 years, and 70% are less than 25 years of age².

As a result, many of the reproductive health challenges the country faces are concentrated among this young age group.

Young people in Uganda are confronted with challenges of high rates of child marriage and other harmful cultural practices such as female genital mutilation. Child marriage is likely to be the cause of more than half of babies born to under 18 years in Uganda, with one in four young girls either pregnant or having given birth by age 19³.

Yet, despite the high rates of pregnancy among adolescent girls, they have a high unmet need for family planning at 30.4%,⁴ meaning that their sexual and reproductive health needs are not being fully met. Among young women aged 15-24, 15% have experienced sexual violence at some point in time⁵.

The high rates of teenage pregnancy and Sexual and Gender based Violence (SGBV) are an indication of the further risk of HIV infection that adolescent girls are faced with. Violence and the threat of violence increases women and girls' vulnerability to HIV by making it difficult to negotiate for equal decision making within relationships.

¹ Uganda Bureau of Statistics (UBOS) and ICF Macro. 2012. Uganda Demographic and Health Survey 2011. Kampala, Uganda, and Calverton, Maryland, USA: Uganda Bureau of Statistics and ICF Macro.

² Uganda Bureau of Statistics (UBOS). Population Projections of Uganda, 2015-2050

³ Uganda Bureau of Statistics (UBOS) and ICF Macro. 2012. Uganda Demographic and Health Survey 2016. Kampala, Uganda, and Calverton, Maryland, USA: Uganda Bureau of Statistics and ICF Macro

⁴ Uganda Bureau of Statistics (UBOS) and ICF Macro. 2012. Uganda Demographic and Health Survey 2016. Kampala, Uganda, and Calverton, Maryland, USA: Uganda Bureau of Statistics and ICF Macro

⁵ Uganda Bureau of Statistics (UBOS) and ICF Macro. 2012. Uganda Demographic and Health Survey 2016. Kampala, Uganda, and Calverton, Maryland, USA: Uganda Bureau of Statistics and ICF Macro.

⁶ Uganda Population-Based HIV Impact Assessment (2016 - 2017)

Even though Uganda has recorded a reduction in the national prevalence of HIV from 7% to 6%, the prevalence is still high among females (7.6%) compared to males (4.7%)⁶.

Between the ages of 15-24 years, HIV prevalence among females is up to three times that of males (0.8% in males compared to 3.3% in females). Among adolescents aged 10-24 years, females take on the largest burden, accounting for over 70% of new infections⁷.

In addition, approximately 90% of the newly identified HIV positive cases in Prevention of Mother to Child Transmission of HIV (PMTCT) sites are from mothers below the age of 24⁸. HIV/ AIDS -related deaths are a significant contributor to Uganda's high maternal mortality rate (336 per 100,000 live births) with young girls aged 15-19 years contributing up to 28% of these deaths.

Pregnant women living with HIV have between a two to 10 times increased risk of death than uninfected pregnant women⁹. Integrating comprehensive HIV services with maternal health services is therefore fundamental to reducing maternal morbidity and mortality.

Quick Facts



5.4 is the total fertility rate (TFR) of Uganda, one of the world's highest total fertility rates.



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7% to 6% Reduction in prevalence of HIV, but is still high among females (7.6%) compared to males (4.7%).



90% of the newly identified HIV positive cases in Prevention of Mother to Child Transmission of HIV are from mothers below the age of 24

Sexual and Reproductive Health, GBV, HIV and the demographic dividend

Uganda's youthful population structure poses a potential for the country to realise a demographic dividend.

The demographic dividend refers to the economic benefit a society enjoys when fertility and mortality decline rapidly and the ratio of working-age adults significantly increases relative to young dependents. Earning the demographic dividend, can however only happen if actions are taken to prioritise investments in human capital to ensure a healthy and well-educated population; accelerate economic growth and job creation to ensure that the "surplus" labour force is gainfully employed and has strong purchasing power; and enforce accountability and efficiency in the use of public resources and delivery of social services.

Investment in the sexual and reproductive health and rights of young people is particularly critical to attainment of the demographic dividend because it can facilitate gains in their health, well-being, and educational attainment. Long-term investments in the health of adolescents and youth, including in their sexual and reproductive health, can help accelerate economic growth when combined with the appropriate investments in education and economic planning. When the sexual and reproductive health needs of young people are adequately met they can better access the information and services they need to stay healthy, avoid unwanted pregnancy and childbearing, prevent and treat sexually transmitted infections including HIV, complete more years of school, and obtain the skills necessary to be economically productive. Access to SRH information, services, and care helps young women exercise their sexual and reproductive rights, stay healthy, and become better prepared to contribute to household finances and ultimately to local and national economies.

Integrating SRHR/HIV and SGBV services

Integration refers to the process of bringing together different types of Sexual and Reproductive Health and Rights (SRHR)/HIV and SGBV interventions or operational programmes to ensure access to comprehensive services in an efficient and effective manner

Integrating Sexual and Reproductive health and Rights and SGBV services can provide a platform for reaching young people and women with HIV prevention, care, and treatment interventions. At the same time, HIV services can provide an effective entry point for key SRHR and SGBV services such as family planning, cervical cancer screening, maternal and management of SGBV.

Evidence demonstrates that integrating comprehensive SRHR/ HIV and SGBV services provides an opportunity to increase access to and uptake of quality HIV and reproductive health services and improve programme efficiencies and effectiveness. Integration therefore provides a platform to address sexual and reproductive health and rights needs of young people in a more comprehensive and efficient manner.



⁷ Uganda Population-Based HIV Impact Assessment, 2016-2017. ICAP/CDC/MOH, 2017.

⁸ The presidential fast track initiative on ending AIDs as a public health threat in Uganda by 2030 – Year 1 report UAC-June 2018

⁹ USAID & Maternal and Child Health Programme: Maternal Mortality and HIV: An Overview. https://www.mchip.net/sites/default/files/Maternal%20Health_HIV%20Brief.pdf

¹⁰ Harnessing the Demographic Dividend. Accelerating socio-economic transformation in Uganda



Integration in Uganda: The journey so far

The national SRHR/HIV and SGBV integration and linkages strategy was developed and endorsed in 2012 to guide integrated programming, and resource mobilization by stakeholders engaged in SRHR/HIV and SGBV programming.

The development of this strategy indicates strong potential for strengthening linkages between SRHR and HIV services in Uganda. These linkages are indicated within the existing policies such as; the Uganda National SRHR Policy, Uganda HIV/AIDS Policy, the National Strategic Plan (NSP) for HIV/AIDS, the Health Sector HIV Strategy among others. Uganda has further signed international and regional legislations and policies that obligate the country to support SRHR/HIV and SGBV services. These policies are providing the frameworks and setting the rules for implementing SRHR-related programmes and services.

In collaboration with the UN, the Government of Uganda has taken significant steps to strengthen integration of SRHR/HIV and SGBV services. Significant progress has been made; HIV programming in Uganda has seen some impressive successes; for example, in making HIV testing and antiretroviral therapy (ART) available, preventing vertical transmission, and rolling out voluntary medical male circumcision. Many of these successes have, however, been delivered through vertical programme interventions. Collaboration between SRHR, HIV and SGBV programming is mainly through planning and coordination of activities rather than the actual implementation. The logistics systems as well as data management and monitoring and evaluation systems are separated for SRHR, HIV and SGBV which is hindering an effective implementation of the integrated services.

Integration models

Kiosk model: Services are fully integrated enabling clients to receive medical attention in one room

Supermarket model: services are partially integrated e.g. in larger clinics/hospitals with several rooms. Clients can be referred to different service points within the facility

Mall (referral) model: Clients are referred to other facilities to access required services.

Specific efforts to promote integration of SRHR/HIV and SGBV in Uganda include:

- Development of the National SRHR/HIV Integration and Linkages Strategy to guide integrated programming and resource mobilization. The strategy highlights opportunities and entry points for SRH/HIV integration
- Establishment of technical platforms to support coordination, promote adherence to standards and facilitate learning, a number under the leadership of the Ministry of Health. These include the Integration Technical Core Team comprising of membership from the AIDS Control Programme and Reproductive Health Units of Ministry of Health and UN agencies (UNFPA, WHO and UNICEF and UNAIDS); National SRHR/HIV Task Team and the National SRHR/HIV Stakeholder's Forum.
- Assessments and studies on integration including the National SRHR/HIV Linkages and Integration Rapid Assessment; a facility assessment on SRHR/HIV integration and an assessment on SRHR/HIV integration in Global Fund programming. Results of these assessments are being used to inform resource mobilization efforts, revision of the national SRHR/HIV Integration and Linkages Strategy and development of standard tools and job aides to support service delivery.

¹¹ Adapted from the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: a Generic Guide, prepared and published by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives, 2009.

¹² UNAIDS and UNFPA (2015) Linking Sexual and Reproductive Health and Rights and HIV in Southern Africa

Despite this, progress integration efforts in Uganda are still beset by some challenges:

Inadequate domestic funding for HIV response. This has resulted in vertically funded HIV prevention programmes with resources specifically targeted towards vertical programming. This poses a challenge to integration at programming and implementation level

- Inefficiencies within the supply chain system which limit effective delivery of both HIV and SRH commodities, with frequent stock outs of commodities experienced across health facilities.
- Inadequate training of health workers and Community Health Extension workers in integrated SRHR/HIV and GBV services delivery
- Socio-cultural barriers including harmful cultural practices and value systems which overlook violence against women and girls.
- At facility level, limited coordination and effort by health workers to offer services beyond what clients seek for at health facilities and inadequate referrals
- General Health systems challenges; the infrastructure for delivery of health services is not well developed thereby compromising privacy and confidentiality for provision of integrated HIV/SRH services.
- Inadequate Human resource to support HIV/AIDS/SRH&R integration. Recruitment and retention is a big challenge especially in the remote areas. The few available staff tend to be overworked, thus posing a risk of compromising quality of care.

Plugging the gaps: Recommendations to strengthen integration

Strengthen provision of packages of integrated interventions for by including efforts to address early and/or unintended pregnancy, unsafe abortion, sexually transmitted infections (STIs), violence against women and girls, and efforts to combat harmful practices such as child marriage and female genital mutilation (FGM).

Scale up of Youth friendly integrated SRH/HIV and GBV services including culturally acceptable and age-specific Comprehensive Sexuality Education for youth both in-school and out-of-school. Undertake systems strengthening for provision of integrated services including trained Health workers and Community health extension Workers.

The Ministry of Health should strengthen coordination and accountability in resource mobilisation and allocation. There should be more efforts towards ensuring resources are mobilised and directed towards the provision of integrated services as opposed to vertical programming;



Scale up proven models and innovations for integrated SRH/HIV and GBV service and information delivery. Empower communities to demand for services. Political, cultural and religious leaders as key gatekeepers within communities can play a key role in Behaviour Change Communication for increased uptake of integrated services as well as promotion of male involvement and involving men and boys in preventing violence against women and girls.

Prioritise human resources for health through recruitment and retention of skilled health workers especially in hard to reach areas. In addition, efforts should be taken to strengthen pre and in-service training to enhance health workers' skills in integrated SRH/HIV service delivery. Undertake capacity assessment at facility level to assess staffing shortages or surpluses to facilitate reallocation of duties and task shifting where recruitment may not be possible.

Strengthen and harmonize the Commodity supply chain system to ensure last mile delivery of commodities for both SRH and HIV services

Strengthen the national monitoring and evaluation system by developing a comprehensive M&E framework, inclusion of more SRHR/HIV and SGBV indicators in the Health Management Information Systems and conducting periodic surveys and operations research.

Conclusion

The evidence highlights the potential benefits effectiveness, and efficiency of SRH-HIV integration and support for integration at the highest policy levels. Concerted efforts are needed to strengthen integrated service provision so that optimal SRHR/HIV and SGBV outcomes are achieved thus contributing to nurturing a healthy and productive young population for Uganda.