Policy and Institutional Frameworks:
Mainstreaming Adolescent Reproductive Health (ARH) and Gender in HIV/AIDS Programs:
Examples from Ethiopia and Uganda

Health, Nutrition, and Population Unit, Human Development Network and AIDS Campaign Team for Africa (ACTafrica)
Policy and Institutional Frameworks:
Mainstreaming Adolescent Reproductive Health (ARH) and Gender in HIV/AIDS Programs: Examples from Ethiopia and Uganda

Front Cover Painting
About the artist:
Mr. Paul Olaja is a 19-year-old AIDS orphan from Uganda. Mr. Olaja passionately shares the stories of his homeland and conveys young people’s aspiration towards life through his artistic works. His paintings are vivid and dynamic, revealing his love of movement, harmony and community.

Policy and Institutional Frameworks:
Mainstreaming Adolescent Reproductive Health (ARH) and Gender in HIV/AIDS Programs: Examples from Ethiopia and Uganda

Haddas Wolde Giorgis
Nilufar Egamberdi

September 2007
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# Acronyms and Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<td>AAYA</td>
<td>Addis Ababa Youth Association</td>
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<tr>
<td>ACP</td>
<td>AIDS Control Program</td>
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<tr>
<td>ADA</td>
<td>Amhara Development Association</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ARH</td>
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<tr>
<td>ART</td>
<td>Anti-Retroviral Treatment</td>
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<td>AWEAPON</td>
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<td>AYRH</td>
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<td>BCC</td>
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<tr>
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<td>Baseline Sentinel Surveillance</td>
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<tr>
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<td>CERTWID</td>
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<td>CORHA</td>
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<tr>
<td>CPR</td>
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<td>CRDA</td>
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<tr>
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<td>Commercial Sex Worker</td>
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<td>Group for the Advancement of Women</td>
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### Policy and Institutional Frameworks:

Mainstreaming Adolescent Reproductive Health (ARH) and Gender in HIV/AIDS Programs: Examples from Ethiopia and Uganda

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<td>Gender Budget Project</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>Gross National Income</td>
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<td>Government of Uganda</td>
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<td>HDI</td>
<td>Human Development Index</td>
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<td>National AIDS Council</td>
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<td>NAPW</td>
<td>National Action Plan on Women</td>
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<td>National Association of Women Organization of Uganda</td>
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<td>NCTPE</td>
<td>National Committee on Traditional Practices of Ethiopia</td>
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<tr>
<td>NEWA</td>
<td>Network of Ethiopian Women Association</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NOP</td>
<td>National Office of Population</td>
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<td>SSA</td>
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<td>Young Men Christian Association</td>
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Acknowledgements

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The draft report was prepared by Haddas Wolde Giorgis. Nilufar Egamberdi prepared the final version of the report under the overall supervision and guidance of the study by Elizabeth Lule. James E. Rosen reviewed the document.
Foreword

The international development community has demonstrated its commitment to intensify and further explore linkages between adolescent reproductive health (ARH), gender and HIV/AIDS through its various program and policy instruments. Key policy statements\(^1\) clearly indicate that linking HIV/AIDS, gender and reproductive health interventions has great potential to control the spread of HIV/AIDS. The Millennium Development Goals (MDGs), 2000 and the World Summit, 2005 also reaffirmed that reproductive health is critical for attaining the MDGs, particularly those pertaining to the health of women and children, prevention of HIV/AIDS, gender equity and poverty eradication. Most recently, UNGASS (the UN General Assembly on AIDS) emphasized the need to strengthen policy and program linkages and coordination between HIV/AIDS, sexual and reproductive health, and national development plans and strategies.\(^2\)

Protecting over one billion young people (adolescents and youth) – those aged 10-24 - from HIV/AIDS - is a global health need and a fundamental human rights issue, especially given that adolescents and youth have been at the centre of the epidemic including high prevalence rates, direct and easy exposure, severity of impact, and various modes of possible transmission. Until recently, this age group has been overlooked in HIV/AIDS interventions. However, international HIV activists, health practitioners and policy makers began to concur that young people represent a great potential for change in the battle against HIV/AIDS in light of newly available evidence suggesting that changing sexual behavior of adolescents and youth through appropriate social influences is critical in tackling HIV/AIDS\(^3\).

Young people make up about 20 percent of the world’s population, yet they represent more than half of the newly HIV infected. Eighty five percent of young people reside in developing countries, where they are hit the hardest by the epidemic - at the estimated rate of nearly 6,000 infections per day. Young people are prone to HIV infection as they seriously lack adequate knowledge about the transmission of and protection from HIV/AIDS while the best available information, education and services are not tailored to their specific needs and interests. Social and cultural identities that encourage early marriage coupled with gender stereotypes (e.g. sexual double standards) and social expectations that allow early sexual relationships highly increase the odds of contracting the virus for young people. Stigma around condoms associated with lack of trust and unwanted sexual experience for women hinders condom distribution programs while social barriers between parents and children seriously hamper communications about safe sex.

This pattern is particularly evident in Sub-Saharan Africa, the region most devastated by the epidemic, where the face of AIDS is predominantly young and increasingly female. The latest UNAIDS estimates mark 10 million young people living with HIV/AIDS worldwide with 6.2 million of them in Sub-Saharan Africa or roughly one in every fourteen young adult with 75 percent of them being female\(^4\). Young women – aged 15-24 – account for 3 out of 4 of all women living with HIV/AIDS in the world\(^5\). In a number of African countries, over 5 percent of girls aged 15-24 are infected while the ratio of male-female HIV prevalence is as high as 1:8.\(^6\)

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\(^2\) Political Declaration on HIV/AIDS, 60/262, UNGASS, 2006

\(^3\) C. Marston and E. King, Factors that Shape Young People’s Sexual Behavior: A Systematic Review, Lancent, 2006

\(^4\) UNAIDS, 2006

\(^5\) Educate Girls, Fight AIDS, The Global Coalition on Women and AIDS, 2005

\(^6\) J. Bruce and E. Chong, The Diverse Universe of Adolescents, and the Girls and Boys Left Behind: A Note on Research, Program and Policy Priorities, Millennium Project, 2006
In the context of the growing HIV epidemic, the vulnerability of African youth and women in particular is directly related to sex, marriage and pregnancies that occur at early age. Ramifications of early exposure to sex which is largely unprotected and often takes place with multiple concurrent and older partners translates into serious health risks, including HIV above all. The susceptibility of this demographic to HIV/AIDS is rooted in a variety of socio-economic, political, institutional and culturally constructed disadvantages that fuel the epidemic. Young African women are also exposed to HIV infection as they tend to have children unintentionally and in large numbers while their family planning and reproductive health needs are mostly unmet. Unplanned pregnancies that lead to serious complications and often death, resulting from unsafe abortions and unattended deliveries are some of the examples of a myriad of problems African young women face today. These issues contribute to significant gender and age inequalities that African women and youth are trapped into and are manifested by continuous social and economic inferiority, exclusion from political representation and decision making processes, and limited access to resources and services.

Establishing and strengthening linkages between ARH and HIV/AIDS programs with consideration for youth and gender at their core is critical to the effectiveness and appropriate targeting of these programs. Mainstreaming these linkages as well as employing multi- and cross-sectoral approaches in programming, planning, implementation, monitoring and reporting of HIV/AIDS programs will help facilitate adequate treatment of such considerations at a policy level. Attention must be given to promoting social arrangements, institutions, laws, policies and customs that can influence the ability of young people to engage in protective behavior. The World Bank has made several efforts to emphasize the centrality of these issues.

In this regard, the Population and Reproductive Health Unit of the Human Development Network of the Bank, expanded its interventions towards policy advocacy and capacity building to mainstream issues of ARH, youth and gender by carrying out this study in Ethiopia and Uganda in 2005. The study aimed to document promising approaches for scaling-up and learning what is working in the region, and to identify existing implementation challenges and gaps that would help define future programs and policies.

Elizabeth Lule
Manager, AIDS Campaign Team Africa (ACTAfrica)
Executive Summary

International HIV activists, health practitioners and policy makers concur that young people represent great potential for change in the battle against HIV/AIDS in light of newly available evidence suggesting that changing sexual behavior of this group through appropriate social influences is critical in tackling the epidemic. Attention has been given to promoting social arrangements, institutions, laws, policies and customs that can influence the ability of young people to engage in protective behavior. A review of the evidence on effective programs for targeting youth pointed to a need for promoting a wide range of interventions linked to intermediate outcomes that would help achieve the global goal of decreasing HIV prevalence among young people. The consensus on the components of scaling-up HIV/AIDS interventions for adolescents and youth include: (a) school, health services-and mass-media-based interventions; (b) geographically defined communities; and (c) young people at risk.

Protecting over one billion young people (adolescents and youth) – those aged 10-24 - from HIV/AIDS - is a global health need and a fundamental human rights issue, especially given that adolescents and youth have been at the centre of the epidemic including high prevalence rates, direct and easy exposure, severity of impact, and various modes of possible transmission. Youth and adolescents who are sexually active face specific reproductive health concerns that, if not addressed, critically increase their exposure to serious health risks, with HIV/AIDS infection above all. At present, almost one third of the estimated 28 million people living with HIV/AIDS worldwide are under age 25 and represent more than half of new HIV infections each year. The devastating impact of HIV/AIDS on young people (6,000 infections daily or 5 every minute) is evident not only through high prevalence rates, especially in Southern Africa, but also through a multiplicity of serious economic, social and human development costs of the epidemic on African nations.

Adolescents (ages 10-19) and youth (ages 15-24) combined comprise a third of the total population in almost all Sub-Saharan Africa. Although only 10 percent of the world’s youth lives in Africa, the continent contains three-quarters of all young people living with HIV/AIDS. Sixty-three percent of 10 million young people (15-24 years) living with HIV/AIDS worldwide today are Africans. HIV infection is generalized among youth in almost half of the African nations. UNAIDS estimated in 2006 that the survival time from HIV infection to death is approximately 8 to 9 years since most of those who died between the ages of 20 and 34 were infected as teens and younger adults. This undoubtedly points to the magnitude of the impact HIV/AIDS has on young people.

In Africa HIV/AIDS remains mainly a sexually transmitted disease with over 85 percent of cases spread through heterosexual contact, casual sex and mother-to-child transmissions. Women and young girls are considered to be of particularly high-risk, unmistakably reflecting the feminization of the epidemic. Around the world, there are 17.3 million women with HIV/AIDS, with three quarters or 13.2 million of them in Africa. Fifty-nine percent of all people living with HIV/AIDS on the continent are women. Young women and girls between 15-24 years of age comprise 76 percent of all young people living with HIV/AIDS in Africa (the total number of young Africans living with HIV/AIDS is 6.2 million). Regional data also indicates wide gender discrepancies regarding the age at which HIV prevalence is the highest. The average peak of HIV prevalence is estimated at 25 among women and 35 to 45 for men or 10 to 15 years later. Furthermore, in Southern African countries, infection peaks at a much earlier age –15 to 19 among girls and 20 to 24 among boys.

A variety of complex issues must be taken into account to understand the susceptibility of young people to HIV/AIDS. Regional data points at a number of issues that predispose adolescents, especially young women, to HIV including the following: (a) biological factors; (b) multiple concurrent sexual relations;

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(c) intergenerational sex; (d) unprotected sex; (e) high-risk behavior; (f) low and inconsistent condom use; (g) early sexual debut, (h) early marriage; (i) unplanned pregnancies; (j) unsafe abortions; (k) poverty as a cause of economic dependence and transactional sex; (l) rape and sexual abuse; (m) armed conflict, war and displacement; (n) lack of information about HIV/AIDS and misconceptions about susceptibility to HIV; (o) perceptions of sexuality and social expectations; (p) lack of negotiating power to use protection; (q) previous history of exposure to STIs and lack of willingness to seek treatment due to stigma and fear of being exposed; and (r) lack of health care services available specifically for youth.

In Ethiopia and Uganda, sexual and reproductive health among youth is a major concern. Many are sexually active at an early age and premarital sex is common especially among 15-19 years olds. According to health experts, problems faced by this group are largely behavior related. As a result, many of them face sexual and reproductive health concerns that affect their health and development. These include STDs and HIV/AIDS, early pregnancy, early marriage and childbirth, maternal mortality, and high infant mortality rates. Young people are also affected by poverty, drug and alcohol abuse, low educational attainment, child sexual abuse, gender violence, human trafficking, war and displacement. In both countries this group demonstrated little knowledge concerning the risk of unprotected sex, making unwanted pregnancies, abortions, STIs and HIV/AIDS and considered these to be unavoidable consequences.

HIV/AIDS prevalence rates among youth and adolescents are high in both Ethiopia and Uganda, making it a disease of young people and women. Young people in Uganda aged 10-24 comprise 33 percent of the total population but nearly 50 percent of the HIV/AIDS cases. Young women are four times as likely to be infected as their male peers. According to the latest estimates for 2005 (UNAIDS, 2006), the HIV prevalence among young Ethiopian women (15-24 years old) was 2.3 compared to 0.8 for young men. The corresponding figures in Uganda show a much higher prevalence rate - 5.7 among young women and 2.6 among young men. However, among those aged 15-19 in Uganda, 2.7 percent are girls compared to only 0.3 percent among boys in this age group. Recently made available data from Uganda demonstrates that the HIV prevalence by age at sexual debut remains high; young girls under 15 years of age account for 11 percent compared to 4 percent among young boys of the same age group.

Best available statistics for Ethiopia and Uganda indicate the ratio of youth (aged 15 to 24 years) to be over 15 percent in both countries reflecting high fertility rates and high adult mortality rates that overall produce a significant population base of youth. According to Demographic and Health Surveys conducted in Ethiopia in 2005 (EHDS, 2005) and Uganda in 2005 (Uganda HIV/AIDS Sero-Behavioral Survey, UHSBS, 2004-2005), adolescents (10-19 years of age) in both countries comprise one-fourth of their populations, with a vast majority (over 80 percent) residing in rural communities. Over 40 percent of Uganda’s population is under the age of 15 while every fourth person in the country is an adolescent (23 percent). About 47.7 percent of the Ethiopian population is under the age of fifteen.

More rural Ethiopian adolescents (60 percent) live with their parents. In this group, nearly one-third of urban girls between 10-14 years of age live with neither parent. Less than half of Ugandan adolescents live with both parents whereby one-third of 10-14 year-olds do not live with either parent; moreover, virtually one in three adolescents has lost one or both parents in Uganda.
In 2001, in both countries the proportion of adolescents (15-19) engaged in early sex or sexual activity before 15 was estimated as high. The highest incidence was reported among Ugandan boys (18 percent) and Ethiopian and Ugandan girls (16 percent) compared to a much lower corresponding figure for Ethiopian boys (8 percent). Nevertheless, a comparison of the available data over time regarding those who have never had sex in this age group in Uganda shows a steady increase from 48 percent in 2000-2001 to 54 percent in 2004-2005 among girls and a slight decrease from 61 percent to 58 percent among boys respectively (UHSBS 2004-2005).

While sexual activity among unmarried girls is unlikely in Ethiopia, in Uganda premarital sex is not condoned. In Ethiopia, ninety-four percent of sexually active girls aged 15-19 are married. By contrast, in Uganda most unmarried teenage girls are sexually experienced with proportions being higher in urban areas than national average (34 percent compared to 29 percent respectively). Analysis of the DHS data for Ethiopia and Uganda on early marriage in both countries demonstrate high ratio of married adolescent girls under 18. Over fifty percent of adolescent girls in Uganda and 49 percent in Ethiopia fall into this group, making the third and fourth highest rates in East and South Africa.

The surveys also revealed that in regards to high-risk sex, including sex with multiple partners, more young men (15-24 years old) than young women reported having sex with 2 and more partners in the last 12 months. Both Ugandan and Ethiopian young girls of 15-19 years of age reported a higher incidence of having sex with multiple partners than those of 20-24 years of age, who also happen to be previously married and those who never married. It was also indicated that urban and rural young girls aged 15-19 are equally likely to engage in sex with a partner more than 10 years her senior. More girls with incomplete education were reported to have relationships with older men.

The available statistics for both countries also point to a high incidence of age-mixing in marriage. High mean of age difference between partners is illustrated through the incidence of polygyny observed in both countries. Discrepancies were reported in regards to the age gap between spouses, reflecting that more Ugandan than Ethiopian girls marry men who are up to 4 years their senior, i.e. 40 percent versus 23 percent respectively. By contrast, slightly more Ethiopian than Ugandan girls marry men who are 5-9 years older than them (47 percent versus 39 percent) and 10-14 years older (19 percent versus 12 percent). Finally, relevant statistics also showed another surprising difference between the countries indicating that the proportion of girls in polygynous unions, in Uganda ages 15-19, is almost 5 times higher than in Ethiopia (28.3 percent versus 4.5 percent respectively).

Early pregnancies in both countries result in complications during delivery and eventual poor health. Such pregnancies are at higher risk of obstetric complications leading to obstructed labor, still birth, postpartum hemorrhage and maternal distress. Adolescent mothers are usually single, poor and uneducated with low rates of antenatal attendance. According to UNICEF and DHS surveys conducted in both countries, the incidence of young women and adolescents having children early and in large numbers is apparent, with Ethiopia topping the list. Ethiopian married girls ages 15-19 who reside in rural areas are more likely to have been pregnant than those living in urban areas. More than half of ever-married girls between ages 15-19, have ever been pregnant. More than forty percent of this group and nearly none of those in unions outside marriage have had a child.

In both Ethiopia and Uganda, unwanted pregnancies among young people are common place. Abortions were illegal in both instances, which in turn make women seek out unsafe procedures. In 2006, the

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16 The World Youth Report, 2003  
17 Ethiopia Demographic and Health Survey, 2000  
18 Reducing Unintended Pregnancy and Unsafe Abortions in Uganda, The Alan Guttmacher Institute, 2005  
19 J. Bruce and S. Clark, 2004  
20 According to the UNICEF, Mozambique shows the highest rates in the sub-region with 56 percent.  
21 Early Marriage: A Harmful Traditional Practice, UNICEF, 2005  
Ministry of Health of Ethiopia issued Guidelines and Procedures for Safe Abortion. According to some estimates, each year 297,000 abortions are performed and nearly 85,000 women are treated for complications.\(^{23}\) In Uganda, unsafe abortion is the leading cause of maternal death. In Ethiopia, unsafe abortion is the second leading cause of death for women of reproductive age, accounting for 33 percent of maternal mortality and causing one-fifth of all hospital admissions.\(^{24}\)

**Human trafficking for labor and sexual exploitation** has been acknowledged as a growing problem in Uganda. For over fifteen years, Uganda has been a source country for women and children trafficked to Sudan as a result of the Lord Resistance Army (LRA) involvement in the abduction of thousands of people forced to work as servants, rebel soldiers and sex slaves.\(^{25}\) Some suggest that at least 20,000 children have been abducted by the LRA with girls and women forced into “marriages” or given to commanders as rewards and incentives.\(^{26}\) Figures on HIV prevalence are unknown, but are assumed to be very high. Data available on the STI prevalence among the escapees indicate over 50 percent.\(^{27}\) There are also indications that the LRA engages in mass rapes and deliberate HIV infection against civilians. Little is known about the magnitude of the risks and HIV prevalence in IDP and refugee camps. There are assumptions that the highest HIV rates are present among these populations, including LRA soldiers and the army. Soldiers, who are mainly young and unmarried, seriously increase the odds of HIV infection and become a vector of contraction and transmission of HIV or other STIs, when they return home after war.\(^{28}\)

Data for 2004-2005 show that contraceptive prevalence (any method) is particularly higher among unmarried sexually active women, and especially among those of 20-24 years of age rating between 60.7 percent in Ethiopia and 69.7 percent in Uganda. Among all married women (15-49 years of age), 14.7 percent of Ethiopian women reported currently using any method compared to slightly higher rate of 19.7 percent of Ugandan women of the same age group. More Ugandan women of 15-19 years of age, including married and non-married, reported using any contraceptive method (12 percent and 19 percent respectively) compared to Ethiopian women of the same age group (8.9 percent and 16 percent).

A number of specific lessons to learn have been drawn from the findings of the study relevant in each country case, including:

- **Lesson 1: Further Analytical Work:** While moving towards the next steps of the global response to HIV/AIDS, it is critical to identify and understand key factors that fuel the epidemic and are attributed to socio-economic, political and cultural factors for a specific country or region.

- **Lesson 2: Targeting those at Risk:** Finding adequate and effective mechanisms to address the issues and targeting the most vulnerable groups and populations must be considered a priority for HIV/AIDS policy design, programming, and implementation.

- **Lesson 3: Linking ARH and Gender in HIV/AIDS Programs:** The centrality of youth and gender issues and linkages between ARH and HIV/AIDS should be among priority items in HIV/AIDS programming within the framework of poverty reduction and MDG achievement as well as country level development frameworks.

\(^{23}\) Singh, International Family Planning Perspectives, 2005
\(^{26}\) S. Berry and R. Noble, Why Uganda is Interesting? [http://www.avert.org/aidsuganda.htm], 2006
\(^{27}\) S. Berry and R. Noble, *Ibid*
\(^{28}\) S. Berry and R. Noble, *Ibid*
Lesson 4: Innovation and Dynamism: The “business-as-usual” and traditional approach of programs and projects may not be enough to cope with the rapid and complex devastation of the epidemic.

Lesson 5: Monitor and Evaluate Use Evidence (Facts): Developing an M&E mechanism that allows effective and timely tracking of the inputs, outputs and outcomes of HIV/AIDS interventions aimed at addressing issues of ARH, youth and gender through indicating changes and impact on young people, women and other groups at risk is vital for combating HIV/AIDS.

Lesson 6: Mainstreaming and Multi-Sectoral Participation: Mainstreaming of gender, ARH and youth in HIV/AIDS programming requires a systemic approach institutionalized with sufficient resources and skills, coupled with strong leadership, commitment and goodwill to bring about the necessary behavioral and attitudinal changes.

Lesson 7: Setting Gender Based Indicators: The inclusion of fast-tracking and target-based indicators and reporting facilitates processes where youth, women and other vulnerable groups that are exposed to HIV/AIDS benefit from the interventions that are targeted to their needs and concerns.

Based on the study findings, some of the recommendations proposed include:

Share of Vision and Direction: Wider dissemination and promotion of policy and institutional frameworks and mechanisms to reach the communities involved.

Community Dialogue: Deepen the community involvement element of the local response to appropriately and systematically include among others, parents, teachers, youth and women groups, and religious and traditional leaders in youth HIV/AIDS programs.

Enforce Legislation: Align legal frameworks and customary practice to ensure the human rights of citizens, particularly vulnerable groups, youth and women.

Intensify Women Empowerment and Male Involvement: Increase participation of young people in policy making, planning, implementation and monitoring and evaluation of national frameworks as well as in all programs and activities.

Strengthen Linkage Between ARH and HIV/AIDS: Adolescent reproductive health (ARH) within HIV/AIDS programming is central when institutionalizing youth and gender issues for long-term, sustainable results.

Mainstream Youth and Gender Issues: The linkage between ARH, gender and HIV/AIDS must be considered in World Bank policy mechanisms, existing national frameworks, including the PRSP, CAS, Mid-Term Financial Review (MTFR), budgeting, sector development programs, and other activities.

Strengthen the Capacity of Communities and Institutions: Local institutions charged with youth, gender, ARH and HIV/AIDS must be strengthened within the context of accelerating the achievement of the relevant MDGs.

Develop M & E to scale up evidence based interventions: Develop a system to track youth-oriented activities by upgrading information systems and working towards consistent reporting across countries. Enhance impact evaluation, including investments in promising yet under-evaluated approaches.
✓ **Documentation and Learning:** Attention must be paid to taking stock and documenting activities that facilitate mainstreaming ARH, gender, youth and HIV/AIDS programs for scaling up and further exploring implementation gaps through participatory dialogue and learning.

✓ **Strengthen Multi-sectoral Linkages of Social Issues:** Review existing policies, strategic frameworks and programs on ARH, gender and youth in HIV/AIDS from a wider development context to increase mainstreaming and multi-sectoral linkages of programs and institutional tools.

✓ **Harmonization:** A mechanism to improve coordination and harmonization of goals, reporting and resources among partners, sectors and all key stakeholders must be developed.
1 Background

This assessment was conducted in Ethiopia and Uganda in 2005 for a number of reasons. The study has been a part of the World Bank’s support to Ethiopia and Uganda, as the low-income countries, in accelerating the achievement of the committed MDGs through scaling-up their battle against HIV/AIDS and facilitating their national poverty reduction strategies. It was also initiated as a part of the Bank’s effort to provide assistance to these countries in: (a) assessing the effectiveness of their policies pertaining adolescents, women and HIV/AIDS, and (b) mainstreaming the linkages between ARH and gender in HIV/AIDS interventions. In addition, Ethiopia and Uganda are among the first group of countries that benefited from the Multi-Country HIV/AIDS Programs (MAP I) of the World Bank in Africa.

Finally, tackling issues of ARH and gender in HIV/AIDS programming is vitally important in the context of both Ethiopia and Uganda considering that youth and adolescents not only comprise over thirty percent of their populations, but also are the most affected by HIV/AIDS with young girls bearing the heaviest burden. According to UNAIDS and UNICEF, in 2005 in both countries, there are at least two infected girls for every infected boy aged 10 to 24 years old. In the age group of 15 to 19 years, the corresponding figures reflect an even more alarming situation where the ratio is five to six HIV infected girls for every single infected boy.

The document is divided into six parts (Part I-VI). Part I covers (a) the study background including objectives, methodologies and activities; and (b) an overview of the HIV situation among young people and adolescents in the Africa region. Part II and III present key findings from Ethiopia and Uganda, including a review of policies and the institutional environment in both countries in regards to gender, youth, ARH and HIV/AIDS. Part IV includes key findings of six country assessments of youth issues in the Multi-Sector Programs on HIV/AIDS of the World Bank. Part V identifies approaches to gender, youth, ARH and HIV/AIDS that are working. Part VI summarizes conclusions and policy recommendations presented as promising approaches, gaps and challenges to policy implementation. The annexes and a bibliography conclude the report.

1.1 Objectives and Methodology

1.1.1 Objectives

The overall objective of this study was to develop the capacity of key policy makers, program managers, partners and stakeholders to better understand the linkages between ARH, gender and HIV/AIDS and to increase the participation of vulnerable groups (young people, adolescents, women, and PLWHA) in HIV/AIDS interventions, as the beneficiaries and key stakeholders in policy and decision making for HIV/AIDS programs.

This study also focused on three MDGs, including: Goal 3: Gender Equality and Women Empowerment, Goal 5: Improving Maternal and Reproductive Health and Goal 6: Combating HIV/AIDS and other Communicable Diseases.

Specific objectives included the following:

- Review policy frameworks, institutional arrangements and identify implementation gaps;

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29 Millennium Development Goals (MDGs) include eight goals to be achieved by 2015 that respond to the world’s main development challenges. MDGs were adopted during the UN Millennium Summit in September 2000.

30 These programs include: Sustainable Development and Poverty Reduction Program (SDPRP) in Ethiopia and Poverty Eradication Action Program (PEAP) in Uganda.

31 Other MDGs include: Goal 1: Eradicate Extreme Poverty; Goal 2: Achieve Universal Primary Education; Goal 4: Reduce Child Labor; Goal 7: Combat HIV/AIDS, Malaria and other Diseases; and Goal 8: Develop a Global Partnership for Development.
✓ Increase the visibility and participation of young people, women, PLWHA and other vulnerable groups in HIV/AIDS programming as partners and key stakeholders;

✓ Identify challenges and implementation gaps, and increase the commitment and collaboration among partners and countries working on ARH, gender and HIV/AIDS programs;

✓ Strengthen the commitment and collaboration among partners and countries working on youth friendly ARH and HIV/AIDS programs;

✓ Document and disseminate gender responsive, youth-friendly successful institutional frameworks for scaling-up (policies, actions, programs, tools, good practices, lessons learned) and identify challenges and implementation gaps, and

✓ Strengthen the commitment and collaboration among partners and countries working on youth friendly ARH and HIV/AIDS programs.

1.1.2 Methodology

This assessment was conducted through the collection, review and analysis of qualitative and quantitative secondary data, as well as in-country stakeholder consultations in both Ethiopia and Uganda. For the purposes of this study, two individual core in-country teams were formed to work jointly with expert consultants and World Bank staff. This exercise aimed to provide information and guidance to local stakeholders, reinforce existing partnerships, and promote local country ownership. The country teams included representatives from national HIV/AIDS councils, population secretariats, line ministries such as those in charge of reproductive health, gender, women and youth affairs, as well as various CSOs/NGOs working on ARH, gender and HIV/AIDS respectively. Participatory methodologies that encourage learning and sharing of knowledge and experiences were employed in the course of this assessment, including: (i) a Desk Review of Key Resource Materials, (ii) Use of Applicable Tools, (iii) Identification of Successful and Promising Approaches, and (iv) Stakeholder Consultations.

(i) Desk Review of Key Resource Materials: This task involved a desk review of policies, frameworks, strategic plans, tools, program reports, and related literature in regards to gender, youth, women and HIV/AIDS in both countries. It aimed to assess the level of existing linkages between ARH, adolescents, women and gender in HIV/AIDS programs. In addition, related policies in education (youth at school), agriculture (youth in rural/agriculture sector), social welfare (out-of school and vulnerable youth and children) and population were also reviewed.

(ii) Use of Applicable Tools: SWOC (Strengths, Weaknesses, Opportunities, and Challenges) analysis, a ranking tool used to identify priority areas and issues in each country and a matrix developed to analyze the degree of integration and a checklist with a set of criteria were to analyze the extent to which the key issues of ARH, gender and HIV/AIDS are integrated with the aim of identifying promising practices and

(iii) Identification of Successful and Promising Approaches: In order to learn what has been working successfully and/or is promising for scaling up policy implementation mechanisms as well as to identify critical challenges and gaps that need priority attention, a set of criteria was agreed upon in both countries as follows:

✓ Effectiveness: degree of response to local issues, concerns and needs designed to bring about positive change,

✓ Linkages/cooperation: with multi-dimensional and multi-sectoral application and outcomes/impact,
Efficiency: cost effective, possible to apply and bring desired outcomes with the given resources and situation,

Transferability: if having clear procedures and steps that are flexible to adopt and can be easily and successfully replicated and/or scaled-up in another situation or setting,

Visionary strategic direction: strong leadership with long term, coordinated and sustainable results, and

Sustainability: if based on locally available resources, community and public ownership and acceptance and support.

(iv) Stakeholder Consultations: This task included a variety of activities such as stakeholder meetings, focus group discussions, facilitated learning sessions and dissemination forums held with key stakeholders at different levels including in-country teams, local policy makers, national actors at highest levels such as ministers and parliamentarians, executives, technical staff, development partners (donors), as well as PLWHA, youth and women from different sectors and communities. The people and organizations contacted are listed in Annex 1. A series of participatory learning sessions and focus groups were organized to foster an understanding of the concept of mainstreaming ARH and gender in HIV/AIDS programs and to agree on country specific issues and priorities. Finally, a number of dissemination forums were organized to enhance the learning process (i.e. personal interaction, videoconference and web-based communications) and to encourage intra-sectoral, cross-sectoral, and country level dialogues.

1.1.3 Why ARH, Youth and Gender are Important in HIV/AIDS Interventions?

1.1.4 Vulnerability of Adolescents and Young People to HIV/AIDS in Africa

Today, youth and adolescents32 - those between the ages of 10 and 24 - comprise more than one billion or one fourth of the world’s population. Adolescents (ages 10-19) and youth (ages 15-24) combined comprise a third of the total population in almost all Sub-Saharan Africa33. According to the UNICEF data, over 40 percent of the continent’s population is under 15 years of age compared to 29 percent of those in the rest of the world. More than half the population is also below the age of 18 (with one in four between 10 and 19)34, thus making Africa demographically one of the youngest regions.

Africa remains to be the region most devastated by HIV in the world. In 2005, there were 24.5 million Africans living with HIV/AIDS, accounting for 64 percent of all people living with HIV/AIDS (UNAIDS, 2006). Also in 2005, an estimated 2.7 million Africans became newly infected and 2 million adults and children died of AIDS. Ten percent of 12 million children and young people under 17 have lost one or both parents to AIDS. Eighty percent or 12.1 million of all those orphaned by AIDS reside on the African continent.

As soon as they become sexually active, youth and adolescents face specific reproductive health concerns that, if not addressed, critically increase their exposure to serious health risks, with HIV/AIDS infection above all. At present, almost one third of the estimated 28 million people living

32 The words “youth” and “adolescents” are used interchangeably in this document and will be specified in a given context. WHO and UNFPA define “adolescents” as aged 10-19, “early adolescents” as aged 10-14, “late adolescents” as aged 15 - 19, “youth” as aged 15 and 24, and young people as youth and adolescents combined (10-25). By contrast, national programs and policies in Ethiopia and Uganda make different distinctions. Youth” are considered to be those aged 15-29 in Ethiopia and those aged 10-30 in Uganda. For the purposes of this assessment, the study group (adolescents and youth also referred to as young people) will include those between 10-25 years of age.

33 For the purposes of this report, hereinafter “Sub-Saharan Africa” will be referred to as “Africa”.

with HIV/AIDS worldwide are under age 25. This age group also bears the burden of more than half of the new HIV infections each year. The devastating impact of HIV/AIDS on young people (6,000 infections daily or 5 every minute) is evident not only in high prevalence rates, especially in Southern Africa, but also through a multiplicity of serious economic, social and human development costs ranging from drastic loss of workforce and decrease of GDP, significantly lower life expectancy at birth, increased poverty as well as the burden of providing for families and caring for the sick; tasks which fall excessively to young women, adolescents and children.

Although only 10 percent of the world’s youth lives in Africa, the continent contains three-quarters of all young people living HIV/AIDS. Sixty-three percent of 10 million young people (15-24 years) living with HIV/AIDS worldwide today are Africans. HIV infection has become generalized among youth in almost half of the African nations. UNAIDS estimated in 2006 that the survival time from HIV infection to death is approximately 8 to 9 years since most of those who died between the ages of 20 and 34 were infected as teens and younger adults. This undoubtedly points to the magnitude of the impact HIV/AIDS has on young people.

In Africa HIV/AIDS remains mainly a sexually transmitted disease with over 85 percent of cases spread through heterosexual contact, casual sex and mother-to-child transmissions. Women and young girls are considered to be of particularly high-risk, unmistakably reflecting the feminization of the epidemic. Around the world, there are 17.3 million women with HIV/AIDS, with three quarters or 13.2 million of them in Africa. Fifty-nine percent of all people living with HIV/AIDS in the continent are women. Young women and girls between 15-24 years of age comprise 76 percent of all young people living with HIV/AIDS in Africa (total number of young Africans living with HIV/AIDS is 6.2 million). There are three HIV-positive females for every male in this group while girls of 15-19 years of age in some countries of the region show HIV prevalence up to six times higher than that of their male peers. In several Southern African countries, more than 30 percent of pregnant women are HIV-positive. Regional data also indicates wide gender discrepancies regarding the age at which HIV prevalence is the highest. The average peak of HIV prevalence is estimated at 25 years of age among women and 35 to 45 years of age for men or 10 to 15 years later. Furthermore, in Southern African countries, infection peaks at a much earlier age for young women – between ages 15 and 19 among girls and 20 to 24 among boys.

Factors that position women at higher risk for HIV/AIDS have been exacerbated by their biological susceptibility coupled with discrimination against women rooted in the socio-economic, cultural and institutional fabric of African societies. Lower economic and political status of women, widespread gender and age prejudice predisposes women’s limited access to health services and care and keeps them out of decision-making processes. Other contributing factors include unprotected sex, multiple concurrent sexual relations, inter-generational sex, early marriage, prostitution, human trafficking and sexual exploitation of young girls and women. African women are particularly prone to HIV infection as they are often forced into unprotected sex that leaves them with no negotiating power for protected sex. Their vulnerability also increases as they are expected by societal pressure to have children at an early age and in large numbers while their family planning and reproductive health needs are unmet. Finally, poverty and gender stereotypes that empower men over women for matters of sex, including

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35 Samuel Mills, 2006. HIV/AIDS Sex Differentials and Prevention Among Young People in Sub-Saharan Africa
36 UNAIDS, Sub-Saharan Africa Fact Sheet, 2006
37 According to UNAIDS and WHO, generalized HIV epidemic is an HIV epidemic in a country in which 5 percent or more of women attending urban antenatal clinics are infected; infection rates among individuals in groups with high-risk behavior are also likely to exceed 5 percent in countries with a generalized HIV epidemic. Concentrated or low HIV epidemic is an HIV epidemic in a country in which 5 percent or more of individuals in groups with high-risk behavior, but less than 5 percent of women attending urban antenatal clinics, are infected. Nascent HIV epidemic is an HIV epidemic in a country in which less than 5 percent of individuals in groups with high-risk behavior are infected.
38 UNAIDS, Global Report on HIV/AIDS 2006
39 UNAIDS, Ibid
sexual attitudes, dominance and safety makes women inferior vis-à-vis men and consequently, places them in tremendous danger of HIV infection.

A variety of complex issues must be taken into account to understand the susceptibility of African adolescents and youth to HIV/AIDS which has steadily increased over the last decade, despite efforts made to arrest the spread of infection among this demographic. Regional data points at a number of issues that predispose adolescents, especially women, to HIV which include: (a) biological factors; (b) multiple concurrent sexual relations; (c) intergenerational sex; (d) unprotected sex; (e) high-risk behavior; (f) low and inconsistent condom use; (g) early sexual debut; (h) early marriage; (i) unplanned pregnancies; (j) unsafe abortions; (k) poverty as a cause of economic dependence and transactional sex; (l) rape and sexual abuse; (m) armed conflict, war and displacement; (n) lack of information about HIV/AIDS and misconceptions about susceptibility to HIV; (o) perceptions of sexuality and social expectations; (p) lack of negotiating power to use protection; (q) lack of health care services available specifically for youth. The section below summarized these factors.

(a) Biological Factors
Research shows that biologically HIV infection as a result of unprotected vaginal intercourse makes girls and young women more likely not only to receive and contract the virus, but to experience a faster progression of the disease, often without their knowledge. The immaturity of young female reproductive organs exposes young girls to the infection considerably faster compared to mature women. Contributing factors include poor hygiene, genital mutilation and complications associated with abortions and early pregnancies.

(b) Multiple Concurrent Sexual Relations
Globally, it is reported that high-risk behavior that facilitates HIV infection among young people includes unprotected sex outside marriage with multiple and concurrent partners. More young men than women are involved in multiple and concurrent sexual relationships. Sporadic sexual experiences that take place among people who do not know each other well, seriously add more risk of HIV transmission. Many young men who are engaged in more than one sexual relationship are less likely to use protection. Young people are more likely to be promiscuous than their elders and practice unsafe sex with multiple partners and thus are more likely to be infected. The contributing factors include lack of information, inability of assessing the risks associated with having sex at early age, peer pressure, impaired judgment due to intoxication, and the inability to refuse unsafe sex. Commonly perceived low susceptibility to HIV also leads to such high-risk sexual behavior including casual sex (often with prostitutes) that typically excludes condom use.

(c) Intergenerational Sex
Social-cultural norms that reinforce gender inequalities and make young women and girls also economically inferior to men allow for age-mixing and sexual networking as a coping strategy for young women and girls. Many young girls have their first sexual experience with older men. Older men are “high risk partners”, as they are more sexually experienced and thus more likely to be infected. In countries where HIV prevalence is high and condom use is low, this situation translates into substantial HIV transmission and high prevalence rates among young girls compared to young boys. Studies show that intergenerational sex that typically involves an age gap of six to ten years seriously hinders the power of young women to resist unsafe sexual practices. Polygamy is also a serious concern in countries where it is common, making young women more likely to contract the virus as

42 Ibid
well as other STIs. Intergenerational sex is linked to the nonuse of condoms and non-discussion of HIV while assertive actions from young women can lead to violence.43

(d) Unprotected Sex

Unprotected sexual activity is a central issue in the transmission of HIV/AIDS among young people and adults alike. Reported high HIV and STI incidence among young people suggests significant unprotected sexual activity. Youth and adolescents all over the world are engaged in unprotected sex for various reasons that are described throughout the sections of this report. Most agree that it is not the sex, but unprotected sex that puts people at high risk of HIV infection44.

In Africa, some surveys revealed that the ratio of unmarried, sexually active females aged 15-19 who use condoms is low, ranging from 2 to 18 percent.45 Among adolescent males, the prevalence of condom use is also much lower compared to adult males46. Similarly, inconsistency of condom use is reported to be very high among both young males and females. For example, some data show that only 20 percent of sexually active adolescents use contraception47.

Adolescents and young people who become sexually active in their teens also have a high partner turnover including casual sex as well as short-term monogamous relationships.48 They are less likely to use protection and are misguided by the assumption of being at “no-risk” because of the healthy-looks and “apparent” safety of a regular partner. However, the cumulative risk of unprotected sex based on such false assumptions of safety is reflected in the high incidence of STIs and unwanted pregnancies among teenagers that further increases their exposure to HIV.

(e) High-Risk Behavior

Young people are more likely to engage in high-risk behavior compared to their elders. Adolescence for many young people is a time when they begin to engage in high-risk behavior that includes sex, but also sometimes involves experimenting with drugs and alcohol. Young people become more vulnerable to HIV when they use alcohol and drugs. Sex under the influence is largely unprotected and casual. Young people also become victims of rape and other forms of violence when alcohol and/or drugs are involved. Given that force is used, condoms are not utilized, thus escalating the possibility of getting HIV infected in addition to other sexually transmitted infections (STIs).

Similar to other regions, in Africa the issue of young bisexual men, also referred to as MSM (men sleeping with men) has become central in the discussion over “viral bridges” of HIV transmission. MSM often continue to have sex with women or resort to bisexual relationships due to the stigma associated with homosexuality. This significantly increases a woman’s risk for HIV infection, particularly given that women are often unaware of the MSM behavior of their partners.

(f) Low and Inconsistent Condom Use

The reasons for inconsistent and low condom use are multiple and vary across countries and demographic groups. Some of those include: economic factors (the high price of condoms make them unaffordable for many); limited access (condoms are not easily obtained in some cases because they are only available in urban centers); cultural misconceptions that create stigma around condoms (e.g. condoms question fidelity, loyalty and trust especially regarding women or may be considered as a sign of carrying a disease); perceived beliefs (e.g. many young people and adults alike believe that being in a

44 The World Youth Report, 2003
46 For example, a study in Burkina Faso showed a 45 percent prevalence rate of condom use among adolescent males compared to 64 percent in adult males (The World Youth Report, 2005)
monogamous relationship grants protection from STIs and HIV and means the end of condom use; or behavioral attitudes (e.g. wanting to have children immediately after getting married excludes condoms altogether or young girls wanting to keep a relationship by getting pregnant). Many young people also dislike condoms because they are perceived to reduce pleasure or to be ineffective.

(g) Early Sexual Debut

Studies clearly point out that in most parts of the world; young people have sex at an early age outside of marriage. Many unmarried girls and boys have their sexual debut before the age of 15, including those in Africa. Early sex typically involves unprotected sex and with high-risk partners (older males and females) or multiple concurrent partners. Some reports on Africa indicate that younger men (15-19 years old) are less likely to use condoms with non-marital, non-cohabiting partners and far more so at a sexual debut.49

(h) Early Marriage

International research on reproductive health shows that every year millions of girls are forced into early marriage before they reach 18 years of age, whether defined as a formal or customary union. In 29 countries studied in Africa in 2005 (UNICEF, 2006), 42 percent of females aged 15 to 24 were married before 1850. The phenomena is a human rights issue and is perpetuated by several driving forces including traditional gender norms, the value placed on virginity, fertility and childbearing, as well as the need to secure social, religious and ethnic affiliations and to provide economic gains. Young married girls are expected to assume the roles of adult women that in addition to domestic duties include frequent, unwanted and unprotected sex and immediate motherhood. Typically, young girls are married as second or third wives, to someone who is much senior to them. They have restricted mobility, poor social connections and low status in the household which in turn traps them into deep economic and social dependency from their husbands and new families, impeding their self development and self-esteem. Poverty is a central factor that reinforces early marriage. It partially explains high presence of early marriages among rural West and Central Africa indicating 56 percent and 43 percent in Eastern and Southern Africa, according to the UNICEF report51. Another factor that is becoming commonplace is associated with the perception of marriage granting protection from HIV.52

There are numerous adverse ramifications of early marriage in the context of the growing HIV epidemic. Emerging evidence shows that marriage not only does not translate into protection from HIV/AIDS, it even becomes dangerous for young girls married to older men who typically fall into a category of “high risk partners”. According to the UNFPA, about 60 to 80 percent of African women are infected by their husbands, their only sexual partners53. Early marriage means an end of condom use (in cases where condoms were ever used), an increase in the frequency of sex, and involvement with a more sexually experienced partner, all leading to a higher risk of STI and HIV transmission.54 Comparisons made between the prevalence rates among young married and unmarried sexually active girls point at significant differences between these groups with much higher HIV rates among the married girls. For example, in surveyed communities of Kenya and Zambia the rates for married girls were respectively 33 and 27 percent compared to 22 and 16 percent of those unmarried. Prevalence

50 However, the incidence of early marriage varied widely between 77 percent of those in Niger, 74 percent in the DRC and 8 percent in South Africa.
51 The corresponding figures for the urban communities showed lower rates of 28 percent in West and Central Africa and 21 percent of early marriages in Eastern and Southern Africa respectively.
53 UNFPA, The State of World Population, 2005
54 J. Bruce and S. Clark, The Implications of Early Marriage for HIV/AIDS Policy, 2004; S.Clark, Early Marriage and HIV Risks in Sub-Saharan Africa, 2004
rates among husbands of young girls also showed much higher rates compared to their unmarried counterparts, i.e. 31 percent versus 12 percent in Kenya\(^5\).

**(i) Unplanned Pregnancies**

Early sex and early marriage are also associated with unwanted pregnancies, unsafe abortions and death among young women and girls partly stemming from their ignorance about the risks involved in being sexually active at a young age. One in every ten births worldwide happens to a teenage mother. Value placed on fertility and children also puts young women at risk of having many children at an early age. In Africa, one in five births is to a female under 20 years of age, placing the region among countries with the highest ratio of childbearing adolescents. The incidence of unwanted pregnancies in this group is very high. Information available for a number of countries shows that from one-third to almost half of the surveyed adolescents in Ghana, Kenya, Zimbabwe, Cote d'Ivoire reported their pregnancies to be unintended\(^6\).

**(j) Unsafe Abortions**

According to some estimates, unsafe abortions contribute to 13 percent of all maternal deaths or 68,000 per year. In Africa, the chances of death related to pregnancy or delivery is as high 1 in 16, reflecting both high incidence of pregnancy and greater risks associated with pregnancy\(^7\). WHO reported that nearly 60 percent of all abortions in Africa are among women of 15-24 years of age. It also estimated that up to 70 percent of African women hospitalized for abortion related complications are among the same age group\(^8\). In some countries (e.g. in Uganda), almost 60 percent of abortion-related deaths reported to be among teenage girls\(^9\).

**(k) Poverty and Transactional Sex**

Poverty is a central issue in the context of HIV/AIDS. The spread of HIV is both its cause and consequence. Poverty is an important contributor to the vulnerability of young people and adolescents especially in Africa. The majority of HIV infected young people in the region and those at risk live in poverty. Adolescent and youth exposure to the virus is extremely exacerbated by the need for survival where economic opportunities, access to education and health services are limited or close to non-existent. As African women and especially young females among them suffer serious gender discrimination over income, property rights, land and financial opportunities (i.e. credit), they are destined to remain economically and socially dependent upon men.

Survival is highly sexualized in Africa, like in many other regions. Left without options, many young people and women among them are engaged in high-risk behaviors including bartering sex for money, shelter or protection that does not involve safe sex. Studies also indicate that young men and boys are being forced into both homo-and heterosexual relations or sex trade for economic survival, which dramatically increases their exposure to HIV. There are also some indications that young men engage in sexual relationships with older women who help them raise the money necessary (e.g. bride’s price) for marriage\(^10\).

In many countries of the region survival is largely associated with prostitution (commercial sex), human trafficking and the bartering of sex. Women and young women in particular comprise the majority of sex workers who serve as a vector of HIV/AIDS transmission. Data show that HIV prevalence among young sex workers is very high in many countries, and more so in Africa\(^11\). In

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\(^{5}\) Child Marriage in the Context of the HIV Epidemic, Population Council, 2005
\(^{7}\) Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals, Millennium Project, 2006
\(^{8}\) WHO, 2005
\(^{9}\) World Youth Report, 2005
\(^{10}\) Mataure P, Men and HIV in Swaziland, , 2000, PANOS, SAfAIDS, UNAIDS
\(^{11}\) A study in Cote d'Ivoire showed as high as 70 percent of adolescent sex workers in Abidjan being HIV positive (UNICEF/UNAIDS, 2002)
several countries, young women lacking income-generating opportunities seek support from men by trading sex. Many also engage in transactional sex for money, goods and/or to advance their social status. Economic hardships, civil unrest and displacement also increase chances of young women, e.g. IPD and refugees to enter into such arrangements. The best available information (ILO, 2005) also indicate that the majority of sexually exploited Africans are young girls who are abducted, tricked or forced into prostitution, sometimes by their parents62.

Other examples of how HIV/AIDS operates in the context of poverty include educational losses that young people bear. Students, who have lost parents to AIDS, drop out because they can no longer afford the tuition, must care for the sick and/or seek income. Furthermore, HIV infected students and orphans are stigmatized and are forced to leave school. An estimated one million African children and youth have lost their teachers to AIDS63.

(I) Rape and Sexual Abuse
Rape and sexual abuse of girls and young women commonly known in many societies drastically increases the odds of contracting STIs and the HIV virus. UNFPA estimates that nearly fifty percent of all sexual assaults worldwide involve girls under 15.64 Young females and males alike, often suffer injuries from forced sex.65 Reports on sexual violence at sexual debut, partner violence, virgin and child rape in many countries of the continent have alarmingly demonstrated the extent of the danger that young girls face in the context of HIV. In the countries of Southern Africa, young girls and children as young as nine months old have been raped by older men fueled by a commonly spread misconception that HIV can be cured by having intercourse with a virgin.66 Evidence also indicates that many young males resort to coerced sex at sexual debut with young female partners, consequently increasing chances for both parties to contract HIV67.

(m) Armed Conflict, War and Displacement
War, civil conflict and displacement significantly increase the magnitude of sexual violence, rape and forced sex, as well as reliance on sex for economic survival. Such situations provide a fertile environment for HIV/AIDS since sex is used as an instrument of war and domination. Studies on conflict in Africa clearly show that the vulnerability of young people to HIV is amplified as they comprise a significant portion of high-risk groups (e.g. sexual workers) in high-risk settings (e.g. IDP and refugee populations, military)68. Sexual exploitation of young people, adolescents and children is heightened by the increasing number of children and youth caught in armed conflicts (child-soldiers) or displacement. Worldwide, women comprise about 80 percent of 35 million refugees and IDPs. International evidence also points to the growing population of orphans and street children, who are also being abused, traded for sex or become dependent on sex for survival69.

Young men caught in war and conflicts are particularly prone to HIV/AIDS owing to the higher risk of sexual abuse, forced military recruitment and prostitution. Some estimates indicate that when STI prevalence is 2 to 5 times higher in the military than in the general population during peacetime, it becomes as much as 50 times higher during armed conflict70. Most soldiers are young, single males who

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62 International Labour Organization, A Global Alliance Against Forced Labour, 2005
64 The State of World Population, UNFPA, 2005
66 Due to common under-reporting of rape and violence against young males, discussions on HIV/AIDS transmission being fueled by sexual violence often exclude male victims.
68 Studies conducted in Cameroon and Kenya revealed that 40 percent of the surveyed adolescent girls reported being raped at their first sexual experience.
69 Gender and Social Assessment Among IDP and Refugee Populations in Great Lakes Region of Africa: the DRC, Tanzania and Uganda, The World Bank, 2005
70 UNAIDS, Ibid
71 World Youth Report, 2005
after war, return to their locations and represent a high-risk group as they become a vector of transmission of STIs and HIV/AIDS to their sexual partners.

(n) Lack of Information About HIV/AIDS and Misconceptions About Susceptibility to HIV

The susceptibility of young people is directly related to the degree of their awareness about HIV/AIDS and the safety of their sexual behavior. Many young people and especially adolescents are not able to fully comprehend the magnitude of their exposure to HIV/AIDS. The majority of young people living with HIV/AIDS do not know about being infected. Numerous studies around the world and those conducted in Africa also indicate that although young people may be aware of the HIV/AIDS epidemic, the knowledge is not universal or adequate, especially in regards to transmission and protection from the virus. Data show that in countries with generalized HIV (e.g. Cameroon, Central African Republic, and Sierra Leone) more than 80 percent of young women aged 15 to 24 do not possess adequate knowledge about HIV. In Somalia, only 26 percent of girls had heard of HIV and only 1 percent knew how to avoid it. Many young people, including women have serious misconceptions about their susceptibility to HIV.

HIV/AIDS awareness does not necessarily translate into a consideration of personal risks and safe sexual behavior. In various instances, young people and adolescents engage in unprotected sex even when they possess knowledge about the dangers of HIV. There are also many young people who are not aware of HIV/AIDS or ways of protecting themselves because they do not have access to reliable and adequate information. Many young people undermine and downplay their HIV risks and mislead themselves with feelings of invincibility vis-à-vis HIV as they do not recognize that the sexual behavior of their partners also puts them in danger of infection.

Social, cultural and religious influences prevent young people and adolescents from obtaining the necessary knowledge to protect themselves. Taboos that prohibit open discussion of sex and sexuality between parents and children, stigma associated with HIV/AIDS and religious considerations that present sex as a sin often seriously hinder youth’s easy access to adequate information.

(o) Perceptions of Masculinity and HIV

A wide body of research on sexuality and gender also indicates how ideas of masculinity and femininity in traditional societies, including those in Africa influence people’s decisions to seek information regarding sex, sexual and reproductive health. Manifestations of traditional perceptions of masculinity that support men to be promiscuous and maintain control over women is often associated with risk-taking sexual behavior (early sex, promiscuity, unprotected sex, domination and violence against women). Norms that emphasize men assuming to be more knowledgeable, aggressive and experienced about sex, self-reliable and having sole power in decision-making over sexual matters, including reproductive health are learned and reinforced in the region. These norms in turn, despite greater power given to men, increase their own vulnerability to HIV.

(p) Lack of Negotiating Power

The lack of negotiating power for women and girls to engage in safe sex is one of the fundamental causes of the gender disparity. Gender inequalities drive the HIV epidemic in Africa and make it difficult for women and young girls to avoid exposure to the virus. Analysis of prevalence and incidence of HIV/AIDS among women and young girls worldwide and in Africa above all, indicate the devastating impact of the infection apparent in the growing disparity between male and female infection rates. Projections suggest that such disparity is expected to grow.

72 UNAIDS, Ibid
73 UNICEF, 2002
74 In Their Own Right: Addressing the Sexual and Reproductive Health Needs of Men Worldwide, The Alan Guttmacher Institute, 2003
75 Gender, Sexuality and HIV/AIDS, International Center for Research on Women, Geeta Gupta, 2000
As mentioned above, gender discrimination is clearly present in matters where condom use is discussed. In the context of Africa, negotiations over condom use initiated by a female represent a special challenge, as it defies the long-accepted gender roles, and raises questions of loyalty, trust and fidelity. Even those women who are aware of the effectiveness of condoms or other forms of protection prefer not to engage in a discussion over condoms for fear of being misunderstood or physically hurt by men. Some women and especially young girls also end up engaging in unprotected sex because they lack skills to negotiate abstinence or condom use or are embarrassed to discuss sex with their partners.

(r) Previous Exposure to STIs and Lack of Willingness to Seek Treatment
International data show that over 100 million of STIs, excluding HIV, infect those under the age of 25. Medical research clearly indicates that STIs drive HIV transmission, especially when they go untreated. The risk of HIV infection increases with the growth of STI episodes. The danger associated with STIs also lies in the rapid spread of the infections without symptoms or disappearance of signs over time, commonly among women. According to the UNICEF data, even after infection is known, many young people do not seek treatment as either they do not feel at risk or services are not available to them. There are gender differences in young people’s willingness to seek information and treatment. Accordingly, younger men do not seek treatment because they cannot afford the costs. Young women and girls fail to treat their infections mainly due to the stigma of being infected and for fear of being exposed.

(s) Lack of Health Care Services for Youth
A number of issues explain the low access to HIV-related health services that young people experience and consequently their exposure to infection intensifies. Lack of resources and adequate infrastructure to deliver the needed services for HIV prevention, care and treatment play a vital role. Other constraints include lack of affordable, private and confidential youth-and teen-friendly services. The stigma around HIV and people living with HIV/AIDS also fuels people’s unwillingness to seek services. African societies, as evident elsewhere, often make it difficult for young people and adolescents to learn about and utilize sexual and reproductive health services, including those services for HIV.

1.2 Overview of Key Issues Pertaining to Young People, ARH, Gender and HIV/AIDS in Ethiopia and Uganda

Sexual and reproductive health among adolescents is a major concern in Ethiopia and Uganda where many adolescents are sexually active at an early age and premarital sex is common among 15-19 years olds. According to health experts, most problems faced by adolescents are behavior related. As a result, adolescents face many sexual and reproductive health problems that affect their health and development. These include STDs and HIV/AIDS, early pregnancy, early marriage and childbirth, maternal mortality, and high infant mortality rates. Adolescents are also affected by poverty, drug and alcohol abuse, low educational attainment, child sexual abuse, human trafficking, war and displacement. Adolescents in both countries demonstrate little knowledge regarding the risk of unprotected sex, making unwanted pregnancies, abortions, STI and HIV/AIDS unavoidable consequences. According to the Demographic and Health Surveys (DHS) for Uganda, in 1995 contraceptive prevalence using any method among the age group of 15-19 was reported to be 7 percent. A decade later, the 2004-2005 data on Uganda (UHSBS, 2004-2005) demonstrated almost no
change by reporting 7.2 percent. However, women of 20-24 years of age reported much higher rate of contraceptive use (both any method and any modern method) at over 18 percent rate.

### Tables 1-2: Proportion of Young People in Ethiopia and Uganda and PLWHA Among Them

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Total Population - 77 million</td>
<td>Total Population – 28 million</td>
</tr>
<tr>
<td>Adolescents (10-14) – 8 million</td>
<td>Adolescents (10-14) – 3 million</td>
</tr>
<tr>
<td>Youth (15-24) – 12 million</td>
<td>Youth (15-24) – 5 million</td>
</tr>
<tr>
<td>Total – 20 million</td>
<td>Total – 8 million</td>
</tr>
<tr>
<td>10-24 year-olds - 32 percent of the total population</td>
<td>10-24 year-olds - 33 percent of the total population</td>
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</table>

**Young PLWHA:**

<table>
<thead>
<tr>
<th>Ethiopia</th>
<th>Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td>620,000 – 15-24 years old females</td>
<td>130,000 – 15-24 years old females</td>
</tr>
<tr>
<td>350,000 – 15-24 years old males</td>
<td>58,000 – 15-24 years old males</td>
</tr>
<tr>
<td>The gender ratio F:M is 1.7:1</td>
<td>The gender ratio F:M is 2.25:1</td>
</tr>
<tr>
<td>Total – 970,000 young males and females</td>
<td>Total - 188,000 males and females</td>
</tr>
</tbody>
</table>

1.2.1 Proportion of Youth and Adolescents

Best available statistics for Ethiopia and Uganda indicate the ratio of youth (aged 15 to 24 years) to be over 30 percent in both countries reflecting high fertility rates and high adult mortality rates that overall produce a significant youth population base. According to DHS Surveys conducted in Ethiopia in 2005 (EHDS, 2005) and Uganda in 2005 (Uganda HIV/AIDS Sero-Behavioral Survey, UHSBS, 2004-2005), adolescents (10-19 years of age) in both countries comprise one-fourth of their populations, with a vast majority (over 80 percent) residing in rural communities. Over 40 percent of Uganda’s population is below the age of 15 while every fourth person in the country is an adolescent (23 percent). About 46.5 percent of the Ethiopian population is below the age of 15.

In Ethiopia, more 15-19 year-olds than those between 10-14 years of age live in urban areas. In Uganda, a slightly greater percentage of boys in the same age group (90 percent) live in rural areas compared to girls (87 percent). Among the 15-19 year-old Ugandans, the ratio was similar (over eighty percent among both girls and boys).

More rural Ethiopian adolescents (60 percent) live with their parents. However, nearly one-third of urban girls between 10-14 years of age live with neither parent. By comparison, less than half of Ugandan adolescents live with both parents whereby one-third of 10-14 year-olds do not live with either parent; moreover virtually one in three adolescents has lost one or both parents in Uganda.

Other studies also indicate that the majority of urban adolescents reside in poor communities (one-third of boys and half of girls) as they migrate from their rural families. For example, a study in the slums of Addis Ababa suggested that many adolescents live alone and are much more vulnerable to various health risks compared to youth native to the city. The former have fewer opportunities to generate income and/or have access to health and educational services. As a result, many young people from the slums accept low-paying, low-status jobs in occupations that are often risky and exploitative, including sex work.

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81 Ethiopia Demographic and Health Survey (EDHS) 2005 and Uganda Demographic and Health Survey, 2001, Population Council, 2001
83 EDHS, 2005, *Ibid*
1.2.2 Incidence of Early Sex

In 2001, in both countries, it was estimated that a high proportion of adolescents aged 15-19 years engaged in early sex or sexual activity before age 15.\(^{87}\) The highest reported incidence was for Ugandan boys (18 percent) and Ethiopian and Ugandan girls (16 percent) compared to a much lower figure for Ethiopian boys (8 percent). In Uganda, half of girls aged 15-19 and nearly four in ten boys have ever had sex. Among 18-19 year-olds, this proportion is 77 percent among girls and 59 percent among boys.\(^{88}\) Comparison of the available data over time regarding those who have never had sex in the age group of 18-19 year-olds in Uganda shows a steady increase from 48 percent in 2000-2001 to 54 percent in 2004-2005 among girls and a slight decrease from 61 percent to 58 percent among boys respectively (UHSBS, 2004-2005).

While sexual activity among unmarried girls is unlikely in Ethiopia, premarital sex is not condoned in Uganda. In Ethiopia, ninety-four percent of sexually active girls aged 15-19 are married.\(^{89}\) By contrast, in Uganda most unmarried teenage girls are sexually experienced with proportions being higher in urban areas than the national average (34 percent compared to 29 percent respectively).\(^{90}\) Nearly 7 in 10 Ugandan adolescents did not use any contraceptive method the first time they had sex. Ugandan data also shows that between 1989-2000-2005 the percentage of 15-24 year-olds who had sex by age 15 remained somewhat the same, indicating a slight decrease for females from 28 percent in 1989 to 18 percent in 2000 and back to 26 percent in 2005. The corresponding figures for males of the same age group indicate an increase, i.e. from 19 percent in 1995 to 25 percent in 2005.\(^{91}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Females</th>
<th>% of Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>28</td>
<td>N/A</td>
</tr>
<tr>
<td>1995</td>
<td>26</td>
<td>19</td>
</tr>
<tr>
<td>2000</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>2005</td>
<td>26</td>
<td>25</td>
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</tbody>
</table>


At the same time, figures on the percentage of 15-24 year-olds Ugandans who have ever had sex show a definite increase with age for both genders, rising from 18-25 percent at the age of 15 to 80-98 percent at the age of 21. These figures are much lower, particularly for young males, in Ethiopia.

<table>
<thead>
<tr>
<th>Age</th>
<th>% of Females</th>
<th>% of Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>16</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>19</td>
<td>80</td>
<td>75</td>
</tr>
<tr>
<td>21</td>
<td>98</td>
<td>80</td>
</tr>
</tbody>
</table>


\(^{87}\) The World Youth Report, 2003  
\(^{88}\) Adolescents in Uganda: Sexual and Reproductive Health, Protecting the Next Generation, 2005  
\(^{89}\) Ethiopia Demographic and Health Survey, 2000  
\(^{90}\) Reducing Unintended Pregnancy and Unsafe Abortions in Uganda, The Alan Guttmacher Institute, 2005  
### 1.2.2.1 Early Marriage

According to an analysis of the DHS data for Ethiopia and Uganda on early marriage, both countries demonstrate a high ratio of married adolescent girls under age 18. Over fifty percent of adolescent girls in Uganda and 49 percent in Ethiopia fall into this group, representing the third and fourth highest rates in East and Southern Africa. According to the latest accounts from UNICEF (2005), over 23 percent of Ethiopian girls and 28 percent of Ugandan girls aged 15-19 are married. They are largely uneducated in Ethiopia (79 percent) compared to 19 percent in Uganda. In addition, married young girls comprise a majority of rural households (between 88 percent in Uganda and 90 percent in Ethiopia). Many in Uganda (64 percent) and almost half (47 percent) in Ethiopia have 1-2 children.

In Ethiopia, the rates of early or child marriage are among the highest in the world. It is estimated that although nationwide only 19 percent of girls aged 15-24 are married before 15, half are married before they reach 18 years old. In some regions of the country, such as Amhara, 42 percent of girls are married before 15 and eighty percent are married before 18. Some studies suggest that over 70 percent of girls in this group experience their sexual debut before their first menstruation. Urban girls between ages of 15-24 are less likely to be married than their rural counterparts – 10 percent versus 27 percent respectively.

Data indicate that in Uganda over fifty percent of young women are married before 18 and three-quarters of them before 20. Only one-quarter of men are married before 20. Regarding the age at first marriage, the corresponding figures (best available at the time of the study) reflect the increase of incidence of marriage before ages 20 and 22 as illustrated in Figures 5a-5b.

#### Table 4b: Percentage of Young People Aged 20-24 Who Have Ever Had Sex, Ethiopia, 2005

<table>
<thead>
<tr>
<th>Age</th>
<th>% of Females</th>
<th>% of Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>21.9</td>
<td>1.7</td>
</tr>
<tr>
<td>18</td>
<td>48.6</td>
<td>14.1</td>
</tr>
<tr>
<td>20</td>
<td>62.3</td>
<td>29.3</td>
</tr>
</tbody>
</table>

Source: Ethiopia DHS, 2005

### Table 5a: Age at First Marriage, Uganda, 2005

<table>
<thead>
<tr>
<th>Age</th>
<th>15</th>
<th>18</th>
<th>20</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>5.3</td>
<td>N/A</td>
<td>70</td>
<td>N/A</td>
</tr>
<tr>
<td>20-24</td>
<td>16.6</td>
<td>51</td>
<td>71</td>
<td>82</td>
</tr>
</tbody>
</table>


### Table 5a: Age at First Marriage, Ethiopia, 2005

<table>
<thead>
<tr>
<th>Age</th>
<th>15</th>
<th>18</th>
<th>20</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>12.7</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>20-24</td>
<td>23.9</td>
<td>49.2</td>
<td>62.4</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: Ethiopia DHS 2005

---

92 J. Bruce and S. Clark, 2004
93 According to the UNICEF, Mozambique shows the highest rates in the sub-region with 56 percent.
94 Early Marriage: A Harmful Traditional Practice: Statistical Exploration, UNICEF, 2005
95 J. Bruce and S.Clark, The Implications of Early Marriage for HIV/AIDS Policy, 2004
96 Annabel Erulkar and Tekle-Ab Mekreb, Reaching Vulnerable Youth in Ethiopia, 2005
1.2.2.2 Sex with Multiple Concurrent Partners, Intergenerational Sex and Polygyny

EDHS 2005 indicated that in Ethiopia most young people of 15-24 years of age fall into a category of never-married, higher-risk sex, including sex with multiple, concurrent partners than in other age groups. However, the reported cases show 0.5 percent of girls in this age group to have 2 and more sexual partners in the last 12 months compared to 4.8 percent of boys in the same group. Such low rates are associated with serious under-reporting among the surveyed young women about their sexual behavior. Consequently, when only between 5.8 percent of women compared to 37.4 percent of men in this group reported that they have ever been engaged in “higher-risk sex,” defined as “having sexual intercourse with a non-marital, non-cohabiting partner in the last 12 months”. Interestingly, among this group the highest incidence of “higher-risk sex” was reported by men of 15-19 years of age with 68 percent rate while only 44 percent of them used a condom at their last high-risk intercourse. EDHS also indicated that more urban men and women than those living in rural areas report a higher prevalence of engaging in high-risk behavior.

Similarly, in Uganda, UHSBS 2004-2005 revealed that in regards to higher-risk sex, including sex with multiple partners, more young men (15-24 years old) than young women reported having sex with 2 and more partners in the last 12 months. About 21 percent of males aged 15-19 and 32.6 percent of those aged 20-24 reported having sex with multiple partners compared to 7.6 percent for 15-19 year old girls and 3.8 percent for those girls aged 20-24 years. As in Ethiopia, Ugandan young girls of 15-19 years reported a higher incidence of having sex with multiple partners than those aged 20-24 years, who also happen to be previously and never married.

Nevertheless, comparisons made within the same gender groups across various age cohorts reveal that a larger number of young men reported engaging in higher-risk sex including 92.3 percent of those aged 15-19 years compared with 63 percent of their older peers (20-24 year olds). Similarly, young women aged 15-19 years reported 45.4 percent compared to a much lower rate of 16 percent among girls aged 20-24 years.

Data on the use of condoms during the last high-risk sexual intercourse did not demonstrate a significant difference across genders in Uganda, indicating only a slightly lower rate of condom use among young girls aged 19-24 years (between 49-55 percent) compared to 50-59 percent of males of the same age cohort. However, the differences appear to be evident among young males. More men in the age group of 20-24 years reported using condoms (59 percent) compared to younger men aged 15-19 years who reported a 50.5 percent rate.

UHSBS, 2004-2005 also indicated that in Uganda urban and rural young girls aged 15-19 are equally likely to engage in sex with a partner who is more than 10 years her senior. More girls with incomplete education were reported to have relationships with older men. By comparison, Ethiopia EDHS 2005 did not provide adequate data on this matter, except for an indication “that less that 1 percent of a small number of women who had engaged in higher-risk sex reported having sex with a man who is ten or more years her senior” (EDHS, 2005).

Nevertheless, the available statistics for both countries reflect a high incidence of age-mixing in regards to marriage. For instance, high mean of age difference between partners is illustrated through the incidence of polygyny observed in both countries. Discrepancies were reported in regards to the age gap between the spouses, indicating that more Ugandan than Ethiopian girls marry men who are up to 4 years their senior, i.e. 40 percent versus 23 percent respectively. By contrast, slightly more Ethiopian than Ugandan girls marry men who are 5-9 years older than them (47 percent versus 39 percent) and 10-14 years older than them (19 versus 12 percent). Relevant statistics also showed another surprising difference between the countries indicating that the proportion of girls in polygynous unions in
Uganda aged 15-19 is almost 5 times higher than in Ethiopia (28.3 percent versus 4.5 percent respectively).97

The UHSBS (2004-05) shows similar, yet slightly lower figures of the ratio of young women in polygynous marriages ranging from 20 percent among those aged 15-19 and 23 percent among those aged 20-24. The EDHS (2005) indicated that 12 percent of all married women are in polygynous unions. The number of women in polygynous unions tends to increase with age in Ethiopia showing a low prevalence rate of 4 percent among those aged 15 – 19 years being in such unions compared to 17 percent of those aged 45-49 years. The report also shows that more uneducated and poor women are likely to be in polygynous unions, with a 13 percent rate among women with no education and a 3 percent rate for women with some secondary and higher education98.

1.2.2.3 Early Pregnancy

Early pregnancies in both countries result in complications during delivery and eventual poor health. Such pregnancies are at higher risk of obstetric complications leading to obstructed labor, still birth, postpartum hemorrhage and maternal distress. Adolescent mothers are usually single, poor and uneducated with low rates of antenatal attendance. According to UNICEF and DHS surveys conducted in both countries, the incidence of young women and adolescents having children early and in large numbers is apparent, with Ethiopia topping the list. Ethiopian married girls ages 15-19 who reside in urban areas are more likely to have been pregnant than those living in the rural areas. More than half of ever-married girls between the ages of 15-19 years have ever been pregnant. More than forty percent of this group and nearly none of those in unions outside marriage have had a child.99

Adolescent pregnancy in Uganda was reported as 43 percent in 2001100. Since 1995, teenage fertility has risen with one third giving birth annually as a result of a low 7 percent contraceptive prevalence rate. The leading cause of inpatient morbidity for adolescents over age 15 is associated with pregnancy and child birth, accounting for 24 percent of admissions. Studies have revealed that there are numerous factors influencing youth sexual behavior, such as the need to experiment, peer influence, lack of guidance and poor role modeling by adults (parents and older siblings).101 According to some accounts, 26 percent of young girls (15-24) and 5 percent of young boys in Uganda have ever had a child. Similar to Ethiopia, among 18-19 year-olds, almost half of women have had a child102.

1.2.2.4 Unsafe Abortions

In both Ethiopia and Uganda, unwanted pregnancies among young people are common place. Abortions were illegal in both instances, which in turn make women seek out unsafe procedures. In 2006 the Ministry of Health of Ethiopia issued Guidelines and Procedures for Safe Abortion. According to some estimates, each year 297,000 abortions are performed and nearly 85,000 women are treated for complications. 103 In Uganda, unsafe abortion is the leading cause of maternal death. In Ethiopia, unsafe abortion is the second leading cause of death for women of reproductive age, accounting for 55 percent of maternal mortality and causing one-fifth of all hospital admissions.104

1.2.2.5 War, Displacement and Trafficking

As a result of the conflict in Northern Uganda, human trafficking for labor and sexual exploitation has been acknowledged as a growing problem in Uganda. For over fifteen years, Uganda has been a source country for women and children trafficked to Sudan as a result of LRA involvement in the abduction of thousands of people forced to work as servants, rebel soldiers and sex slaves.105 Some suggest that

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97 Early Marriage: A Harmful Traditional Practice, UNICEF, 2005
98 EDHS, 2005
102 Adolescents in Uganda: Sexual and Reproductive Health, Protecting the Next Generation, 2005
103 Singh, International Family Planning Perspectives, 2005
at least 20,000 children have been abducted by the LRA with girls and women forced into “marriages” or given to commanders as rewards and incentives.\textsuperscript{106} Figures on HIV prevalence are unknown, but are assumed to be very high. Data available on the STI prevalence among the escapees indicate over 50 percent. There are also indications that the LRA engages in mass rapes and deliberate HIV infection against civilians. Little is known about the magnitude of the risks and HIV prevalence in IDP and refugee camps. There are assumptions that the highest HIV rates are present among these populations, including LRA soldiers and the army. Soldiers, who are mainly young and unmarried, seriously increase the odds of HIV infection and become a vector of contraction and transmission of HIV or other STIs, when they return home after war.

1.2.2.6 Contraceptive Use

In 2000, Contraceptive prevalence rates, including use of condoms, in Ethiopia were reported as low with an average of 8.1 percent (EDHS, 2000). By contrast, in 2005 EDHS showed an increase to 14.1 percent (EDHS, 2005). In 2000, while condom use among non-cohabiting partners was reported at 17 percent for women and 31 percent for men, among cohabiting partners it was 2 percent for women and 20 percent for men. The condom use between spouses both for men and women was even less than a half percent and was probably under-reported (EDHS, 2000)\textsuperscript{107}. Five years later, the EDHS 2005 reported a 5 percent increase in condom use among currently married men.

The 2001 data for Uganda show that among sexually active teenagers, only 19 percent of 15-19 year old females and 42 percent of males currently use any contraception method. Thirty-five percent of sexually experienced females and 44 percent of males have ever used any method. Most recent corresponding data (2004-2005) show the following tendencies among young women in both countries: (a) contraceptive prevalence (any method) is particularly higher among unmarried sexually active women, and especially among those aged 15 – 24 years rating 60.7 percent in Ethiopia and 20 - 24 years 40.0 percent in Uganda (Tables 6a and 6b); (b) among all married women (15-49 years of age), 10.3 percent of Ethiopian women reported currently using any method compared to a slightly higher rate of 16.5 percent for Ugandan women in the same age group.

Table 6a: Contraceptive Use Among Young Women, Uganda, 2005

<table>
<thead>
<tr>
<th></th>
<th>Any Method</th>
<th>Any Modern Method</th>
<th>Pills</th>
<th>Injectable</th>
<th>Male Condom</th>
</tr>
</thead>
<tbody>
<tr>
<td>All women (15-49), among them:</td>
<td>16.5</td>
<td>15.6</td>
<td>2.4</td>
<td>7.7</td>
<td>2</td>
</tr>
<tr>
<td>15-19 year-olds</td>
<td>7.2</td>
<td>6.8</td>
<td>0.9</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>20-24 year-olds</td>
<td>18.6</td>
<td>18</td>
<td>3.2</td>
<td>9.4</td>
<td>2.3</td>
</tr>
<tr>
<td>Currently married women, including:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19 year-olds</td>
<td>12.4</td>
<td>12.1</td>
<td>2.5</td>
<td>5.2</td>
<td>0.9</td>
</tr>
<tr>
<td>20-24 year-olds</td>
<td>19.3</td>
<td>18.8</td>
<td>3.4</td>
<td>10.4</td>
<td>1</td>
</tr>
<tr>
<td>Sexually active unmarried women, including:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19 year-olds</td>
<td>29.7</td>
<td>29</td>
<td>4</td>
<td>5.6</td>
<td>19.3</td>
</tr>
<tr>
<td>20-24 year-olds</td>
<td>40</td>
<td>39</td>
<td>6</td>
<td>18.6</td>
<td>14.6</td>
</tr>
</tbody>
</table>


\textsuperscript{106} S. Berry and R. Noble, Why Uganda is Interesting? \url{http://www.avert.org/iadsuganda.htm}, 2006

\textsuperscript{107} Ethiopia Demographic and Health Survey, 2000, Population Council
Table 6b: Contraceptive Use Among Young Women, Ethiopia, 2005

<table>
<thead>
<tr>
<th></th>
<th>Any Method</th>
<th>Any Modern Method</th>
<th>Pills</th>
<th>Injectables</th>
<th>Male Condom</th>
</tr>
</thead>
<tbody>
<tr>
<td>All women (15-49), among them:</td>
<td>10.3</td>
<td>9.7</td>
<td>2.1</td>
<td>6.8</td>
<td>0.3</td>
</tr>
<tr>
<td>15-19 year-olds</td>
<td>2.5</td>
<td>2.5</td>
<td>0.3</td>
<td>1.8</td>
<td>0.3</td>
</tr>
<tr>
<td>20-24 year-olds</td>
<td>11.4</td>
<td>10.4</td>
<td>2.3</td>
<td>7.3</td>
<td>0.5</td>
</tr>
<tr>
<td>Currently married women, including:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19 year-olds</td>
<td>8.9</td>
<td>8.6</td>
<td>1.3</td>
<td>7</td>
<td>0.3</td>
</tr>
<tr>
<td>20-24 year-olds</td>
<td>16.7</td>
<td>15.4</td>
<td>3.7</td>
<td>11.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Sexually active unmarried women, including:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19 year-olds</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>20-24 year-olds</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>15-24 year-olds</td>
<td>60.7</td>
<td>48.9</td>
<td>4.4</td>
<td>8.4</td>
<td>36.1</td>
</tr>
</tbody>
</table>

Source: Ethiopia DHS, 2005

As data presented in Tables 6a-6b also illustrates, more Ugandan young women aged 15-19 and 20-24, including those married and non-married, have higher rates of using any contraceptive method compared to Ethiopian women in the same age groups. EDHS 2005 did not provide specifics for unmarried women of 15-19 and 20-24 years, which would have provided a more accurate cross-country comparison.

1.2.3 Reproductive Health Indicators

In Ethiopia, the rapid population growth of 2.4 percent per annum has not matched with the slow economic growth of the country where about 80 percent of the population has an income of less than 2 USD a day (UNAIDS, 2006). Poor provision of social services, including inadequate access to reproductive health services compounded by the inherent gender-based discrimination and violence, are weakening efforts to combat HIV/AIDS. STI/HIV surveillance and VCT sites are few and close to non-existent, especially in rural Ethiopia. As of 2005, the country’s maternal mortality rate was estimated at 850/100,000 live births. Infant mortality is 97/1,000 live births while the under 5 mortality rate is 172/1,000. The total fertility rate for Ethiopia has only slightly declined in the past decade, from 6.4 percent in 1990 to 5.4 percent in 2005 (EDHS, 2005). The number of births among young women aged 15-24 is 89/1,000.

In Uganda, gains being made in the fight against HIV/AIDS are not apparent in related reproductive health indicators. The data suggests that the major reproductive health indicator - maternal mortality rates - have remained stagnant and even deteriorated. Despite the high rates of antenatal clinic attendance, institutional deliveries have been declining, from 35 percent in 1995 to 25 percent in 1999/2000; 22.6 percent in 2000/2001; 19 percent in 2001/2002 and 20 percent in 2002/2004. Infant mortality has remained high and constant in the last 15 years, currently standing at 88/1,000 live births. Under age 5 mortality rate stood at 152/1,000 live births in 2001 with 80 percent of it impacting 20 percent of the poorest (UDHS, 2001). In the last ten years, the total fertility rate has slightly increased from 6.9 in 1995 to 7.10 in 2005. The number of births among young women aged 15-24 is 207/1,000.

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108 HSSP 2003; MoFPED 2003; UDHS 2001/02
1.2.4 General HIV/AIDS Situation in Ethiopia and Uganda

Table 7: HIV Prevalence in Eastern Africa, 2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Ethiopia</th>
<th>Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997-1998</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>1999-2000</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>2003-2004</td>
<td>12</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: The World Bank, 2006\textsuperscript{109}

Ethiopia, a country of 77.4 million people (2005), had its first cases in 1984. The HIV epidemic has become generalized, among the highest rates next to South Africa and Nigeria and is among the top twenty countries in the world. In 2000, there were 2.6 million people infected by HIV. According to the MoH, the national adult HIV prevalence rate was estimated at 6.6 percent including 13.7 percent in urban areas (15.6 percent in Addis Ababa) and 3.7 percent in rural areas\textsuperscript{110}. Recent estimates indicate the prevalence rate among ages 15-49 up to 3.8 percent for men and 5 percent for women, showing a decline in urban areas (UNAIDS, 2006). Women (aged 15 and above) comprise nearly sixty percent (up to 730,000 persons) of the total number of adults and children with HIV/AIDS estimated at over one million (up to 1,300,000) persons.

Although HIV/AIDS prevalence is reported to have been on the slight decline - from 8.6 percent in 2000 to 6.4 percent in 2004 (Figure 1), yet some studies indicate that the number of AIDS related deaths is on the rise. Life expectancy at birth has dropped from 46 in 1995 to 42 in 2002 (WHO, 2005). The EDHS, 2005 reported HIV/AIDS prevalence for those between the ages of 15 - 49 years as 1.9 percent among women and 0.9 percent among men, with a total of 1.4 percent. In the EDHS, 2005, data on age patterns confirm that young women remain more vulnerable to the epidemic than young men. Between the ages of 15 – 19, 0.7 percent of women and 0.1 percent of men are infected. Between the ages of 20 -24 years, women are infected three times more than men of the same age, reporting 1.7 percent of prevalence versus 0.4 percent respectively. The data indicates that HIV prevalence among men peaks between the ages of 30 -35 years.

![Figure 1: Estimated HIV/AIDS Prevalence in Ethiopia (1984-2004)](source)

A decline in HIV prevalence has been recorded for women aged 15-24 years from 23.7 percent in 1995 to 11.3 percent in 2003. However, some argue that poor and inconsistent data collection has resulted

\textsuperscript{109} D. Wilson, \textit{Ibid.}

\textsuperscript{110} Evaluation of the World Bank’s Assistance in Responding to the AIDS Epidemic: Ethiopia Case Study, The World Bank, OED, 2005
in a wide range of prevalence rates from as low as 3.8 by UNAIDS and the Ministry of Health to as high as 10 and 18 percent by the National Intelligence Council. Overall, studies suggest that the diffusion of the HIV epidemic in Ethiopia is geographically heterogeneous (rural-urban divide) and is fueled by poverty, socio-cultural and religious practices and a relatively highly mobile population (in and out migration). The epidemic is considered “mature” in urban areas while its course is not well-known in the rural areas. The EDHS 2005 indicated that urban residents have a higher risk of HIV/AIDS infection with a prevalence of 5.5 percent and 0.7 percent for rural areas. Most disturbing is that HIV infection levels increase directly with education among both women and men and was higher for those with a secondary and higher education.

Uganda, a country of 28.8 million people, is commonly cited as the HIV/AIDS success story due to the country’s political leadership, community involvement and unique communication processes. Since its first identification in 1982 in the Rakai region, Uganda has been one of the first countries in Africa that has successfully reversed the spread of HIV/AIDS and is considered to have achieved the MDG target of Goal 6. Through openness and massive campaigns from the top leadership to the bottom, Uganda has managed to reduce its HIV/AIDS prevalence among those aged 15-45 years from 18 percent in 1992 down to 7.6 percent (UNAIDS, 2006). The prevalence rate among women (15-45) is 4.9 compared to 3.7 among men in the same age group. Nevertheless, the impact of HIV/AIDS on women remains disproportionately high. The latest available data demonstrates the number of Ugandan adults and children living with HIV/AIDS to be around 1.2 million where women share most of the burden (730,000 women aged 15 and over).

In the late 1980s and early 1990s, condom use became more common among unmarried sexually active men and women as condom promotion and distribution in Uganda increased dramatically. It is understood that this has helped to suppress the number of new infections over the last few years. On the other hand, a recent decline in condom use was reported in 2005. A shift from prevention to abstinence and faithfulness may have contributed towards the slow decline in the prevalence of the epidemic.

1.2.5 HIV/AIDS Prevalence Among Young People and Adolescents in Ethiopia and Uganda

Correspondingly to most of Africa region, HIV/AIDS prevalence rates in youth and adolescents are high in both Ethiopia and Uganda making it a disease of young people and women. Young people in Uganda aged 10-24 comprise 33 percent of the total population, but nearly 50 percent of the HIV/AIDS cases. Young women are four times as likely to be infected as their male peers.

According to the UNAIDS latest estimates for 2005 (UNAIDS, 2006), the HIV prevalence among young Ethiopian women (15-24 years old) was 2.3 compared to 0.8 of that in young men while the corresponding figures in Uganda show a much higher prevalence rate - 5.7 among young women and 2.6 among young men. However, among those aged 15-19 in Uganda there are 2.7 percent of girls compared to only 0.3 percent among boys in this age group. The recent studies reconfirm that HIV prevalence rises with age. For example, in Uganda the increase has been reported to be from under 2 percent for females and under 1 percent for males at the age of 15 to 8 percent at the age of 21 and 23 among females and up to 4 percent for males of the same age group.

112 D. Wilson, Ibid
113 Goal 6 of the MDGs includes: Combating HIV/AIDS and other Communicable Diseases
114 However, recent data suggest that the HIV prevalence is on rise among adults
115 HIV and AIDS in Uganda, AVERT, International AIDS Charity, 2006
116 Adolescents in Uganda: Sexual and Reproductive Health, The Alan Guttmacher Institute, 2005
Additionally, the HIV prevalence rate among pregnant women in urban areas is even higher, especially in Ethiopia with a 11.5 prevalence rate indicated in 2005. In Uganda, the prevalence rate among pregnant women is reported to be much lower and almost the same as the national rate (5.2 percent compared to 5.7 percent respectively). Overall, both countries demonstrated a decline in these rates from 15 percent in 2000 to 11.5 percent in 2005 in Ethiopia and from 8.5 percent in 2000 to 5.2 in 2005 in Uganda (UNAIDS, 2006). Recently made available data from Uganda\textsuperscript{\textsuperscript{119}} demonstrates that the HIV prevalence by age at sexual debut remains high among young girls under 15 years of age accounting for 11 percent compared to 4 percent among young boys of the same age group. However, these rates decrease with age for females with HIV prevalence at sexual debut dropping to 5 percent at the age of 20.

\subsection*{1.2.6 Policy and Institutional Frameworks in HIV/AIDS Programming}

A review of policy and institutional mechanisms is fundamental for effective programming as well as for mobilizing resources. A human rights-based approach to programming and resource mobilization is also gaining popularity. Members of the international community, both in Ethiopia and Uganda have endorsed several international instruments, and thus have been developing in-country policies and implementation tools to fulfill their global commitments as agreed upon in various forums.

This study reviewed specific national policies related to HIV/AIDS, gender and women, youth sexual and reproductive health and other related information in Ethiopia and Uganda. These policies emanated from various international instruments and conferences where Ethiopia and Uganda have also adopted them as members of the United Nations and in some cases being a signatory party. The following international conventions are relevant for this study:

* The World Summit for Children (Children Summit), New York; 1990;
* International Conference on Population and Development, (ICPD), Cairo, 1994\textsuperscript{\textsuperscript{120}};
* Forth World Conference on Women: Action for Equality, Development and Peace, Beijing, 1995;
* World Summit for Social Development, Copenhagen, 1995;
* World Food Summit, Rome, 1996, and
* Millennium Summit, New York, 2000

International policy instruments relevant to HIV/AIDS, ARH, and Gender complementing the development of national policies include:

* The Universal Declaration of Human Rights adopted on December 10, 1949,
* The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), 1979;

\textsuperscript{119} UHSBS, 2004-2005, \textit{Ibid}

\textsuperscript{120} There are also Five and Ten-Years Reviews of ICPD (1999, 2004)
The International Convention on the Elimination of Racial Discrimination (ICERD), 1966;
The African Charter on Human and Peoples' Rights (1986);
The African Charter on Human and People’s Rights on the Rights of Women in Africa (2003),

The United Nations recognition of the vital role young women and men play and contribute to the
development of society initiated various communiqués, including:

✓ The Declaration on the Promotion among Youth of the Ideals of Peace, Mutual Respect and
Understanding between People (1965);
✓ The International Youth Year (1985) and endorsement of the Guidelines for Youth Planning
and Suitable Follow-up;
✓ The Tenth Anniversary of the International Youth Year and World Programme of Action for
Youth to the Year 2000 and beyond (1995); and

Policies which are particular to women and being used for setting international and national framework
for gender equality, youth and adolescent reproductive health (ARH) are:

✓ Program for Action on International Conference on Population and Development
(ICPD), 1994;
✓ The Nairobi Forward Looking Strategy of 1985,
✓ The Beijing Platform for Action of 1995 and their periodic reviews;
✓ Social Summit of Copenhagen of 1995,
✓ The Millennium Development Goals (MDGs) of 2000,
✓ The African Charter on Human and Peoples’ Rights and the Rights of Women in Africa
(2003), and
✓ The Solemn Declaration on Gender Equality in Africa (SDGEA) of July 2004.

These documents have been effective instruments in guiding public policies, programs and actions at
country levels. This study was carried out to review policy and institutional mechanisms to ensure that
the global commitments and national policies are addressing HIV/AIDS within the context of
adolescent reproductive health and gender.
2 Key Findings from the Ethiopia Report

2.1 Youth, Gender, ARH and HIV/AIDS in Ethiopia

The young people are vigilant and crying for help to fight the HIV pandemic. If we do not reach out and give them our supporting hands, this generation will never forgive us." An Ethiopian MP, Social Sector Standing Committee.

Young people in Ethiopia – those aged 15 to 24 years comprise 27.9 percent or one-third of the country’s population (EDHS, 2005) while adolescents and youth combined (ages 10 to 24) represent 40 percent of the total population in 2003 (Figure 2) and increased to 42.4 percent (EDHS, 2005).

![Figure 2: Age Pyramid, Ethiopia, 2003](image)

Source: U.S Census Bureau, International Database, 2003

Of the total births, 45 percent occur among adolescent girls and young women. The maternal mortality rate is 871 per 100,000 life births. The median age at which women of 25 to 49 years of age first have sex is 16 years. Three in ten women in this age group have had sex by age 15, two by age 18, and more than 80 percent by age 20. In 2000, among sexually experienced women aged 15 to 24, the rates of condom use are significantly low with 0.9 percent and 7.4 percent respectively for women and men currently using condoms (EDHS, 2000). Five years after this survey, a lower rate of condom use was reported for the same age group of 15 to 24 years: 0.3 percent among women and 6.3 percent among men (EDHS, 2005).

National contraceptive coverage has increased over a five year period with the use of any method increasing from 8.3 percent (EDHS, 2000) to 14.7 percent (EDHS, 2005). However, there is a marked difference between urban and rural areas with 46.7 percent contraceptive prevalence in urban and 10.9 percent in rural areas. EDHS, 2005 indicated that among currently married women who ever used any method the rate rises from 16 percent among those aged 15 to 19, peaks at 27 percent among those age 25-29, and remains consistently high for women aged 40-44 years.\(^{121}\)

Provision of maternal health services in Ethiopia is very low (Figure 3), even compared with other Sub-Saharan African countries while maternal mortality is highly reported for young mothers. Recent data show that Ethiopia remains to be among countries with the lowest rate (estimated at 5.6 percent) of delivery by a skilled attendant (WHO, 2006). By comparison, across the Africa region, Uganda has a

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\(^{121}\) EDHS, 2005
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39 percent rate while South Africa is at 82 percent.\textsuperscript{122} EHDS, 2005 reported no improvement in maternal care, with remaining differences in access to maternal services among rural and urban women. Data show that disparities exist in the use of delivery services across various age groups. Thus, 11 percent of young women aged 15-19 years access those services compared to 6.4 percent of those aged 20-34.

Figure 3: ARH Service Coverage for Pregnant Women of 15-24 years in Ethiopia

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{Fig3}
\caption{ARH Service Coverage for Pregnant Women of 15-24 years in Ethiopia}
\end{figure}

In 2000, the HIV prevalence rate among adolescents aged 15-19 was estimated to be 2.4 times higher for females than males of the same age group (EDHS, 2000). The EDHS 2005 reported an increasing HIV prevalence rate with age, peaking at the age of 29 for women and seemingly decreasing after age 29. HIV prevalence increases for men after age 30 (Table 8).

Table 8: HIV Prevalence Rates in Ethiopia, 2005

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|}
\hline
\textbf{Age} & \textbf{Women} & \textbf{Men} \\
\hline
15-19 & 0.7 & 0.1 \\
20-24 & 1.7 & 0.4 \\
25-29 & 2.1 & 0.7 \\
30-34 & 1.5 & 1.9 \\
\hline
\end{tabular}
\caption{HIV Prevalence Rates in Ethiopia, 2005}
\end{table}

In Ethiopia, girls are forced into early marriage, unwanted sexual relationships, and polygamous unions mostly for economic reasons. Women are highly engaged in low status domains such as housekeeping, wood fetching, street vending and commercial sex work (CSW), exposing themselves to high health risks, HIV/AIDS and violence.\textsuperscript{123} In 2002, Ethiopia reported one of the world’s highest prevalence rates for HIV/AIDS among CSW at 73 percent (UNAIDS, 2002).

According to EDHS 2005 data, awareness about HIV/AIDS among Ethiopian youth is high, although it varies across gender and geographic location. Among those aged 15 to 19 years, boys are more likely than girls to know about HIV/AIDS. Thus, 94 percent of boys compared to 89.2 percent of girls (EDHS 2005) know about the epidemic. More boys than girls are likely to recognize that a healthy-looking person may have HIV (68 percent of boys and 55.8 percent of girls (EDHS, 2005). Knowledge about HIV/AIDS is greater among young men than young women and more so in urban areas than in rural areas. In 2000, the number of women aged 15 to 24 years who were aware of HIV/AIDS was 96 percent in urban areas and 78 percent in rural areas (EDHS, 2000). 2005 data show surprisingly higher figures of HIV awareness for young women in rural areas (88 percent) and a slight rise to 98.6 percent in urban areas (EDHS, 2005). Of these, 70 percent know there is a way to avoid

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|}
\hline
\textbf{HIV Prevalence Rates} & \textbf{Women} & \textbf{Men} \\
\hline
15-19 & 0.7 & 0.1 \\
20-24 & 1.7 & 0.4 \\
25-29 & 2.1 & 0.7 \\
30-34 & 1.5 & 1.9 \\
\hline
\end{tabular}
\caption{HIV Prevalence Rates in Ethiopia, 2005}
\end{table}

\textsuperscript{122} Skilled Attendant at Birth 2006 Updates, WHO, 2006
contracting HIV. While among men aged 15 to 24 years, about 99 percent in urban areas and 90 percent in rural areas know about HIV/AIDS, while 99 percent in urban areas and 81 percent in rural areas also know there is a way to avoid HIV/AIDS. Interestingly, EHSD, 2005 shows that young women aged 15 to 24 are more knowledgeable of the various modes of prevention than older women, while the reverse pattern is observed among men.

According to a recent comparative analysis of DHS in 54 countries carried out by USAID on measures and knowledge of HIV prevention, condom use was reported to be lowest in Ethiopia than in neighboring countries. Only 40 percent of women and 64 percent of men knew that using a condom during sexual intercourse can help reduce the risk of getting HIV/AIDS. By comparison, 68 percent of women in Uganda, 79 percent of women in Tanzania, and 61 percent of women in Kenya knew this method of prevention.

### 2.2 Gender Disparities in Education, Employment, and Other Related Areas

Existing gender inequalities in Ethiopia are manifested in lower educational attainment and economic status of women (Table 8). These inequalities result from limited available employment and income generating opportunities coupled with serious social and gender-biases that hinder women’s access to information and resources, including access to health and reproductive services. These disparities reinforce the need for gender and segmented analysis in policy-making, programming and design of future interventions, particularly for complex issues such as HIV/AIDS.

<table>
<thead>
<tr>
<th>Age</th>
<th>Employed in the 12 months preceding survey</th>
<th>Unemployed in the 12 months preceding the survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Currently employed</td>
<td>Currently Unemployed</td>
</tr>
<tr>
<td>15 – 19</td>
<td>52</td>
<td>7.3</td>
</tr>
<tr>
<td>20 – 24</td>
<td>59.5</td>
<td>7.1</td>
</tr>
<tr>
<td>Women</td>
<td>52.3</td>
<td>6.9</td>
</tr>
<tr>
<td>Men</td>
<td>74.4</td>
<td>9.2</td>
</tr>
<tr>
<td>Urban</td>
<td>40.3</td>
<td>5.1</td>
</tr>
<tr>
<td>Rural</td>
<td>58.9</td>
<td>7.8</td>
</tr>
<tr>
<td>Never married</td>
<td>53.4</td>
<td>6.9</td>
</tr>
<tr>
<td>Married</td>
<td>54.5</td>
<td>7.8</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>71.6</td>
<td>6.5</td>
</tr>
</tbody>
</table>

Source: Population Council, 2002

In Ethiopia, the impact of HIV/AIDS on the education system is high, contributing to an increase in drop-outs, particularly among young girls, and a decrease in the quality of education. On the other hand, education and income status of the population are key determinants that also have an impact on HIV/AIDS prevalence. Education is critical to the general socio-economic welfare of communities and particularly to the reproductive health of women. Women with higher educational status have a better chance of getting well-paid jobs (higher income) and are more likely to send their children to better schools, maintain their nutritional status and the health of their family. Highly educated women also have a better chance of protecting themselves from risky activities and HIV/AIDS.

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124 EDHS, 2005
In spite of the improvements in school enrollment rates throughout the country, gender disparities remain, particularly in secondary and higher education. In 2003 primary school enrollment rate was 59 percent among male students and 41 percent among female students (Figure 4). Access to education and enrollment remains higher in urban areas than in rural areas. By 2005, the primary school enrollment rate increased considerably with an estimated 77.8 percent rate among urban males and 39.1 among rural males, compared with similar rates for women at an estimated 79.6 percent among urban women and 38.5 percent among rural women. The education system is being reviewed and geared for employment generation.

Additionally, more technical and vocational training centers have become available. The Ministry of Education (MoE) reported in 2004 that the enrollment to Technical Vocational Education and Training (TVET) was 85.2 percent among males and 14.8 percent for females.

![Figure 4: Primary School Enrollment in 2000 and 2003 in Ethiopia](image)

Source: Ministry of Education of Ethiopia (MoE), 2003

There is a gender gap in employment in the country. In the civil service, the largest formal employer, women hold only 28 percent of jobs, and almost 90 percent of women are in low paid and unskilled jobs (Civil Service Report, 2000). Levels of employment among women and men stand at 52 percent and 74 percent in urban, and at 40 and 59 percent in rural areas respectively. Forty one percent of women were unemployed during the 12 months preceding the EDHS, 2000 as opposed to 16 percent of men (EDHS, 2000). In 2005, the corresponding figures showed a significant increase with 61 percent of women being out of work compared to 12 percent of men (EHDS, 2005).

Ethiopian women are also under-represented in policy and decision making positions. In 2000, women in Ethiopia held only a few key government decision-making positions, comprising about 8 percent in the House of Representatives, 6 percent in the House of Federation, 13 percent in regional councils, and 14 percent in kebele127 councils (Ashenafie, EWLA, 2000).1

| Table 9b, Ethiopia: Key ARH and Gender Disparity Indicators of Age 15 – 24 years: |
|-----------------------------------------------|---|---|
| Indicators | Female | Male |
| Percentage of youth with completed primary education | 22.0 | 36.2 |
| Percentage of youth exposed to at least one media source (newspaper, radio, television) at least once a week | 25.8 | 38.2 |
| Percentage of youth employed in the 12 months preceding the survey | 31.4 | 73.1 |
| Percentage of youth (age 20-24) married by age 18 | 49.2 | 5.7 |
| Percentage of youth (age 15 – 19) who have begun childbearing | 16.6 |

127 In Ethiopia, kebele or neighborhood is the lowest administrative unit or local government.
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<table>
<thead>
<tr>
<th>Indicators</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of youth (age 18-24) who had sexual intercourse before age 18</td>
<td>44.5</td>
<td>8.0</td>
</tr>
<tr>
<td>Percentage of never married youth who had sex in last 12 months</td>
<td>1.5</td>
<td>7.5</td>
</tr>
<tr>
<td>Percentage of youth who used a condom the last time they had high risk sexual intercourse</td>
<td>28.4</td>
<td>49.4</td>
</tr>
<tr>
<td>Percentage of youth currently using a modern method of family planning</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td>Percentage of youth with comprehensive knowledge of HIV/AIDS</td>
<td>20.5</td>
<td>33.3</td>
</tr>
<tr>
<td>Percentage of youth tested for HIV and received the results in last 12 months</td>
<td>1.9</td>
<td>33.3</td>
</tr>
<tr>
<td>Percentage of youth who are HIV positive</td>
<td>1.1</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Source: Ethiopia DHS 2005

2.3 Policies and Institutional Frameworks for ARH, Gender and HIV/AIDS in Ethiopia

Policies are guiding documents and can be effective when complemented with institutional mechanisms and resources, and employed through implementation programs and actions. Structural set-ups considering the relevance of social capital fostering accountability, dialogue and participation among key stakeholders, including policy makers, communities and vulnerable groups has to be in place. Taking a policy to implementation requires a systemic and strategic approach to incorporate and coordinate the needs and demands of all partners and stakeholders. Study findings on policy and institutional mechanisms are mixed. While there are successes, there are challenges and gaps that need to be addressed. In addressing the complex and interlinked issues of ARH, gender and youth and HIV/AIDS, mainstreaming (if supported by strong commitment and resources) becomes relevant for effective results.

Young people and women are often more vulnerable and excluded from HIV/AIDS prevention programs despite the fact that they are the key stakeholders. Gender and youth issues are closely related and common IEC prevention messages for RH and HIV are disseminated via media (radio and TV). However, there are wide disparities in people’s access to radio and TV, as the data for ownership of radio and TV show that only 26 percent of the rural households own a radio while even almost none of them (0.1 percent) own a TV. In urban households, 75.6 percent of households own TVs and 33.1 percent own a radio (EDHS, 2005).

Issues of HIV/AIDS, gender and ARH are managed in Ethiopia with little or no linkages made between them. The National Policy on Women formulated in 1993 gives no reference to young people, ARH or HIV/AIDS, though it was issued when the epidemic was escalating in the country. There seems to be low or lack of understanding about the linkages of ARH, gender and youth. Strengthening this linkage becomes more critical with the prevalence of HIV/AIDS. Highlights of the analysis of the policy areas of key ARH, gender and HIV/AIDS findings are summarized below.

2.3.1 National HIV/AIDS Policy and Institutional Set-up

Ethiopia issued its National HIV/AIDS Policy in 1998 and the Strategic Framework for the National Response to HIV/AIDS (2001/2005) in 2002. Subsequently, a number of guidelines were developed. Established by Proclamation No. 276/2002 in June 2002, the National HIV/AIDS Council (NAC) is the highest body involved in HIV/AIDS Policy implementation. NAC also oversees the implementation of the Strategic Framework, examines and approves annual budgets and monitors performance and impact. The HIV/AIDS Control and Prevention Office (HAPCO) serves as the

128 NAC Members are: deputy PM, Ministers of the Federal government, Speaker of House of Peoples’ Representatives, heads of regions, DPPC, Federal Civil Service commissioner, Science and Technology commissioner, Religious leaders (Orthodox Church, Islamic Supreme Council, Catholic Secretariat, Evangelical Church of Mekaneyesus, and Evangelical Church Fellowship of Ethiopia), director of CRDA, president of Ethiopian Red Cross Society, president of FGAE, president of Confederations of Ethiopian Labor Unions, president of Chamber of Commerce, president of Ethiopian Teacher’s Association, leaders of PLWHA, president of Ethiopian Medical Association, heads of other NGOs and prominent individuals to be designated by the Council.
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secretariat of the NAC. Of the total funds mobilized through HAPCO from various donors, IDA/the World Bank's MAP funded 42 percent, and 43 percent is funded by the Global Fund. The Prime Minister's Office coordinates and facilitates HIV/AIDS program implementation. HAPCO is headed by a director appointed by the NAC and has service-giving and operational departments that include advocacy, mobilization and coordination, planning and programming departments that support operational activities. These bodies implement the day-to-day activities at different levels of the government (federal, regional and local/district or woreda)\(^\text{129}\). The HAPCO Secretariat has federal and regional councils, chaired by the Minister of Health and the Head of the Health Bureau, respectively. The woreda administration heads the woreda HIV/AIDS Councils. At the lowest level, there is the kebele (local/neighborhood) AIDS Committee, which is composed of members of the local administration and community representatives. The federal HAPCO in Addis Ababa coordinates and disperses funding to the regional HAPCOs and to national programs with NGOs operating in more than one regional state. Similarly, the regional and woreda HAPCOs coordinate and disperse funding to their woreda and kebele HIV/AIDS operations and initiatives respectively.

All of those interviewed indicated that there is a staffing shortage at all levels of HAPCO and staff turnover is high. Also, as a new structure and an institution charged with complex duties, the management system of HAPCO does not seem to be prepared to cope with the fast moving nature and response to the epidemic (financial disbursements and reporting, M&E, human resources). Efforts to improve the activities of HAPCO and the overall performance of HIV/AIDS programs are underway. A number of guidelines, manuals, and management system tools are being developed by HAPCO, the MoH and related bodies, including NGOs. Among the instruments developed are Antiretroviral Therapy (ART) Policy and Guidelines, national PMTCT Guidelines, STI Syndromic Case Management, Adult and Pediatric HIV/AIDS Case Management, Voluntary Counseling and Testing (VCT) guidelines and training manuals, national HIV/AIDS Communication Framework and Guidelines, Guidelines for HAPCO Funded Project Preparation, a National Monitoring and Evaluation Framework, and a Manual on Community Home-based Care. Discussions with various stakeholders indicated that efforts to disseminate and promote these various guidelines are inadequate.

There are different funding sources for HAPCO’s program implementation activities. A consolidated Action Plan and Budget for 2004/2005 was prepared by HAPCO that incorporated all funding from various donors. All major HIV/AIDS programs, particularly those facilitated through HAPCO, are donor funded. The major funding sources are EMSAP (Ethiopian Multi-Sector HIV/AIDS Project or MAP) from the World Bank/IDA, Global Fund and PEPFAR (President Emergency Plan for HIV/AIDS Relief) from the U.S. Government, UNICEF, Irish Government, Action AID, DFID, UNDP and other funds\(^\text{130}\). Reporting requirements for the funds received are varied and stretch the already weak capacity of the institutions. Harmonizing and responding to donors’ demands has been indicated as a key challenge to all levels of HAPCO and their stakeholders.

Although the HIV/AIDS Strategic Framework\(^\text{131}\) clearly defines youth and women, particularly those in childbearing age as primary focuses, this does not seem to translate in programming and budget allocation for these target groups. HAPCO funding and programming is based on interventions with no attention to targeting of already identified most vulnerable groups.

\(^{129}\) In Ethiopia, woreda or wereda is an administrative sub-division, or local government, an equivalent to a district.

\(^{130}\) World Bank MAP project funded 42 percent, and 43 percent from the Global Fund.

2.3.2 National Women Policy and Institutional Set-Up

In 1993, a National Women Policy was issued and the Women Affairs Office (WAO) was established under the Prime Minister's Office (PMO) to coordinate, facilitate and monitor the Women's Policy at all levels. WAO and focal persons are appointed at the Federal Ministry, regional and woreda levels and report directly to their line agencies in the government, the Federal Ministry, Regional and woreda councils respectively, with voluntary communication with federal WAO. This set-up weakens the relationship and the coordination role of the federal WAO. Recently, after the May 2005 elections in the country, the WAO was upgraded at the federal level has to the level of the Ministry of Women’s Affairs.

Most of the federal ministries, regional states and NGOs, have Women’s Affairs Departments (WAD), a gender focal point or other set-ups to promote gender mainstreaming within their institutions. Usually this body is under-staffed, under-funded and has a weak institutional voice. There is silent acceptance that the WAO also takes care of gender issues in the country. At the same time, there is a gross public misperception at all levels that gender is a women’s only concern rather than a development issue. Some institutions are charging the gender focal points with additional duties related to HIV/AIDS, reproductive health and other social issues with no due consideration to inadequacy of their capacities or available resources. The attention and resources (structures, skills, funds, facilities) given to WADs, gender focal points and activities are inadequate, a pattern observed even at a global level, and are barriers to effective gender mainstreaming. Limitations in the appropriate skills needed to work with gender issues have resulted in gender not being adequately mainstreamed into the overall education system in the country, making it even more difficult to obtain experts on gender issues.

Today, over a decade after its establishment, Ethiopia has recently developed a National Strategic Framework or a National Action Plan to take the National Women's Policy as prioritized by the MDGs and the Beijing Platform for Action to implementation. WAOs at all levels are inadequately staffed and incapacitated in terms of resources (Beijing Platform of Action (POA) Report, 2005). However, several efforts are being made to implement the commitments made at the Beijing POA and related instruments such as ICPD and CEDAW. A progress report was also given at regional and international forums. For the national implementation of the Beijing POA, Ethiopia adapted five priority areas including: (i) women, poverty and economy, (ii) education and training for women, (iii) health care and related services for women, (iv) institutional mechanisms for the advancement of women, and (v) violence against women. Following the international forums and conferences (a) mainstreaming, (b) capacity building, (c) networking and advocacy were adopted as key strategies in implementing the Women’s Policy and Gender Equality Agenda in the country.

The 1995 Constitution’s articles 35 and 36 on women and children respectively also spurred an enabling policy environment for mainstreaming gender and youth/children issues, increasing the number of organizations and networks, including groups working on gender, youth, RH, and HIV/AIDS. Some of such groups are the Ethiopian Women Lawyers’ Association (EWLA); Panos Ethiopia Gender Forum (PEGF); Forum for African Women Educationalists (FAWE) - Ethiopia Chapter; Network of Ethiopian Women Associations (NEWA), and issue focused associations such as the Consortium of Reproductive Health Associations (CORHA) and the National Association of Women PLWHA (recently established). These organizations and networks can be classified as promising approaches.

WAO works in close collaboration with all sectors, its development partners, community institutions and NGOs on women and gender issues effectively, which is a promising partnership and keeps its operations going and alive. The prominent donors for major gender initiatives in the country are the Royal Netherlands Government, UNICEF, WHO, UNDP, UNFPA, Irish AID, and SIDA. These

development partners have a gender focal point and a structure that works directly with WAO at policy and implementation levels.

2.3.3 National Youth Policy and Institutional Set-up
According to the Ministry of Youth, Sports and Culture (MoYSC) and the Youth Policy, “youth” in Ethiopia are defined as the population between 15 and 29 years of age. The Ethiopian Constitution, the Penal and Civil Codes define “a minor” as a person below 18 years of age. The Ethiopian Family Law puts the minimum age of marriage at 18 years for both girls and boys.\textsuperscript{134}

The MoYSC was established in March 2001 by Proclamation No. 256/94 with a mandate to lead, monitor and coordinate youth affairs. As the name suggests, the Ministry has three sub-bodies or units, the Youth, Sports and Culture Affairs. The MoYSC also has a Women’s Affairs Department (WAD), which has been trying to mainstream gender issues within the institution’s activities. For example, the WAD is currently preparing to develop guidelines on integrating gender.

It is important to note the changes and development of youth issues in Ethiopia. The youth sector has undergone reorganization, mostly following political lines. Youth have been involved in nation building and at times used for political gains. Prior to the military government that ruled from 1974 to 1991, there were several youth initiatives and groups such as the Boy Scouts, YWCA, YMCA and various school-based clubs and associations. The military government abandoned all youth groups and put them under one local community structure which was highly influenced by the government. When the current government took over in mid-1991, the then Children and Youth Commission was dissolved and its functions were moved to the Ministry of Labor and Social Affairs (MoLSA), established as a department (Youth Section). A decade later in 2001, the Youth Section was moved from MoLSA to the MoYSC. A National Policy on Youths was issued in March 2004. This was initiated by the MoYSC. Key stakeholders involved in the drafting and discussion of the Policy were MoE, MoH, MoLSA, WAO/PMO, NGOs working on youths/adolescent programs, UNICEF, UNFPA, Save the Children, youth representatives from the regions and associations and professionals and institutions working in the country.

The guiding principles of the MoYSC, translated into the National Policy on Youth\textsuperscript{2}, are to:

Ensure constitutional rights and rule of law protecting human and democratic rights and freedoms;

- Establish a democratic system, good governance and justice, creating a system where accountability and transparency prevails;

- Combat poverty and backwardness, bringing rapid and sustainable development and protecting economic and social rights; and

- Ensure gender equality and participation of female youth.

The Youth Policy of Ethiopia mentions health and HIV/AIDS as major policy issues. Although gender equality and the participation of female youth are among the guiding principles, they are not considered among the major policy issues for programming, a matter that needs more attention. ARH has not been strongly emphasized in the document, though covered under “general youth health”.

\textsuperscript{134} However, health facilities use 15 years as the minimum age for independent service provision due to the fact that many of their clients include young mothers - girls aged 15 and under.
The National Culture Policy of Ethiopia (issued in 1993) clearly stated the existence of harmful traditional practices resulting in physical, psychological and moral damage to women and girls in the country. This policy, however, failed to specifically mention issues related to HIV/AIDS and adolescents or young people. Making gender and ARH central in the Youth Policy, National Culture Policy and in all programming and interventions will be important. The issues faced by young people, as is the case with gender, are crosscutting and require strong integration and mainstreaming.

There are also associations and groups of youth, artists, athletes and other professionals whose work compliments the activities of the MoYSC. As a new institution, while the structures are in place, the staffing of MoYSC has been inadequate and with a high staff turnover rate. As the demand for the implementation of the policy increases, more attempts and preparations have been made to move the policy to implementation. Through a participatory process, an in-country core-team, including the World Bank and major stakeholders, has been involved in developing a draft youth strategy and a ten year implementation plan which has not yet been finalized. The inadequacy of capacity (human and financial resources) incompatibility with the responsibility charged to MoYSC and increasing demand to respond to youth issues has been expressed by stakeholders at all levels, including youth groups. However, some regions such as the Addis Ababa City Administration have been implementing innovative life skills and economic empowerment packages. MoYSC works very closely with sectoral bodies, multi-sectoral and bilateral partners and NGOs, including HAPCO.

MoYSC, with technical support provided by Family Health International (FHI), carried out the first National Youth Consultation Forum on Sexual and Reproductive Health and HIV/AIDS in June 2002. Regional and local youth offices are being opened, which may facilitate the formation, registration and involvement of youth groups and better coordination of these activities. However, these offices are not being staffed and prepared to respond to the exploding demand and needs of youth.

Since the Youth Policy has just been issued and is ready for implementation, the opportunity for systematically mainstreaming and addressing youth issues taking the lessons from other organizations, programs and countries will be relevant. Currently, youth issues and programs had not been effectively integrated into social and programmatic areas though their potential and bulging population clearly justifies their priority. NGOs and youth groups themselves, based on an ad hoc and scattered manner, mostly implement the few existing youth friendly programs and initiatives. There is hope that the implementation tools, national strategic framework and plan of action to take the youth policy to task may be developed soon and provide focus to the growing needs of young people.

With the Ethiopia MAP ending in June 2006, eleven youth centers are under construction in every region of the country. About 100 information centers (libraries) had been established in key cities and towns. These are opportunities of good hope to address AYRH and HIV/AIDS issues, making gender central to all interventions as stated in the National Youth and RH Policies.

The Ministry of Health has developed a comprehensive extension package (HEP) and is training health extension workers to scale up coverage. ARH and HIV/AIDS are among the key components of the HEP.

2.3.4 Adolescent Reproductive Health (ARH) and HIV/AIDS Policy and Institutional Set-Up

Ethiopia has put in place a National Reproductive Health Strategy in September 2006. National Adolescent and Youth Reproductive Health strategy has been drafted and is in the process of being finalized. In the absence of an operational ARH policy in place, this study analyzed the presentation of issues of youth and HIV/AIDS mainly within the framework of the National Health Policy (NHP)
and some youth AYRH and HIV/AIDS activities implemented by different partners, including civil society/NGO groups.

Issued in September 1993 and enacted by the Parliament in August 1995, the Health Policy (HP) is the only policy rectified by parliament among the policies analyzed for the purposes of this study. The overall objective of the HP was to restructure and expand the health care system to make it responsive to the health needs of the less privileged rural population. The policy supports a decentralized democratization process and the strengthening of inter-sectoral activities. Under family health service priorities, it accords the need to give special attention to the health of women, adolescents and children.

To implement the HP, decentralized institutional arrangements and tools were put in place. The Department of Family Health under the MoH is mainly addressing ARH and family health issues, while the Disease Prevention and Control Department is mainly charged with HIV/AIDS programs of the Ministry and a Department of Women’s Affairs (WAD) overlooking the mainstreaming of gender issues. There is also the Health Education Center (HEC) in charge of health statistics and material production. In addition, there are regional health bureaus and woreda health offices that overlook the administration and management affairs at lower levels. Family health, at the regional level is organized as a team, while the other departments of the health structure maintain their departmental status. At the decentralized level, the Head of the Regional Health Bureau reports to the Regional Council. The regional states have autonomous power to adapt and modify the federal policies and tools within the framework of the Constitution. The Federal Ministry of Health has only a functional relationship with the regional offices, providing technical support and supervision if the program is federally managed or when regions request assistance. To facilitate the decentralized services, the health system includes a referral hospital, a regional/district hospital (usually based in urban dwellings), a woreda set-up with a primary health care unit or a referral clinic and a health post\(^{135}\).

To implement the Health Policy and to improve health services, a Health Sector Development Project (HSDP) was launched in 1997 in recognition of weaknesses in the existing health delivery system. HSDP was mainly intended to respond to the prevailing and newly emerging health problems. The 20-year Health Plan (1995/2015), rolling in 5-year segments, is now on its third phase: the HSDP III (2005/2006 – 2009/2010). The HSDP Program Action Plan (PAP) recognized the need for tackling the most prominent gender-related problems faced by women, specified as (i) inadequate RH care, (ii) harmful traditional practices, (iii) poor access to education, training and employment. The PAP stated that the scope of action will not be limited to health service delivery, but will also include taking measures to enhance equality between men and women.

The Family Health Department (FHD) of MoH is charged with maternal, new born and child health, including family health and nutrition. The Community-Based Reproductive Health (CBRH) programs led by MoH, which serve a broad geographic area, have mainly been the basis for ARH interventions in the country. There is vertical aligning of ARH and HIV/AIDS interventions in MoH. The PMTCT programs are under Disease Control and Prevention and the Family Health Department is charged with the mother and child health and nutrition programs. There is an attempt to bring the PMTCT programs of HIV/AIDS interventions within the Family Health Department.

The Family Health Department works closely with multi-sectoral and bilateral partners and NGOs. A Reproductive Health Task Force (RHTF) is composed of representatives of key stakeholders and chaired by the Consortium of Reproductive Health Associations (CORHA)\(^{136}\) and a technical working group led by UNFPA. By working closely with the FHD, Pathfinder International and Family

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\(^{135}\) Primary Health Care Unit (PHCU) or referral clinic is a health center serving about 25,000 people. It will have 5 surrounding satellite health posts covering population of about 5,000 people each.

\(^{136}\) CORHA is a consortium registered as NGO with a membership of over 60 local and international organizations working on development issues. The main focus of CORHA is to increase the integration of RH to all development issues and programs.
Guidance Association of Ethiopia (FGAE) are specifically providing youth friendly services and are among a small group of prominent NGOs supporting ARH and HIV/AIDS services and to some extent gender issues in the country. This is a multi-sectoral set up and process that is working effectively and is a promising approach. The RHTF could be strengthened, promoted and developed as a model to provide opportunity for integrating ARH, gender and HIV/AIDS and other issues for improved health outcomes and for reaching the related MDGs. The FHD has also been participating in and benefiting from the World Bank’s regional capacity building initiatives by sharing with and learning from the experiences of other African countries.

Recognizing the importance of ARH and the need to make the health system youth-friendly, an adolescent reproductive health (ARH) team has been established under the FHD. An action plan, the “Five-Year Action Plan for Adolescent Reproductive Health in Ethiopia” was developed in 2003 with support from development partners. The Action Plan was drafted for the purpose of providing implementation guidance to all partners and stakeholders working on ARH and identified (i) unwanted pregnancy, (ii) HIV/AIDS, (iii) abortion, (iv) drug and substance abuse, and (v) pregnancy and birth complications as the most critical ARH challenges.

A decade after the Health Policy was issued, however, the utilization of and access to maternal health care is still very low, especially among women, adolescents, and children. Interventions to combat the spread of HIV were initiated in 1986 with a MoH National HIV/AIDS Program. In early 2005, the MoH developed a national strategic health sector response to HIV/AIDS in order to take a holistic and multi-sectoral approach to assertively address the epidemic comprehensively. In most sectors including the health sector, adolescents and youth are being identified as a special group needing specialized services.

ARH services in Ethiopia have generally been very limited and have mainly been undertaken by NGOs along with other health programs, mostly those affiliated with Save the Children. Few NGOs have been highly involved in integrated ARH and HIV/AIDS interventions, working closely with the public health system. The Family Guidance Association of Ethiopia (FGAE), a local NGO and affiliate of the International Planned Parenthood Federation (IPPF) is among the first to lead and initiate Community Based Reproductive Health (CBRH) programs since 1992. FGAE now have around 26 youth centers in nine regional states of the country providing RH, VCT, library and entertainment services.

Though gender issues were recognized and listed in the HSDP I and II, these documents did not put clear strategies or actions to specifically mainstream or address gender considerations within the programs. As stated in the HSDP I evaluation report, few issues of ARH were addressed, such as (a) teenage pregnancy prevention, (b) abortion and (c) substance abuse along with (d) STIs and HIV/AIDS. In addition, the following weaknesses related to ARH, gender and HIV were identified in the HSDP I evaluation report:

- RH issues lack adequate political commitment from the highest levels within the MoH;
- Absence of a comprehensive strategy document defining the national health system’s response to HIV/AIDS interventions;
- Lack of set standards for quality assurance and packaging of services, such as VCT, ART, PMTCT and ARH;
- Low utilization of available maternal and child health services, vaccination for pregnant women; and
- Inadequate coordination of activities between HAPCO and the MoH in addressing HIV systematically.
The HSDP III (2006/2007 – 2009/2010), currently under implementation, has focused on family health, and RH being one of the issues which will definitely make adolescent and youth beneficiaries of interventions. Some funds are earmarked for contraceptive commodity security and capacity building. The development of the national RH and the AYRH strategies and the scaling up of the health extension services will hopefully, if taken systematically with full commitment to implementation, accelerate the achievement of the MDGs.

2.3.5 Gaps and Challenges to Policy Implementations
Close analysis of the policy and institutional mechanisms related to ARH, gender and HIV/AIDS identified the following gaps and challenges to effective implementation in Ethiopia:

- **Targeting and Programming:** Response to vulnerable and high-risk groups in HIV/AIDS was neither visible with targeted programs nor systemic, with indicators to show responses. There was no indication to report program impact on the welfare and changes on the groups identified as “vulnerable” in place. Included among those vulnerable to HIV/AIDS in the policies and strategic frameworks were “young people” and “women” of different segments of the society. However, recognition of such groups does not seem to materialize into the programming and beneficiaries of interventions. Existent programming was intervention focused and did not consider targets groups at risk for HIV infection.

- **Disseminating and Clarifying Direction and Roles:** The developed policies and implementation tools were not adequately disseminated and shared. The roles and responsibilities of the various stakeholders and partners were not defined though attempts are made to develop strategic frameworks and some guidelines. Implementation guidelines with indicators of results will be critical.

- **Policy Implementation Process and Packaging:** Delays in developing the appropriate tools to accompany policies were observed, making implementation and coordination difficult. For example, Strategic Framework, National Plan of Action and other tools for effective implementation of Women’s Policy in the case of Ethiopia took over a decade.

- **Legal Instruments vis-à-vis Customary Practices:** The co-existence of customary practices and legal instruments should both uphold the basic human and legal rights of individuals. A number of harmful practices take place in Ethiopia such as FGM, gender-based violence and discrimination against PLWHA, youth and women. Aliening the disparities between the existing harmful practices, norms and the issued legal frameworks require bold and strong leadership and instruments that reinforce people’s dignity and human rights. HIV/AIDS infected and affected people, mostly young people and women experience tremendous stigma, humiliation and violation of their constitutional and legal rights.

- **Weak Linkages of ARH and HIV/AIDS Programs with Gender:** Strong linkages are not being encouraged although they are a prerequisite for the success of addressing issues of vulnerable groups, program effectiveness and sustainability. ARH and HIV/AIDS are both sexual and reproductive issues and use similar resources (skills, facilities, systems).137 However, the study review indicated that HIV/AIDS and ARH programs are vertical and not linked, except in few interventions such as VCT, treatment of infectious diseases and small scale NGO interventions. Vertical programming and neglecting of the gender dimension of HIV/AIDS has made implementation weak and the use of limited resources ineffective.

Weak Coordination Among Actors/Stakeholders: Linkages of the reviewed policies in addressing the related social issues, adolescent/youth health, gender and HIV/AIDS were found to be weak. On the other hand, several stakeholders addressing HIV/AIDS indicated that weak coordination results in the duplication of their work and a waste of resources. Lack of alignment and harmonization was mentioned by all stakeholders, inter-government sectors, NGOs/CSOs and development partners. HAPCO and CSOs/NGOs complained of the diverse demands for reporting by both government and various multi-and bi-lateral donors, stretching their already weak capacity.

Relevance of Adolescent/Reproductive Health Policies and Programs: Lack of understanding and/or inattention to the centrality of ARH to general health outcomes of the population and socio-economic development, particularly in a country with a bulging adolescent/youth population (over 30 percent). The Ethiopian Multi-country HIV/AIDS Program Interim and termination reports review and the Health Sector Development Program (HSDP) II review pointed that ARH, gender and youth were not given sufficient emphasis. Much more understanding of the linkages and responses may require further in-depth search and analysis.

Understanding the Concept of Gender, Youth and HIV/AIDS: There is a lack of understanding that the concept of gender is relevant to both male and female. Gender and youth are not regarded as cross-sectoral issues. The existing socio-cultural barriers, policy gaps and misconceptions broaden the communication gaps, disempowering women and orienting men to be more vulnerable. Men are usually excluded from gender and RH interventions.

Inadequate Focus to Youth Issues and Disparities among Segments: Little is being done to address the needs of youth and rural youth in particular within HIV/AIDS programming. Almost all of the few youth friendly service initiatives, with packages of ARH and HIV/AIDS activities are available only in urban areas. The major micro-economic frameworks and the SDPRP of Ethiopia policy matrix do not focus on youth as special segments based on their disparities and their practical needs. It is hoped that the new PASDEP (Plan for Accelerated and Sustained Development to End Poverty), the PRSC version of Ethiopia, which also lists adolescent youth as special groups and gender as key to development, may include more focused interventions. The PASDEP also links family planning/RH and population and development issues.

Gender, Youth and Adolescent Policies and Implementation Tools: The policies and frameworks to address gender and youth issues should be based and implemented on analysis and principles of equality and equity for and among boys/men and girls/women. Ethiopia has the Women’s Affair’s Office (WAO) and a Women Policy. Considering the complex issues, it may require a comprehensive gender policy. An Ethiopian government progress report on the implementation of the African Union Solemn Declaration on Gender Equality stated that there are still a number of cultural, socio-economic barriers, including poverty unemployment, expansion of prostitution, illiteracy, migration, harmful traditional practices (HTP) and discrimination. Gender, youth and ARH organizations have weak institutional capacities (budget/resources, staff and facilities) though women constitute more than 50 percent of the country’s population and youth aged 15 to 24 years comprise 33 percent of the population.

2.4 Recommendations and Proposed Actions for Scaling-up:

A major stakeholder’s workshop was organized in Addis Ababa by the in-country team on June 1, 2004 to validate the study findings. The following recommendations were put forward:

- Launch wider dissemination of policies and advocacy for their effective implementations;
- Strengthen the legal and judiciary frameworks, aligning legal and customary laws to protect human rights of youth and women and all citizens;
- Revise women policy for a wider gender perspective and facilitate implementation;
- Align all relevant social policies and develop an ARH policy with a strong gender perspective and facilitate and strengthen the implementation of the Adolescent Health plan of action of MoH;
- Conduct institutional assessment(s) for capacity building plans for ARH, gender and HIV/AIDS;
- Improve coordination and harmonization among partners, strengthen and promote the initiated donors issue based working groups such as the HNP group and the Gender Working Group;
- Strengthen partnerships, including public-CSO and private;
- Undertake mapping exercises of who is doing what in mainstreaming ARH, gender and HIV/AIDS issues;
- Scale-up male involvement and women empowerment interventions;
- Strengthen and scale up successful multi-sectoral initiatives, and
- Facilitate the mainstreaming of issues of youth/adolescent and gender within the existing development frameworks (CAS, PASDEP, MDGs) and sectoral goals and actions.

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139 PASDEP is a Plan for Accelerated and Sustained Development to End Poverty, the Ethiopian extension of the poverty strategy outlining main policies for next 5 years (2005/2006 – 2009/2010)
3 Key Findings from Uganda Report\textsuperscript{140}

3.1 Overview of Adolescent Reproductive Health (ARH), Gender and HIV/AIDS in Uganda

3.1.1 Proportion of Young People and Adolescents
The high level of interest currently being given to ARH in Uganda is justified on several grounds. The first justification is the sheer size of this age group. The 2002 Population and Housing Census estimated the population of adolescents aged 10 - 24 years at 7.9 million.\textsuperscript{5} This group provides the momentum for future population growth. The USBS, 2004-2005 confirmed that Uganda has a much larger proportion of young people and adolescents compared with older age groups.

Along with the general increase of its proportion in the total population, young women represent a growing proportion of all women of reproductive age. In 2000, the number of women aged 15 - 24 comprised 43 percent of women aged 15 - 49 (2.1 million compared out of the 4.9 million). It is estimated that in 2015, young women will constitute almost half of all women of childbearing age. The USBS, 2004-2005 indicated slightly higher percentages of males over females under 20 compared to a lower proportion of those aged 20-39 years.\textsuperscript{141}

3.1.2 Early Sex and Early Marriage
Young adults in Uganda initiate sexual activity at a relatively early age. The median age of sexual debut is 16.7 for women. The UDHS, 2000 showed a small increase in the median age at first sex among women from 16.1 in 1995 to 16.7 in 2000. Young men tend to initiate sex more than two years later than women, with a median age at first sex of 19.4. As with women, there was a substantial increase in the age at first sex among men aged 25 – 54, from 17.5 in 1995 to 18.8 in 2000. In 2004-2005, the median age at first sex among young women aged 20-24 increased from 16.7 in 2000-2001 to 17.1. The same figure for men aged 20-24 had almost no change, showing 18.3 in 2004-2005 compared to 18.8 percent in 2000-2001.\textsuperscript{142}

The USBS, 2004-2005 also indicated that since 2000-2001, the proportion of young girls (15-19) who had never had sex increased from 48 to 54 percent while among males of the same age group it decreased from 61 percent to 58 percent. Nevertheless, the 2004-2005 data showed an increase in multiple concurrent sexual relations, especially among young people. More young girls (15-19) than women in older age groups who are sexually active reported having multiple sexual partners.

Overall 31 percent of adolescents in Uganda have begun childbearing; representing one of the highest adolescent pregnancy rates in Africa. Three fifths of 19 year olds are already mothers. Data on pregnancy among teenagers shows that there has been a decline in the number of young women who are mothers. In 1995, 43 percent of adolescents had begun childbearing. The age at initiation of childbearing has not changed much over time. The median age at birth has remained at around 18.5 for the past thirty years.

\textsuperscript{140} Unless specified, Part 3 largely comprises the data available at the time of the study implementation (July, 2004).
\textsuperscript{141} USBS, 2004-2005, \textit{Ibid}
\textsuperscript{142} USBS, 2004-2005, \textit{Ibid}
The USBS, 2004-2005 demonstrated that there has been no significant change in the median age at first marriage among young women since UDHS 2000-2001. One-fifth of Ugandan girls still marry before they reach age 15 and more marry before age 18. In contrast, less than one-third of men marry before they reach 20 while the median age at first marriage among them is 22.

### 3.1.3 Condom Use

Contraceptive knowledge is believed to be high among Ugandan adolescents. Condoms are gaining in popularity in this group as a means of protection. The data indicate that if in 1995, only 4.2 percent of 15-19 year old males were using condoms, in 2000 they comprised 40 percent. Although current contraceptive use is still low in contrast to knowledge, there is an increasing trend of use among adolescent women. Interestingly, the USBS, 2004-2005 showed that young people aged 15-19 years were by far the most likely group to have used condoms at the last sexual episode, including 27 percent of women and 47 percent of men.

### 3.2 HIV/AIDS Situation in Uganda

HIV/AIDS is one of the major contributors to morbidity and mortality in Uganda, accounting for 9 percent of the burden of disease and for low life expectancy at birth, which is now projected at 42 years (HSSP, 2000/01-2004/05). Since the first AIDS case was discovered in the country in 1982, 55,861 clinical AIDS cases have been reported, and an estimated 838,000 deaths due to HIV/AIDS (UDHS, 2000-2001). The number of people living with HIV in Uganda in 2000-2001 was 1,438,000, of which 1,294,200 are adults while 143,800 are children below 12 years. Young people aged 15 – 19 years are the most vulnerable to infection, with female youths in this age group being four times more vulnerable to HIV infection than their male age mates.

![Figure 6: HIV Prevalence Rates in Uganda](image)

In response to the high infection rates of HIV/AIDS, Uganda adopted a Policy of Openness and Massive Campaigns, from the top to the grassroots, which saw a massive decline in HIV/AIDS prevalence from 18 percent in 1992 to 6.5 percent in 2001. However, the gender disparities in HIV/AIDS infection suggest gender inequalities in benefiting from the strategies to combat infection. The HIV infection rate among girls aged 15-19 is three to six times more than for boys; and among people aged 20-24, the rate for women is twice as high as for men (The World Bank, 2000). The higher
proportion of females in both categories highlights significant gender issues, including lower sexual negotiating power, economic dependence on men, early marriage, lower status of women, and less access to information, in addition to their biological vulnerability (UDHS, 2001/2002). Also, women are more likely to bear the burden of caring for the sick and orphans.

The gains being made in fight against HIV/AIDS are not apparent in related reproductive health indicators. The available data suggests that major reproductive health indicators - maternal mortality rates have remained stagnant or deteriorated (HSSR, 2003; MoFPED 2003; UDHS, 2001/02). Maternal mortality rate was 506/100,000 live births in 1995 and was 505/100,000 live births in 2000/01. Despite the high rates of antenatal clinic attendance (92 percent attend at least once), institutional deliveries have not increased. By contrast, the number of infant and neonatal deaths has increased. Infant mortality has remained high and constant for the last 15 years, currently standing at 88 deaths per 1,000 live births, with 80 percent of these amongst the 20 percent poorest of society. The total fertility rate was 6.9 in 1995, and has remained the same to date.

The above situation demonstrates that HIV/AIDS is receiving increased attention and financial assistance, however in isolation of the context that predisposes women to HIV/AIDS. Such context includes cultural factors that reinforce women's inferiority status: the high premium attached to child-bearing at the expense of women's health, limited access to contraception, and inadequate obstetric care. This emphasizes the weak linkage between HIV/AIDS, ARH and gender. Any intervention attempting to address successfully the HIV/AIDS epidemic and its accompanying effects should focus on addressing all three components of the triad, and their associated issues.

### Table 9: Selected RH Indicators for Uganda

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1989</th>
<th>1995</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fertility Rate</td>
<td>7.1</td>
<td>6.9</td>
<td>6.9</td>
</tr>
<tr>
<td>Unmet Need</td>
<td>52</td>
<td>29</td>
<td>35</td>
</tr>
<tr>
<td>Contraceptive Prevalence Rate (CPR)</td>
<td>5</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>Delivery under trained health worker</td>
<td>38</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>Immunization (children 12-23 months)</td>
<td>31</td>
<td>47</td>
<td>38</td>
</tr>
<tr>
<td>Infant Mortality Rate (IMR)</td>
<td>122</td>
<td>81</td>
<td>88</td>
</tr>
<tr>
<td>Maternal Mortality Rate (MMR)</td>
<td>700+</td>
<td>506</td>
<td>504</td>
</tr>
<tr>
<td>Stunting (Chronic Malnutrition)</td>
<td>38</td>
<td>38</td>
<td>39</td>
</tr>
</tbody>
</table>

Source: UDHS, 2000

### 3.3 Gender Disparities in Education, Employment, and other Related Areas

In Uganda in 1985, it is estimated that 40 percent of women could not read, compared with 60 percent of men. It is encouraging to note that the gender gap at primary school enrollment is steadily being closed by the Uganda Poverty Eradication Program (UPEP). In 1980 there were 32 percent more boys than girls enrolled in primary schools and this gap decreased to 6.1 percent in 2001.

More women (73 percent) than men (63 percent) are currently engaged in some form of employment. Most women who are employed (77 percent) are engaged in agriculture, compared to 54 percent of men. Women in general have limited access to economic opportunities with only a 7 percent land ownership.
The Uganda Policy of Affirmative Action has gone a long way in augmenting women's participation in political and public spheres. Nevertheless, women still have limited opportunities for participating in key positions of influence, as illustrated in Table 10.

Table 10: Women’s Participation in Governance in Uganda

<table>
<thead>
<tr>
<th>Position</th>
<th>Percent of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women Ministers</td>
<td>18.5</td>
</tr>
<tr>
<td>Women Permanent Secretaries</td>
<td>19.4</td>
</tr>
<tr>
<td>Female Parliamentarians</td>
<td>18.5</td>
</tr>
</tbody>
</table>

Violence against women and girls is a global epidemic that affects the health and economic stability of women, their families, and their communities. Statistics published in 1997 by the World Health Organization (WHO) revealed that, 46 percent interviewed in Uganda reported that they suffered physical abuse from their male partners. The full magnitude of the problem is unclear since national data on rape, defilement and other forms of gender-based violence is lacking. Suffice to say, however, that the problem exists.

The media has the major focus in the fight against HIV/AIDS, particularly in prevention programs. The gender disparities in access to media and gaps in literacy are usually underestimated or unnoticed in the design of information, education, communication (EIC) and behavioral change communication (BCC) programs. Most of the population of Uganda is exposed to some form of media. Figure 7 shows that in general, men are more likely than women to have access to mass media, and this is true for all types of media.

Figure 7: Access to Mass Media by Gender in Uganda, 2000/01

Source: UDHS, 2000

3.4 Policies and Institutional Frameworks for ARH, Gender and HIV/AIDS in Uganda

3.4.1 Uganda National HIV/AIDS Policy and Institutional Set-up

Uganda developed its National AIDS Policy Draft in August 2003 and the Draft National Policy on Young People and HIV/AIDS in 1998. The National Strategic Framework for HIV/AIDS Activities was developed in 2001 (2000/1-2005/6). The Uganda HIV/AIDS Commission (UAC) established under the Office of the President, headed by a director is responsible for administering the Uganda National HIV/AIDS Strategic Framework, which in turn benefits from the Uganda HIV/AIDS Control Project (UACP), supported by a World Bank soft loan, under the Multi-country HIV/AIDS Program for Africa (MAP). The United Nations Program on HIV/AIDS (UNAIDS) funds the UAC. UAC chairs the AIDS Partnership Committee, organized as Self-Coordinating Entities (SCE). UAC arose out of the need for effective overall co-ordination, in addition to intra-sectoral and intra-institutional co-ordination, created by the large number of participants involved in the HIV/AIDS response. The Ministries of Health and Finance, Gender, Labor and Social Development, UNAIDS and UAC Secretariat each have a permanent seat on the committee. A representative of the Parliamentary Standing Committee on HIV/AIDS also sits on the Partnership Committee.

An annual HIV/AIDS Partnership Forum bringing together all members of the SCE reviews progress and sets priorities for the next year. A jointly managed HIV/AIDS Partnership fund covers coordination costs of the SCEs and key coordination activities of the UAC. The pooling of funds has set a positive precedent for common ownership of strategic responses and increased transparency and accountability. To mainstream HIV/AIDS activities, through the partnership, UAC has been able to set up the AIDS Control Programs (ACPs) in all line ministries. At the decentralized level, the District AIDS Task Force (DATF) undertakes HIV/AIDS policy implementation and programming. The District AIDS Committee, chaired by the Chief Administrative Officer (CAO) ensures coordination of implementation and effective management of the District Integrated HIV/AIDS Programs. Other corresponding structures at lower level include the Constituency AIDS Task Force (CAT), Sub-County AIDS Task Force (SAT) and Sub-County AIDS Committee (SAC), Parish AIDS Task Force (PAT) and Village AIDS Task Force (VAT), (UNDP 2002). For funding of these HIV/AIDS activities at lower level, the UAC is suggesting earmarking some of the Poverty Eradication Action Fund (PEAF), funds for AIDS activities, through the health and education sectors.

Most of the HIV/AIDS specific policies emanating from the Ministry of Health focused on specific medical interventions. Most were guidelines to HIV/AIDS prevention and care, without emphasis on any specific target population for their intervention. The only distinction was made with regard to mothers and children (as in the case of the PMTCT policy) and children and adults (as in the National ARV Treatment and Care Guidelines for Adults and Children).

ARH and gender concerns and critical social issues were not well addressed therein. Even the National Policy on HIV/AIDS and the World of Work (August 2003) from the MoGLSD makes no distinction between the age and gender of workers. The only categories emphasized are employers and employees, and the need for employees not to be discriminated against because of their HIV status. However, it is very clear that age and gender matter in the work place. Employees are discriminated on the basis of their age and gender. Women and child workers tend to earn less than adult men, for similar work. HIV/AIDS is then likely to make the discrimination and vulnerability of these workers worse. Review of the various policy instruments indicated that the policies of the Uganda AIDS Commission, National AIDS Policy Draft Aug 2003, the Strategic Framework for HIV/AIDS Activities in Uganda 2000/1-2005/6; and National Policy on Young People and HIV/AIDS 1998, and the MoH National Strategic Framework for Expansion of HIV/AIDS Care and Support 2001/2-2005/6 were the documents that attempted to address the three components (HIV/AIDS, ARH and Gender).

143 The Uganda AIDS Partnership includes the parliament, government ministries, UN and Bilaterals, National CSOs and NGOs, international NGOs, private sector, faith-based organizations, PLWHA networks, decentralized response to AIDS (local governments) and research, academia and science groups.
The ARH component was lacking in most of the HIV policies and guidelines, despite the fact that young people are the most infected and affected. Where ARH was considered, it was with regard to strategies focusing on HIV prevention, particularly IEC and counseling services, and not with regard to treatment and care, should they succumb to HIV infection. The interviewees noted that whereas policies may not specifically mention adolescents or gender, the provisions of services stipulated in the policies are assumed to integrate adolescents or gender. However, it was not possible for this study to verify the extent and means to which such services are integrated.

3.4.2 Uganda National Women Policy and Institutional Set-Up

The gender specific policies reviewed for the purposes of this study were: the National Gender Policy, 1997; the National Action Plan on Women, NAPW (1999), all originating from the Ministry of Gender, Labor and Social Development. With females comprising the most vulnerable population group to HIV/AIDS, women are key stakeholders in the HIV/AIDS debate.


Uganda has also been active in Nairobi 1985, Beijing 1995, Copenhagen 1995, New York Summit 2000 which includes the Millennium Development Goals (MDGs). This participation has stimulated major efforts to analyze the state of gender equality and the impact of public policy and action. The Beijing Platform of Action was domesticated into the National Action Plan on Women (NAPW144), focusing on four priority areas of concern: (i) Poverty, Income Generation and Economic Empowerment; (ii) Reproductive Health and Rights; (iii) Legal Framework and Decision Making; (iv) Girl Child Education and, (v) Violence Against Women (the latter was added on after 1999, due to increased gender based violence in the domestic sphere and in areas of armed conflict)4.

Uganda developed a gender sensitive constitution, the 1995 Constitution of Uganda, which provides a comprehensive framework for addressing women’s rights, gender equality and affirmative action. Among other things, the 1995 Constitution reinforced the recognition of women’s rights as fundamental human rights and women’s equality with men. Hence, it provided for affirmative action as one mechanism through which women’s equality with men could be achieved. Subsequent policy documents maintained this commitment to equality. Affirmative action has been enshrined in the Local Government Act of 1997, as a means of increasing the number of women in decision-making. Affirmative action is also mandatory for entry into parliament, as well as into institutions of higher learning. The National Gender Policy of 1997 aims at mainstreaming gender concerns into the national development process so as to improve the status of women.

The Government of Uganda has also acknowledged that gender equality and women's empowerment are key development issues, mainly through the 1995 Uganda Constitution, the 1997 Gender Policy and 2004 Poverty Eradication Action Plan (PEAP145) and the Uganda Vision 2025. The PEAP, which is Uganda's macroeconomic development framework, has identified gender as a cross-cutting issue. The PEAP, developed in 1997, and revised in 2000 and 2003/4 is a three-year master plan that guides the formulation of sector investment plans. Previous PEAPs insufficiently addressed gender issues in

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144 The National Action Plan on Women (NAPW, 1999) was Uganda’s strategy to domesticate and prioritize key critical areas as a response to the BPA.
145 The PEAP is Uganda’s Poverty Reduction Strategy Paper that is the overall development framework for the country.
relation to poverty reduction. The overall aim of development in Uganda is the eradication of poverty and the concept that poverty has a clear gender dimension and vice versa. In Uganda, poverty declined from 56 percent of Ugandans living below the poverty line in 1992 to 34 percent in 2000. However, a slightly opposite trend is emerging, with the Uganda National Household Survey (UNHS) 2002/3 showing that poverty has increased from 34 percent to 38 percent. A gender analysis of the UNHS 2002/3 revealed that poverty in Uganda hits more women than men, especially those in female-headed households.

Poverty is also concentrated in rural areas, especially in the north where only 20 percent of the population are benefiting from the 5 percent economic growth. In response to rural and gender poverty concerns clearly articulated in the Uganda Participatory Poverty Assessment Partnership Process (UPPAP) studies, Uganda's current PEAP aims to address increasing poverty and reduce inequalities. Efforts have to focus on its implementation, monitoring and evaluation to ensure that gender inequalities are addressed. Therefore, efforts have been made to conduct more analytical work and gender policy reviews in an attempt to improve gender mainstreaming in the 2004 PEAP and in all policies and programs at sector and district levels.

To implement the gender commitments, the government established the Ministry of Gender, Labor and Social Development (MoGLSD), charged with overseeing and coordinating gender mainstreaming in all other sectors. The government of Uganda has started a gender budget initiative, as stated in the PRSC4 and it is hoped that engendering the government’s budgets of key sectors will release the necessary resources to implement the gender commitments at all levels. Another development is the formation of the Uganda PEAP Gender Team (PGT), comprising gender practitioners in government, civil society, private sector and donors, under the Chairmanship of the Ministry of Finance, Planning and Economic Development (MoFPED) and MoGLSD. The PGT meets monthly to coordinate, strategize and advise government on how to mainstream gender in key policies. As a result, the PEAP (2004-8), and the PRSC (2004) are better engendered.

3.4.3 Uganda National Youth Policy and Institutional Set-up

The National Youth Policy was enacted in 2001 as a step forward in investing in young people. This policy provides an operational framework to all actors with a set of realistic guidelines from which action programs and services can be developed to facilitate meaningful involvement of youth in national development efforts and to respond to their various needs and problems.

The principles underlying the youth policy as per the document are: equity and accessibility, gender inclusiveness, youth involvement and teamwork and partnership. Key strategies and highlights in the document include:

- Advocate for increased accessibility for both formal and informal education and guidance for HIV carriers,
- Promote creation of youth skills centers in all districts to enable youth, their leaders, workers and youth organizations to access information and acquire practical skills,
- Mobilize youth, parents and school authorities to take advantage of available education and retention in schools,

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146 Uganda Participatory Poverty Assessment Partnership Process (UPPAP) report of 2002 produced by the MFPED revealed substantive evidence that gender is a key variable in Uganda's poverty and has to be addressed for development to be realized.

147 The PEAP Gender Team (PGT) put together a Gender Mainstreaming Strategy and work plan for 2004/05

148 The PRSC is the Poverty Reduction Support Credit, which funds the PEAP and is used for negotiation with the World Bank and Donors before funds are released.
Advocate for the promotion of innovative ways to mobilize resources for youth services, emphasizing partnerships with central and local government, NGOs and the private sector,

Build partnerships and coordination mechanisms among stakeholders in youth health and development,

Promote income generating activities among the youth by supporting appropriate micro-credit financial institutions that extend credit facilities to youth, and

Strengthen and promote youth networks at all levels.

Some of the youth related national polices and instruments are: the National Youth Policy (2001); the National Adolescent Health Policy (draft) 2000, the Orphans and Vulnerable Children's Policy (draft) 2003; School Health Policy for Uganda 2003; National Strategy for Girl's Education; and the Uganda Primary Education (UPE) Policy.

The Ministry of Gender, Labor and Social Development (MoGLSD) is the national agency in charge of youth issues. The Youth National Machinery operates under the directorate of Ministry of youth, under the MoGLSD. The role of the MoGLSD is to oversee the mainstreaming of youth issues in all government development policies and programs implemented by its multi-sectoral partners. Specifically, this involves coordinating, facilitating and catalyzing all relevant players for youth sensitive development planning. The key multi-sectoral partners and their implementation roles are: (i) Ministry of Health – spearheading and coordinating adolescent health policy; (ii) MoGLSD – implementation of National Youth Policy and OVC Policy; (iii) Ministry of Education and Sports – UPE, School Health, Education Strategy for Girls; and (iv) Others falling under the relevant line ministries.

3.4.4 Uganda ARH Policy and Institutional Set-up

Many of the factors that predispose people to HIV/AIDS are of sexual and reproductive health nature. First and foremost, this is because HIV in Uganda is mostly transmitted by heterosexual contact. Secondly, one of the causes of female's disproportionate vulnerability to HIV/AIDS has been attributed to the female reproductive health system which retains sexual fluids longer than in males, thus prolonging opportunities for infection. Thirdly, providing good obstetric care is fundamental in successful prevention of mother-to-child HIV/AIDS infection, which is the main mode of infection for young children with HIV/AIDS. Furthermore, sexual and reproductive health has been the main thrust of gender concerns in health and population policy. These factors, together with the fact that HIV/AIDS is itself a reproductive health concern for women makes review of the reproductive health policy for Uganda very important. Such a review would provide insight into how gender concerns, for adolescents or adults, have been integrated in HIV/AIDS policies and programs.

All the policies reviewed under this section originated from the Ministry of Health of Uganda and included the following:

- National Adolescent Health Policy, 2000,
- Sexual and Reproductive Health Minimum Package for Uganda, 2000,
- The Uganda Safe Motherhood Strategic Plan 1997-99,
Decentralization of governance and the health infrastructure is another promising practice, which has led to the creation of Health Sub Districts, which are supposed to be equipped with integrated health care services. This includes HIV/AIDS specific services such as testing, antenatal services, ARH services, and many more, all at the same venue. This has in turn led to the integration of services, regardless of whether the policy clearly makes a case for integration or not. With decentralization, particular conditional grants have been made available for PHC. One area in which youth may benefit is through the emphasis on IEC, particularly HIV/AIDS preventive education for youth, and equipping them with life skills.

The National Adolescent Health Policy, 2000 was the most well integrated policy from the Ministry of Health extensively addressing all three issues of HIV/AIDS, ARH and gender. The strategies to achieve the set targets were clearly stated. Most of the other policies were responses to women's reproductive health concerns. As such, improving women's reproductive health, particularly reducing maternal mortality was their main focus. Reducing the maternal mortality rate is significant to this review, as it highlights the attention given to gender concerns in health care, including HIV/AIDS care. Persistently high levels of maternal mortality suggest that much more needs to be done in addressing women's health concerns, including HIV/AIDS care and treatment. Addressing HIV/AIDS and women's low social economic position were issues of concern in these policies, albeit as a mortality reduction strategy. There was an attempt to detail the several gender issues that predispose women to danger during pregnancy and childbirth. Although women stand to benefit from this, their health and HIV/AIDS concerns should be addressed in their right as citizens, not simply as a means to an end. Most of the strategies in this policy focused on prevention, namely IEC and counseling services.

3.4.5 Gaps and Challenges to Policy Implementation in Uganda:
Policy developments in Uganda have been given emphasis and several policies are in place. Most of these were sectoral policies. Hence, they tended to emphasize the focus of their sectors. Adolescent/youth and gender being cross-sectoral issues had been sidelined. In most of the policies and strategic actions, HIV/AIDS was mainstreamed, but mainly focused upon as a development issue, being mentioned where it impinged on the progress in specific sectors. Hence, each sector highlighted those dimensions of HIV/AIDS specifically related to it. For example, in Health, the National Health Policy mentions HIV/AIDS as a significant contributor to the burden of disease, the Orphans and Vulnerable Children Policy mentions it as a cause for the rise in orphans and vulnerable children and the PEAP as a deterrent to development. Some of the gaps and challenges to effective policy implementation highlighted by the study findings are:

- Limited Dissemination of the Policies: The policies that are made usually stay on the few stakeholders’ shelves. Little is known about them, including those who are supposed to implement them. For example, the recent evaluation of the National Action Plan on Women revealed that it had not been received by several district officials, including those responsible for implementing it, such as the gender focal points.
Most Policies are Drafts: Many officials interviewed stated that these policies were respected and acted upon despite their 'draft' state, given that many implementers played a role in their drafting through the HIV/AIDS partnership. However, as drafts, these policies were not valid or legitimate. This means they have not yet been tabled and debated before parliament, which would enhance their publicity and legitimacy.

Gap in Legal Frameworks and Practices: There is a wider gap between legal instruments and customary practices, contradicting each other. Customs and norms are unfair and discriminating to women. For example, the same 1995 constitution that provides for affirmative action and equality also provides for cultural freedoms, which may include cultures that subjugate women such as female-genital mutilation (FGM) and bride price, which reinforces gender inequality within marital unions. Also, the 1998 Land Act caters for women’s security of occupancy and access to land, but denies them ownership of land. There is also limited access to justice by several women, which is a critical gender issue.

Vertical Programming and Initiatives: Despite several policies, programs and key informant interviews emphasizing integration and linkages of RH and HIV/AIDS, most health services and programs were still being implemented in a vertical manner, with the exception of counseling and testing. For example, Sexual and Reproductive Health and HIV/AIDS components are still vertical programs, with the former emphasizing maternal and child health, while the latter is focused on as a communicable disease.

Lack of Comprehensive Approach for Policy Implementation: For example, the youth policy does not have a strategic framework for implementation. Youth and gender activities are usually undertaken based on donors, imitative of support, rather than on a budget item planned within the national frameworks;

Inadequate Commitment to Gender and Youth: There is no strategic framework for implementing the National Gender Policy. As such, it is not clear how the under-resourced MoGLSD is supposed to coordinate and oversee gender mainstreaming in other sectors and programs. Similarly, the Equal Opportunities Commission, through which issues of marginalized groups including women are to be addressed, is yet to be set up. Youth issues do not have budget line and, if any youth related programs and initiatives were under budgeted. The Department of Gender, Culture and Community Development is just one of seven directorates in the MoGLSD, falling under two directorates, one for Gender and Community Development and the other for Labor.

Lack of Targeting and Understanding of Relevance of ARH and Gender in HIV/AIDS Programming: The programming and budget allocation for HIV/AIDS has been based on interventions, with no emphasis for targeting vulnerable groups. For example, discussions with policy makers revealed that ARH and gender, though not mentioned in specific policies, were catered for implementation. Accordingly, young and poor women were amongst the vulnerable groups targeted by prevention, treatment and care programs, especially since equity was a specific priority issue within Ministry of Health policies, programs and activities. However, without policy commitments and budget lines, it was difficult to establish how exactly this would be done. Though a very critical factor for gender, particularly for young females, ARH issues only appear in the National Action Plan for women, and are hardly mentioned in the National Gender Policy. In gender documents, issues of prevention, treatment and care, and their gender dimensions are not discussed.

Youth are not Given Emphasis while Heterogeneity of the group has not been Recognized: In all of the policies, including the National Adolescent Health Policy, no special consideration is made about treatment and care, should adolescents succumb to HIV
infection, despite young people constituting a significant proportion among those infected with HIV. There is a potential gap in information between urban and rural based youth. Most of the organizations were located in urban areas, or used urban areas as focal points, suggesting limited access for rural youth. There is also a potential gap in information between school going and non-school going youth, with more attention to those in school.

- **Youth and Women are Excluded from Decision-Making**: Young people are not involved in decision-making and the design and implementation of policies that shape their lives and influence their ability to protect themselves from HIV/AIDS. Furthermore, women are given low status in the society.

- **Weak Institutional Capacities**: Inadequate capacity of the Uganda AIDS Commission (UAC); and the gender machineries are weak institutions with inadequate capacities at all levels. For example, the Ministry of Gender, Labor and Social Development, which is supposed to oversee the mainstreaming of gender concerns in other government policies and programs is under-resourced.

- **Weak Coordination**: Inadequate coordination of many donor funded initiatives, donors putting too much demand for different formats and reporting, stretching the weak capacity of recipients.

- **Gender Mainstreaming and its Multi-sectoral Nature Not clearly Understood**: Gender mainstreaming is often mentioned as a token, but requires a clearly set strategy, which should spell out the proposals and recommendations for incorporating gender concerns, addressing needs of both boys/men and girls/women to gain gender equality. In the gender policy, the main focus is on women, particularly adult women. No references are made about female adolescents and their specific gender needs, such as adolescent pregnancy and vulnerability to HIV/AIDS and other risky youth issues. Neither is any reference made about males, particularly young boys and their potential vulnerability to HIV and other risky behaviors. Also, despite the emphasis on the multidimensional nature of gender, emphasis on the policy is with regard to cultural practices. Little reference is made to women’s health needs. HIV/AIDS is only mentioned in the introduction as a number one killer of adults and is hardly featured thereafter, regardless of the potential gender issues in HIV/AIDS prevention, care and treatment. Issues of adolescents and young people (both males and females) are not mentioned at all. There is no attempt to relate women’s position and status in society (which is captured in the policy) to their HIV/AIDS vulnerability.

### 3.4.6 Recommendations for Scaling-Up:

A stakeholders’ dissemination workshop was held in Kampala on May 27, 2004 to validate the study findings and suggest a way forward. The following recommendations were presented:

- Launch wider dissemination of policies and advocacy for their effective implementation;
- Strengthen the legal and judiciary frameworks for effective law enforcement;
- Improve partner coordination and harmonization;
- Enhance research on ARH and HIV/AIDS;
- Scale up male involvement in ARH and gender mainstreaming of HIV/AIDS programming;
- Promote engendering the MTFR (Mid-Term Financial Reviews) and facilitate the gender budgeting initiative;
✓ Promote increased targeting for vulnerable, poor and hard to reach,
✓ Clarify the share of roles and responsibilities between implementing institutions,
✓ Promote skills development and capacity building for ARH, gender and HIV/AIDS bodies,
✓ Scale up successful initiatives and promising approaches,
✓ Strengthen the monitoring and scaling up of policy implementations,
✓ Scale up successful multi-sectoral initiatives, and
✓ Facilitate the mainstreaming of issues of youth/adolescent and gender within the existing development frameworks (CAS, SDPRP, PRSCs, MDGs) and sectoral goals and actions.
4 Findings from a Six Country Assessment Looking at the Youth HIV/AIDS Interventions in the Multi-Country HIV/AIDS Programs (MAPs) of the World Bank

4.1 The World Bank on Youth and HIV/AIDS

The World Bank has been supporting African countries in addressing the HIV epidemic through the Multi-Country HIV/AIDS Program (MAP) in Africa, which has now committed US$1.26 billion to 29 countries and 4 sub-regional projects. Out of the US$1.26 million committed, the World Bank has disbursed about $747 million, and this figure is increasing consistently as implementation of the national and sub-regional projects continues. A recent assessment of how the MAP is addressing youth found that all the MAP countries indicate that youth are a priority group, but coverage of information and services and youth participation in policy formulation, program design and implementation remains fairly inadequate and not systematic.

Several key policy statements of the World Bank clearly assign a priority to action on youth and HIV/AIDS. The Global HIV/AIDS Program of Action (2005) explicitly recognizes the essential role of young people and stresses the need to “stay the course” on prevention, with an emphasis on the young and uninfected. The Program of Action calls for providing young people with access to youth-friendly and gender-specific information, health services, and counseling on and access to condoms. It also highlights the need to reach both in-school and out-of-school youth and to involve young people in designing and carrying out programs. Similarly, the Bank’s Children and Youth Strategic Framework (2005) emphasizes the need for reducing risky behaviors, including those that promote the spread of HIV, as a strategic pillar (The World Bank’s Children & Youth Unit, 2005). HIV and other health risks of young people are also a focus of the World Development Report, 2007.

Much of what was known about the Bank’s work on HIV and youth came from informal reviews and the examination of policy and planning documents such as the Project Appraisal Documents (PADs) prepared for Bank operations and the national HIV/AIDS strategic frameworks. These previous reviews left largely unanswered the question of how the Bank’s articulated youth support translated into concrete actions through the country MAP activities. Furthermore, little was known about the day-to-day challenges facing Bank-supported HIV and youth efforts.

To provide information and answer such questions, an assessment was carried in six MAP countries, mainly, Burkina Faso, Ethiopia, Malawi, Sierra Leone, Uganda and Zambia. Although this study looked specifically at the MAP-supported projects, its findings and lessons learned are relevant to other countries and to non-MAP projects of the Bank and other partners. The study hopes to provide further guidance to the Bank on improving the effectiveness of its investments in HIV/AIDS programming.

4.2 Key Findings of the Six Country Case MAP Assessment

- The World Bank, government officials and other partners generally recognize the importance of young people in fighting HIV/AIDS. Within the context of a generally positive policy environment, almost all MAP Project Appraisal Documents (PADs) identify young people as a key target group, and many include project impact indicators that are youth-specific. However, few PADs mention specific youth programs or put forth a coordinated approach to the concerns of young people.

The MAP supports a wide range of youth-specific programming, with most efforts focused on the local response component. Appropriately, given the beneficiary group, youth-oriented projects concentrate on disease prevention, including information, education, and communication (IEC) and services. The MAP is providing at least a small level of support for youth programs. Information from a range of studies and countries show that a small but significant portion of funding is youth-oriented.

Stand-alone youth-oriented programs and those supported through ministries are less common. Little information is available on the effectiveness of youth initiatives. Although most youth-focused, MAP-funded programs fall within international good practice guidelines, impact evaluation is almost non-existent.

Current programming displays weaknesses that may undermine effectiveness. These include poor links with broader reproductive health concerns, limited duration of activities, lack of coordination, and a lack of attention to high risk and rural youth and to gender concerns.

Further constraints also limit the reach and effectiveness of youth-oriented programs. These include gaps in the capacity of civil society organizations (CSOs) including youth organizations that mostly implement youth focused interventions.

Lack of meaningful youth involvement at all levels, policy programming, implementation and monitoring and evaluation were reported. Poor coordination among donors and youth-serving groups was a critical challenge.
5 Identified Promising Approaches that are working

Despite several gaps and challenges to mainstreaming and the limitation of resources, some achievements have been made. Gender mainstreaming in HIV/AIDS national policies is a promising practice. Progress made in regards to mainstreaming gender and HIV/AIDS in Uganda and Ethiopia at both policy and program level should be scaled up and intensified. More effort is required to add on ARH mainstreaming in policy and program level. This will involve sensitizing the public about the importance of ARH and their role in helping our young people enjoy their youth in a healthy way, making gender equality and women’s human rights key principles. Largely, in Ethiopia and Uganda, there are policy-making and advisory structures and few service providers to be cited as promising approaches and/or could be scaled up. However, making the public health system, the largest health provider more youth friendly and developing a responsive multi-sectoral implementation for the country’s ARH policies and strategies will have a much more effective and sustainable result.

5.1 Uganda Examples

In Uganda, establishing the Uganda HIV/AIDS Partnership has been fundamental to ensure that the interests of all stakeholders, including adolescents, children, women and men are considered in policy-making. Despite many of the policies being drafts, serious consideration is given to these groups because the participatory process of designing and approving has been undertaken by the partnership members themselves:

- The Uganda Network of AIDS Service Organizations (UNASO) is a promising practice worth documenting. As a member of the Uganda HIV/AIDS Partnership representing NGOs, UNASO is in a position to influence policies to address ARH and gender concerns. As a network of AIDS service providers, UNASO is also in a position to direct AIDS services efficiently, to ensure wide coverage where services are needed most.

- A good example of public-CSO and donor partnership established through the Reproductive Health Task Force of the Family Health Department of the Ministry of Health has been noted in Uganda. Composed of key stakeholders, government agencies, donors and CSOs/NGOs and chaired by CORHA (Consortium of Reproductive Health Organizations), the Task Force works as an advisory team to the government body and with UNFPA and UNICEF chairing technical teams.

- Government policies that have integrated ARH, gender and HIV/AIDS, such as the National Adolescent Reproductive Health Policy, the National HIV/AIDS Policy, and National Policy on Young People and HIV/AIDS should be scaled up, and funded appropriately to ensure that integration is maintained at implementation level. Uganda’s institutionalized commitment opens avenues for other partners and wider mainstreaming in different forms as implementation is being observed.

- At organizational level, two critical examples of promising practices of Uganda rated as best practices by UNAIDS: TASO (The AIDS Support Organization) and the Straight Talk Foundation. Such initiatives indicate how far local initiatives can go in helping control HIV/AIDS, with few resources, which should be encouraged and supported.

- TASO presents an example of effective sustainability. A locally founded organization, it pioneered the work of caring for PLWHA even before the government opened up on HIV/AIDS. Currently, it is the oldest AIDS service organization in the country, with the widest coverage in providing care to PLWHA. TASO has been spearheading advocacy and has brought about effective policy and programmatic changes. It also was among the
institutions that played a role in breaking the silence, bringing openness and fighting stigma and discrimination.

✓ *The Straight Talk Foundation* has been the most efficient in addressing ARH concerns, particularly by providing youth with information, and enabling them to express themselves. Using the national newspaper to disseminate their newsletters has been critical in ensuring wide coverage, of both school going and non-school going youth, especially considering that the Straight Talk newsletters are printed in several local languages. Integration, at both policy and service provision levels have serious financial implications.

### 5.2 Ethiopia Examples

In *Ethiopia*, to address the HIV/AIDS epidemic as an emergency and development issue, a number of initiatives and actions have been undertaken by the government and different partners and stakeholders. The HIV/AIDS policy and strategic framework, guidelines and tools have been put in place to facilitate the implementation of programs. There are multi-sectoral structures such as the Reproductive Health Task Team of the MoH, the technical advisory and review board of HAPCO and the national youth council of MoYSC. Women Affairs Office (WAO) is aimed to intensify the mainstreaming of gender in the SDPRP and other national initiatives. There is already a national ARH Five Year Plan of Action which can easily be implemented. However, as HIV/AIDS infects more people, its impact is becoming more complex and the science and approach of addressing it is becoming more demanding and complicated. It requires rapid response, continued learning and sharing as well as adaptive, dynamic approaches and tools and leadership. There are policy instruments, but they need to be disseminated and shared by all stakeholders and implementers. Other institutional set-ups and activities that will help facilitate the mainstreaming of ARH, youth and gender into HIV/AIDS programming include the following:

✓ *The Reproductive Health Task Force of the Family Health Department of MoH*, composed of key sectors, development partners and CSOs/NGOs, with technical working group on key RH issues is a promising multi-sectoral partnership approach that needs to be strengthened and promoted.

✓ *The Youth National Council at the Ministry of Youth, Sport and Culture* composed of representatives from key government sectors, NGOs and civil society, youth groups, and others work on youth issues. In addition, there is the National Advisory Board of HIV/AIDS Prevention and Control Office (NAB/HAPCO) that has sub-committees on key issues such as health and education working on youth issues. Also, the Joint Parliamentary Social and Women Standing Committee which oversees common issues such as population, reproductive health, youth, gender violence and related issues are promising.

✓ Several PLWHA organizations have been established in Ethiopia such as *TILLA PLWHA women's group* based in Awassa, SNNP Region, support women including young girls/women with HIV/AIDS. TILLA provides care and support for women PLWHA, as well as facilitates IEC on gender and HIV/AIDS and mobilizes women’s involvement with HIV/AIDS initiatives. The same PLWHA women who initiated TILLA are heading a national association of women PLWHA. *Don of Hope (Birub Tesfa) and Mekdem* – the national PLWHA NGOs - which are the pioneers working on HIV/AIDS interventions. Prevention, support and care are also among those that can integrate gender and ARH within their project.

✓ *ISAPSO (Integrated Services for HIV/AIDS Prevention and Support Organization)* is an NGO that serves vulnerable and high risk groups (truck drivers, commercial workers) as well as youth, communities and government agencies such as MoH, schools, kebele councils, etc. Mary
Joyce, an NGO that manages a number of comprehensive HIV/AIDS interventions regarding prevention, treatment, care and support. These NGOs have promising initiatives for scaling up.

Pathfinders International supports several ARH initiatives and programs in the country and works with multi-sectoral partners: government, NGOs, community initiatives, private sector and learning/research institutions.

Family Guidance Association of Ethiopia (FGAE) is a pioneer NGO working on ARH issues since 1972 and with youth friendly services since early 1990s, particularly for adolescents. It covers nine regions of the country, working closely with government sectors, communities, and youth groups. It is among the leading CSO undertaking integrated RH and HIV/AIDS youth friendly services. It has a gender focal point to mainstream gender to its on-going projects. It is a member of several national task forces to advocate for ARH and youth friendly services. The new strategic plan of FGAE focuses on rural youth and underserved groups.

DSW (German Foundation for Population) works closely with youth groups and clubs, building their capacity and helping them mobilize and organize their clubs/groups. It is in the process of establishing a youth training center.

The World Bank Summer Camp, a school based Youth Advisory Group (YAG) supported by the World Bank Ethiopia Office, which has now transformed to an NGO indicated that youth when given support and voice can be innovative. Currently the YAG NGO is involved in an information dissemination, and experience sharing forum. There is a plan by the Bank to continue working with new groups of young people to increase their engagement in HIV/AIDS and related Bank initiatives and programs and to give them voice.

Addis Ababa Youth Association (AAYA) with over 73,000 members covers all the kebeles in the Addis Ababa City Administration. Over half of its members are female. It works on ARH issues and is keen to expand gender in its operations. Ethiopia Youth Network (EYN), supported by FHI is involved in developing a database of youth clubs/groups. It is supported by FHI.

Ethiopian Women Lawyers Association (EWLA) is an NGO formed by groups of women lawyers and with membership of diversified women and men; headquarters in Addis Ababa and with branch offices in some Regions. It has been involved in a number of advocacy efforts for gender equality and women’s rights and instrumental in the review of laws and policies. It also provides free legal service to women.

Consortium of Reproductive Health Associations (CORHA): an NGO carries out advocacy work and provides capacity building support to organizations working on RH issues. It has been instrumental in intensifying the integration of RH to development projects and issues in the country. It has been developing manuals and guidelines for standardizing RH services.

The Ethiopian Women’s Associations: formed at regional and all lower levels of governance, they bring women and women’s groups together for advocacy and capacity building efforts.
6 Conclusions and Recommendations for A Way Forward

6.1 Recommendations for Action based on Challenges and Gaps Identified

Taking the summary of the key challenges and gaps identified by the stakeholders from both countries indicates that similarities between Ethiopia and Uganda. Table 11 lists those challenges and provides recommendations and issues for action.

<table>
<thead>
<tr>
<th>Challenges and Gaps Identified and Validated by Key Stakeholders:</th>
<th>Issues and Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited dissemination</td>
<td>Communication/Management Systems</td>
</tr>
<tr>
<td>Most of the policies on draft</td>
<td>Commitment/Leadership</td>
</tr>
<tr>
<td>Gap in legal frameworks and practices</td>
<td>Commitment/Leadership</td>
</tr>
<tr>
<td>Lack of comprehensive approach to policy implementation</td>
<td>Programming/Coordination/Management System</td>
</tr>
<tr>
<td>Inadequate focus/commitment to youth and gender</td>
<td>Commitment/Leadership</td>
</tr>
<tr>
<td>Lack of understanding of relevance of gender in youth and RH issues</td>
<td>Awareness/Change in Attitude. Knowledge and Learning</td>
</tr>
<tr>
<td>Vertical programming/weak linkages</td>
<td>Harmonization/Commitment/Management Systems</td>
</tr>
<tr>
<td>Targeting to reach those at risk</td>
<td>Commitment/Programming</td>
</tr>
<tr>
<td>Weak coordination</td>
<td>Harmonization/Leadership/Accountability</td>
</tr>
</tbody>
</table>

In spite of the several achievements in both Ethiopia and Uganda in the area of promoting gender sensitive legislation, increased media coverage to gender and youth issues and commitment indicated at international and national levels, addressing issues of young people and gender in HIV/AIDS and development policy frameworks, programming and implementation is still lagging. Specific examples of the existing gaps and factors that hinder mainstreaming of ARH, gender, youth and women include among others those presented below.

6.2 Are We Responding to the ARH and HIV/AIDS Needs of Adolescents, Youth and Women?

A summary of key Demographic and Health Surveys (DHS) findings (1984 – 2006) from 54 countries over ten years list the critical challenges to women’s health as: education, childbearing experiences and choices (maternal), relationship, access to health care, household environment, home life and HIV/AIDS being determinant factors for the risks to HIV/AIDS. 

6.2.1 Gender Based Violence, Harmful Practices and Relationships

The DHS summary report indicates that early marriage and early sex still remain common causes for women’s morbidity and mortality though laws are being put in place. It showed that one-fifth to one-half of married women reported that their husbands or partners have physically or sexually abused them. The two country study findings showed that there is wide gap between legislations written to redress harm and discrimination and their implementations. Enough commitment is not seen to enforce the legislations to narrow the gap between the practices on the ground and the laws on paper.

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150 Women’s Lives and Experiences, USAID, June 2006
For example, the 1995 Constitution of Uganda clearly affirms gender equality and denounces all forms of discrimination and violence against women. Uganda has also ratified international treaties requiring the elimination of discrimination, as well as to act with due diligence to prevent, investigate and punish acts of discrimination and violence against women. However in reality, violent crimes against women continue to rise. For example, according to the Inspector General of Police, (cited in *The New Vision* April 17 2004), in 2001, there were 804 reported cases of defilement, 988 cases in 2002, and 3,052 in 2003. Rape cases were reportedly 52 in 2001, 93 in 2002, and 181 in 2003. Defilement is currently the leading crime in Uganda, having the most case backlogs (The Uganda Law Reform Commission 2000). The Human Rights Commission (2002) report observed an escalation of defilement and rape especially in internally displaced camps and war-ravaged areas. Human Rights Watch (2003) explored the link between HIV/AIDS and domestic violence, including other forms of violence such as evicting widows from their property because of suspicion of being HIV positive. The 2003 report also concluded that Ugandan women largely confront an environment that sustains unequal power relations, societal pressure to tolerate violence, physical coercion and emotional abuse from their spouses, including marital rape. The rise in gender based violence and low status of women in Ethiopia has contributed to the increase of factors predisposing women’s vulnerability to HIV/AIDS such as harmful practices, poverty, social injustice, conflict and displacement.

### 6.2.2 Effective Programming and Access to Services

Similarly, the Ethiopia DHS 2005 data on maternal care does not show any difference five years after the previous survey, with delivery care at health services at 5 percent in 2000 and at 5 percent in 2005. The government report indicated an increase of health centers from 382 to 600 and health posts from 1023 to 4211 over five years, showing an increase of 57 percent and 310 percent respectively. These are the only common ANC/MCH delivery services for the rural and poor urban women population. During a dissemination dialogue of this study during mid-February 2005 in Uganda, the head of the parliamentary social (health and education) and HIV/AIDS committee were alarmed why maternal and RH outcomes are not improving as the parliament intentionally increased the budget to address issues of women’s health in the country.

This raises a point of concern and at the same time provides a message for further in-depth research. The findings of the EDHS 2005 cited the problems to accessing maternal health care: getting permission to go for treatment (4.5 percent), getting money for treatment (75.6 percent), distance to health facility (71.6 percent), not wanting to go alone (61.4 percent), concern there may not be a female provider (72.5 percent), concern there may not be a health provider (80.5 percent), concern there would be no one to complete household chores (69.3 percent) and any of the specified problems (95.7 percent). This explains clearly that programs and services are not taking into consideration the needs and environment of their clients. Undertaking a more holistic approach of addressing priority issues which can bring about effective outcomes will be critical. Gender will be central to address these socio-economic issues.

### 6.2.3 Low Status and Poor Representation of Women and Youth

The 1995 Constitution of Ethiopia, Article 35, clearly announces gender equality and even endorsed affirmative actions to address existing discrimination against women. The number of women in federal parliament has increased from 10 percent (year 2000) to 25 percent (year 2006). However, women still hold less decision making positions at all levels. Effective engagement of youth at all levels of programming and decision-making levels as well as policy dialogue is on the rise. Although this is significant, it is not yet institutionalized.

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151 Just Die Quietly: Domestic Violence and Women’s Vulnerability to HIV in Uganda, Human Rights Watch, 2003

Likewise, the 1995 (articles 78 and 100) Constitution of Uganda also provides for affirmative action through the provision of participation of women in the Parliament and local government. Evidence shows that more than one-third of young women aged 15 to 24 have never attended school. In reality, women are largely under-represented in the upper echelons of local and central power. Women, including young females, lack access to quality education, higher education and better employment and income-generating opportunities.

6.2.4 Discrimination of Women Regarding Access to Resources and Economic Opportunities

Article 35 of the Ethiopian Constitution also grants women’s rights and equal opportunity for property ownership, particularly where land rights are concerned. The Federal Rural Land Administration Law issued in 1997 also enforces the equal right of women to land holdings, administration and transfers. Unfortunately, in reality, such Constitutions and laws on the rights of women are tangled with customary practices and laws. This results in serious discrimination in the distribution of land whereby women’s actual access to land is hindered by complex and bureaucratic process. Only few Regional states are trying to take these laws to implementation. Women’s low economic/asset ownership is resulting in men becoming the beneficiaries of women owned land. The majority of the agricultural land is agrarian and uses traditional methods of oxen/animal and local tools. However, it is beyond the economic capacity for the majority of women to own these animals and the necessary tools. Women headed households (the majority of which are poor) end up contracting out their land to men.

Likewise, the 1995 (articles 78 and 100) Constitution of Uganda also provides for affirmative action through the provision of participation of women in the Parliament and local government. However, many customary and statutory laws, including application of Islamic law and traditional institution of polygyny, land and labor laws largely discriminate against women in areas of marriage, divorce, property rights and inheritance and contribute to the economic dependence of women on men.

6.2.5 Inadequate or Lack of Allocation of Funds for ARH, Gender and Youth in HIV/AIDS Interventions

Whereas most of the policies reviewed in both countries, particularly the HIV/AIDS policy and strategic frameworks, reflected integration at the implementation level but not in adequate resource allocation and program targeting. Allocation of funds based on prioritizing and targeting the most vulnerable groups have not been noticed. Currently, HIV/AIDS funds are allocated to organizations that are vigilant in coming up with marketable proposals for funding, regardless of their position vis-à-vis ARH, gender and youth and effective combating of the epidemic’s HIV prevalence.

Despite the international and national level commitments to ARH and gender concerns, the allocation of HIV/AIDS Global Funds in the countries is not ARH, youth or gender specific. For example, in Uganda, the allocations of HIV funding are: 52 percent through the public sector and 48 percent though the private sector, including 32 percent to civil society organizations (CSOs) and 16 percent for not-for-profit organizations.

6.2.6 Absence of Effective Targeted Programs and M&E System

The impact and effectiveness of HIV/AIDS interventions on the most vulnerable groups and populations (youth, adolescents and women) are not tracked via an adequate M&E system in both countries. The agreed upon UNGASS, MDGs and other indicators should be made part of country
M&E systems. Targeting those at risk and vulnerable as a priority will definitely help in curbing the HIV epidemic and minimizing the maternal and RH challenges they face. A systematic review on factors that shape young people’s sexual behavior\textsuperscript{154} found key issues that could help in developing interventions, but could need further in-depth research. The findings include: assessing their sexual potential partner by appearance/dressing, condom use associated with stigma for lack of trust, gender stereotypes (social expectations) in determining social expectations and hampering communication about sex. If policies and programs do not consider the socio-cultural, economic and environmental perspective of their targets, nor take gender, RH and HIV/AIDS as key elements, young people will remain at risk.

6.2.7 High Expectations from Communities and Capacity Building

In most policy documents in both Uganda and Ethiopia, prevention strategies emphasize community input and effort, assuming that communities will always be there and willing to volunteer to sustain HIV prevention activities. One interesting thing about the Multi-country HIV/AIDS Program in both countries was the community response projects (Community HIV/AIDS Initiatives (CHAI) in Uganda and Emergency AIDS Fund (EAF) in Ethiopia. The MAP disbursements and hard to reach local targets were attained with the community outreach projects. All stakeholders, including the HIV/AIDS program managers, agreed that the community response reached the local population and included young people, women and vulnerable groups. The assumption that communities will cooperate without giving enough regard to the poverty level and the inadequacy of the capacity of community structures was not helpful. Assessing the capacity of communities and other relevant institutions is critical and can facilitate strong ownership, participation, raise transparency and accountability, and empower people to take charge.

This study clearly indicated that all the institutions charged in addressing ARH, gender and HIV/AIDS have capacity limitations (human and other resources).

6.3 Lessons to Learn

A number of specific lessons to learn have been drawn from the findings of the study relevant in each country case, as follows.

\textbf{Lesson 1: Further Analytical Work:} While moving to the next steps of the global response to HIV/AIDS, it is critical to identify and understand key factors that fuel the epidemic that are attributed to socio-economic, political and cultural factors of a specific country and the region. The key factors fueling HIV/AIDS in Africa is mainly casual sex, which requires behavioral change. Behavioral change takes time and further research and analytical work is required to respond to the changing epidemic.

\textbf{Lesson 2: Targeting those at Risk:} Finding adequate and effective mechanisms to address the issues by targeting the most vulnerable groups must be considered a priority in HIV/AIDS policy design, programming, and implementation.

\textbf{Lesson 3: Linking AYRH and Gender in HIV/AIDS Programs:} The centrality of youth and gender issues and linkages between ARH and HIV/AIDS should be among priority items in HIV/AIDS programming within the framework of poverty reduction, achievement of the MDGs and country-level development framework.

\textsuperscript{154} Lancet, 2006, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London 2006.
Lesson 4: Innovation and Dynamism: The “business-as-usual” and traditional approach of programs and projects may not be enough to cope with the rapid and complex devastation of the epidemic.

Lesson 5: Monitor and Evaluate Use Evidence (Facts): As the impact of the HIV/AIDS epidemic changes drastically and becomes complex, it is important for countries to vigilantly monitor the effectiveness of HIV/AIDS interventions. Developing an M&E mechanism that allows for effective and timely tracking of the inputs, outputs and outcomes of HIV/AIDS interventions aimed at addressing issues of ARH, youth and gender through indicating changes and impact on young people, women and other groups at risk is vital for combating HIV/AIDS.

Lesson 6: Mainstreaming and Multi-sectoral Participation: intensifying the integration of ARH, gender and youth in HIV/AIDS requires strong mainstreaming and programming through multi-sectoral participation of key stakeholders. This approach would allow for cost-effective use of resources, encourage learning and formation of strong alliances. Mainstreaming of gender, ARH and youth in HIV/AIDS programming requires a systemic approach institutionalized with sufficient resources and skills, coupled with strong leadership, commitment and goodwill to bring about necessary behavioral and attitudinal changes.

Lesson 7: Setting Gender Based Indicators: The inclusion of fast-tracking and target-based indicators and reporting facilitates processes where youth, women and other vulnerable groups exposed to HIV/AIDS benefit from the interventions that are targeted to their needs and concerns.

Lesson 8: Empowering Women and Increasing Men Participation: Addressing issues of ARH, gender, youth, and most importantly in the context of HIV/AIDS, requires wide and continuous participation from men. Women empowerment to make an informed and asserted decision will be critical. If gender issues are not understood and accepted as matters of both genders (men and women) and as a societal concern at large, building multi-sectoral linkages and approaches on ARH, gender and HIV/AIDS may not achieve effective results.

Lesson 9: Commitment for ARH, Gender and HIV/AIDS: Addressing issues that are critical to the majority of the population, youth and women, particularly in the era of HIV/AIDS requires strong leadership. Strong leadership requires having genuine commitment, putting necessary resources and marking direction, strategies and results. There is a need for strong sensitization to increase commitment and realize the significance and centrality of young people and gender in programming and interventions at all levels.

6.4 Recommendations

6.4.1 The Way Forward for Sustainable Results
Based on the study findings, some of the recommendations proposed by the in-country study teams included:

- **Share of Vision & Direction:** Wider dissemination and promotion of policy and institutional frameworks and mechanisms, to reach the communities involved.

- **Community Dialogue:** Encourage continuous dialogue between policy makers with their stakeholders and communities, being a strategic move for increasing commitments (political, resources, social and technological). Deepen the community involvement element of the local response component to appropriately and systematically include parents, teachers, and religious and traditional leaders in youth HIV/AIDS programs.
✓ **Enforce Legislations:** Align legal frameworks and customary practice to ensure the human rights of citizens, particularly vulnerable groups, youth and women.

✓ **Intensify Women Empowerment and Male Involvement:** Increased participation of young people in policy making, planning, implementation and monitoring and evaluation of national frameworks as well as in all programs and activities is critical. For their effective participation, focus on Engender the Education system, including the non-formal and capacity building activities to bring about social transformation. Design specific programs to empower women and increase supportive male involvement.

✓ **Strengthen Linkage of ARH and HIV/AIDS:** Adolescent reproductive health (ARH) within HIV/AIDS programming is central when institutionalizing youth and gender issues for long term, sustainable results. Increase targeted programs for difficult to reach young people such as sex workers, out-of-school youth working in the informal sector, and out-of-school youth in rural areas.

✓ **Mainstream Youth and Gender Issues:** The linkage between ARH, gender and HIV/AIDS must be considered in World Bank policy mechanisms, such as the CASs (Country Assistance Strategies), PRSCs (the Sustainable Development and Poverty Reduction Program (SDPRP) of Ethiopia and Poverty Eradication Action Plan (PEAP) of Uganda). Similarly, the existing national frameworks, including Mid-Term Financial Review (MTFR), budgeting, sector development programs, and others activities should also focus on mainstreaming these matters.

✓ **Strengthen the Capacity of Communities and Institutions:** Local institutions charged with youth, gender, ARH and HIV/AIDS must be strengthened within the context of accelerating the achievement of the relevant MDGs.

✓ **Develop M & E to scale up Evidence Based interventions:** Sound and applicable Monitoring and Evaluation (M & E) mechanisms that report with clear indicators disaggregated by gender, age and relevant socio-economic segments such as income, residency (rural/urban, location), livelihood and others must be developed. Develop a system to track youth-oriented activities by upgrading information systems and working towards consistent reporting across countries. Enhance impact evaluation, including consideration of investments in promising yet under-evaluated approaches.

✓ **Documentation and Learning:** Attention must be paid to taking stock and documenting of the activities that facilitate mainstreaming ARH, gender, youth and HIV/AIDS programs for scaling up and further exploring the implementation gaps, in a participatory and learning based approach. The Bank with its partners can focus on supporting evidence-based findings and emphasizing support for longer-term, multi-pronged programs that aim for sustained behavior change.

✓ **Strengthen Multi-sectoral Linkages of Social Issues:** Review of the existing policies, strategic frameworks and programs on ARH, gender and youth in HIV/AIDS, and from a wider development context to increase mainstreaming and multi-sectoral linkages of programs and institutional tools.

✓ **Harmonization:** A mechanism must be developed to improve coordination and harmonization of goals, reporting and resources among partners, sectors and all key stakeholders.
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ANNEX 1

List of Members of In-country Study Teams for Ethiopia and Uganda

**Ethiopia**
1. Dr Tesfanesh Belay, MoH, Head of Family Health Department, Chair of In-country team,
2. Dr Ermias Getahun, MoH, Family Health Dept., member
3. Mr Yacob Ahmed, Women’s Affairs Office, PMO, member,
4. Mrs Tshai Gulema, Minstry of Youth, Sport and Culture, member,
5. Mr Misganaw Lijalem, HAPCO, member,
6. Mr Mengistu Asnake, Pathfinders International, member,
7. Mrs Bogalech Alemu, Pathfinders International, Ethiopia, member,
8. Ms Tigist Alemu, CORHA, member,
9. Mr Amare Bedada, FGAE, member
10. Mrs Sahlu Haile, Packard Foundation, member,
11. Mrs Beltu Mengsitu, ISAPSO, member,
12. Ms Mahlet Teklesadik, YWCA – Ethiopia, member,
13. Ms Mahlet Abraham, MEKDEM/PLWHA NGO, member,

**Uganda**
1. Dr Angela Akol, National Population Secretariat, MOFPED, Head of Family Health Department, Chair of In-country team,
2. Dr Antony Mbonye, Ast. Commissioner, AIDS Control Commission, Co-chair
3. Dr Chris Baryomunsi, UNFPA, member,
4. Dr Lorna Tumwebaze, African Youth Alliance, member,
5. Mr Brain, Straight Talks Uganda, member,
6. Mr Sam Ocean, Uganda Youth Positive, member
7. Dr Margaret Muganwa, member/consultant,
8. Dr Sarah Sali, membre/consultant
### ANNEX 2

**List of Policies and Related Institutional Instruments Reviewed - Ethiopia**

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ANNEX 3

List of Countries participating via videoconference to share the study findings, 17 June, 2004

1. Ghana
2. Ethiopia
3. Kenya
4. Nigeria
5. South Africa
6. Uganda