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Gender, Youth, and Social Inclusion Analysis

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Cover photo: A young woman in Northern Uganda participates in a community discussion.

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Acronyms

AGYW	Adolescent girls and young women
ART	Antiretroviral treatment
ARV	Antiretroviral
CAB	Community advisory board
CHEW	Community health extension worker
CSW	Commercial sex worker
ECD	Early childhood development
FGD	Focus group discussion
FP	Family planning
GBV	Gender based violence
GoU	Government of Uganda
GYSI	Gender youth and social inclusion
HBV	Hepatitis B virus
HCW	Health care worker
HF	Health facility
HSDP	Health sector development plan
HTS	HIV testing services
IDP	Internally displaced person
IRB	Institutional review board
JSI	John Snow, Inc.
KII	Key informant interviews
KP	Key populations
MNCH	Maternal newborn child health
MoGLSD	Ministry of gender labor and social development
MoH	Ministry of health
MSM	Men who have sex with men

NGO	Non-governmental organization
NSP	National strategic plan
OVC	Orphans and vulnerable children
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PWD	People with disability
SEM	Social Ecologic Model
SMC	Safe male circumcision
STI	Sexually transmitted infection
TB	Tuberculosis
TFR	Total fertility rate
USAID	United States Agency for International Development
UDHS	Uganda demographic and health survey
VMMC	Voluntary medical male circumcision
WASH	Water and sanitation and hygiene
WHO	World Health Organization
YLP	Youth Livelihoods Program

Definition of Key Terms

Social vulnerability: Marginalization of individuals or communities due to factors associated with gender, age, income status, place of residence, nature of predominant trade, or disability (physical or mental).

Vulnerable populations: People who are at risk of poor physical, psychological, and/or social health. These include PLHIV, fishing community residents, truck drivers, commercial sex workers, people working in complex trade industries, like urban area hustlers (individuals who "hustle" to make ends meet by selling small items in the informal sector) and internally displaced persons.

Inclusion: A purposeful act undertaken to ensure that all voices are heard and no one is excluded in social and health related matters

Gender norms: Socially constructed roles, behaviors, activities, expressions, and opportunities, considered appropriate in a particular social and cultural context.

Youth: Young people between 10-24 years of age, according to the World Health Organization (WHO).

Adolescents: Youth ages 10-19, according to the WHO definition.

Barriers to healthy behaviors: Challenges and underlying factors (including structural, social, cultural, and religious, etc.) which contribute to delays in making decisions related to health care seeking behavior(s) and accessing health care services.

Enablers for healthy behaviors: Factors (including structural, cultural, religious, etc.) that promote healthy behaviors among the target population.

Stakeholders: A term used to classify the range of "gatekeepers" in the influence and delivery of health care services and decision-making in the population. The term largely applies to local government political, technical and community leaders, school administrators, religious and cultural leaders, and health care workers both in private and public sector.

Executive Summary

The Regional Health Integration to Enhance Services-North, Lango (USAID RHITES-N, Lango) project aims to increase the effective use of sustainable health services in the Lango region of northern Uganda. RHITES-N, Lango is expected to contribute to measurable improvements in key Ugandan national health indicators (HIV; tuberculosis [TB]; maternal, newborn, and child health [MNCH]; family planning [FP]; water, sanitation, and hygiene [WASH]; nutrition, etc.). Additionally, RHITES-N, Lango will promote the adoption of healthy behaviors by raising awareness at the individual, provider, and community levels, with the goal of reducing delays in seeking care and limiting barriers to service usage.

Purpose of the Gender Youth and Social Inclusion (GYSI) Analysis

The vulnerability dynamics in the Lango sub-region have practical implications that influence how RHITES-N Lango implements its program. Despite the intention to include all categories of people in decision-making in matters related to health, the Uganda Health Services has lacked responsiveness to the needs of marginalized and underserved groups. While gaps related to utilization and access to existing health services have been relatively well documented by gender and youth categories at the national level, the current practices, barriers and enablers of positive health behaviors and utilization of health care services in the greater Lango sub-region have been under-documented. This GYSI analysis consists of a desk review of the current literature coupled with a series of key informant interviews (KII) and focus group discussions (FGD). The primary objective of the analysis is to document factors contributing to vulnerability, while also identifying current enablers and barriers to accessing health and social services among vulnerable populations. Findings will inform RHITES-N Lango programmatic interventions (including our annual gender and youth action plans), and will contribute to the local government's knowledge of the sub-region. Our goal is that this information further informs government priorities in order to sustain improvements in gender and youth related health areas and to reduce social vulnerability in the region.

Key Conclusions

Women, girls, and youth in Lango sub-region continue to experience higher health and social vulnerabilities, relative to the national population. Vulnerability is driven by multiple factors including food and land tenure insecurity, income disparities, youth unemployment, Gender Based Violence (GBV), low education levels, traditional roles of women or gender dynamics within the community and households, cultural practices, climate change, social and economic marginalization, type of employment and HIV status. The post-conflict setting and high poverty rates present in the Lango sub-region exacerbate already high rates of intimate partner and sexual violence and unequal gender dynamics which limit health and social service access for women and children.

The prevailing perspective across the analysis of sub-groups interviewed for this survey was that all groups are vulnerable so long as there is no money to pay for health and/or social services or money to pay for medicines. Notwithstanding this general view, women were considered among the "most vulnerable" given the fact that women shoulder the burden of health care-seeking within their families, tend to have more health care needs than their male counterparts, and are also primarily responsible for their children's needs. Youth, were also found to be vulnerable primarily because they depend on their parents and their decision to seek care still requires parental approval, particularly that of the father. Ensuring the inclusion of voices of marginalized groups especially women, young people, Persons with Disabilities (PWD,) and People Living with HIV (PLHIV) requires special efforts and attention to positively influence service access and delivery and resulting health and social outcomes.

Recommendations

The following recommendations are provided after the completion of data compilation and synthesis, a desktop literature review and an analysis of findings through the GYSI survey. Recommendations are disaggregated by community, institutional (health facility), and household/individual levels. A summary table at the end of this report provides a more extensive summary of recommendations, including rationale for each recommendation along with action steps for the RHITES-N, Lango team.

Community Level:

- Promote family planning services via multi-media specifically targeting local leaders and women's organizations.

- Develop women's groups (or link to existing) for income generation and health education activities.

- Establish quotas for excluded groups to benefit from services and economic opportunities, (e.g. special targets for women, PWDs, youth, etc.)

- Build VHT skills to mobilize communities to enhance service demand.

- Support the districts to implement youth friendly service options for young people as outlined in the Adolescent Health Policy which include a multi-faceted approach to adolescent health including in schools, at clinical level and at community setting.

- Support District Health Service teams to strengthen male engagement in health promotions including through men's groups.

- Expand on current outreach efforts (including Landing Sites) to reach more vulnerable populations.

- Build skills of teachers to integrate health education in the classroom, and develop referral pathways between schools and facilities for preventive and routine healthcare.

- Collaborate with cultural leaders to mobilize communities for norms changes on matters related to health, family planning use, and early marriages.

Institutional Level:

- Revitalize the GBV Focal persons at the health facility level to effectively increase provider skills to screen for, recognize, treat, counsel and refer GBV cases.

- Enhance HCW skills gaps to provide care for PWD, particularly those with hearing impairments.

- Facilitate the availability of medical products and technologies so as to ensure gender equitable access to vaccines and medicines.

- Promote school-based health education through the senior women and male teachers.

- Support service utilization by minimizing supply side barriers including the attitudes of some health care workers towards their patients, drug stock-outs, lack of privacy in maternity wings, etc.

- Support health facilities to promote youth friendly services to meet the reproductive needs and information gaps in a sustainable way.

- Promote gender responsive health service delivery to reduce health inequalities through delivering integrated, safe, effective and acceptable interventions that focus on promotion of, prevention and curative care from community to tertiary level.

- Strengthen existing HF Management Teams and support the constitution of community advisory boards (CABs) to create avenues to report poor treatment at HF including strengthening the MoH hotline for community members to report issues. Also consider conducting periodic exit surveys.

- Support parents through interventions that will enable them to keep their children in school for longer so as to minimize health risks including HIV, STIs and early marriages and pregnancies.

Household/Individual Level:

- Increase men's budgeting skills so they can plan with their families to budget for household healthcare needs.

- Improve mental health and promote health seeking behaviors for mental health symptoms.
- Address harmful substance use.
- Promote the use of soap for hand washing among all households in the region.

INTRODUCTION

The USAID Regional Health Integration to Enhance Services-North, Lango project (RHITES-N, Lango), made possible by the support of the American people through the United States Agency for International Development (USAID), is implemented to increase the effective use of sustainable health services in the Lango region of northern Uganda. With a project life of five years (February 2018-February 2023), RHITES-N, Lango is expected to contribute to measurable improvements in key Ugandan national health indicators (HIV; tuberculosis [TB]; maternal, newborn, and child health [MNCH]; family planning [FP]; water, sanitation, and hygiene [WASH]; nutrition, etc.). Additionally, RHITES-N, Lango will promote the adoption of healthy behaviors by raising awareness at the individual, provider, and community levels, with the goals of reducing delays in seeking care and lowering barriers to service usage. RHITES-N, Lango is supported, in part, by the President's Emergency Plan for AIDS Relief (PEPFAR) to improve and increase HIV testing and counseling, HIV care and treatment, prevention of mother-to-child transmission (PMTCT), provision of voluntary medical male circumcision (VMMC), viral load (VL) monitoring, TB/HIV service delivery, and antiretroviral therapy (ART) retention.

The vulnerability dynamics in the sub-region have practical implications that will influence how the RHITES-N, Lango project implements its interventions/activities. Despite the intention to include all categories of people in decision-making in matters related to health, the Uganda Health Services has historically lacked responsiveness to the needs of the marginalized and underserved groups (e.g., youth, PWD, people living in fishing communities and PLHIV). Nationally, gender and youth gaps in the utilization of and access to existing health services have been relatively well documented. However, the current practices, barriers and enablers of positive health behaviors and utilization of health care services in the greater Lango sub-region have been under-documented. This necessitated RHITES-N, Lango to document such practices to inform not only our own programmatic interventions but also the local governments' priorities in the region.

This report draws upon the current evidence available in the literature and our GYSI survey assessment findings to develop evidence-based practical solutions that will be integrated throughout our program activities. RHITES-N, Lango also draws upon these practices to examine how these solutions can be sustainably ingrained within the larger Lango health system so that solutions are in place to support vulnerable communities well into the future beyond the life of the project.

OBJECTIVES

The overall objective was to document current practices, enablers and barriers for healthy behaviors among women, men, youth and other vulnerable populations in the 9 districts that make up the greater Lango sub-region of Northern Uganda with the aim to identify innovative

approaches to improve access to quality care among these marginalized groups of people, based on the local context and needs.
Specifically, the study team intended to:

1. Assess the extent to which gender issues influence and impact health status in terms of risk and vulnerability, severity or frequency of health problems, health-seeking behaviors, access to and use of health care services, adherence to treatment, psychosocial well-being; decision making on seeking health care, access, control and ownership of resources; involvement and participation in community initiatives, leadership and community demand for services;
2. Identify activities that promote gender equitable norms and increase constructive engagement of men in Maternal, Newborn and Child Health (MNCH), Prevention of Mother to Child Transmission of HIV (PMTCT), TB, HIV/AIDS, Family Planning (FP), Malaria, Early Childhood Development (ECD) and other health services;
3. Identify and assess innovative youth-focused service delivery models, Social Behavioral Change campaigns, and community events which serve as key approaches for reaching youth and adolescent sub-populations;
4. Identify and document age-specific risks and opportunities to access health services as part of a comprehensive gender and youth analysis; and recommend how these can be factored in the design and implementation of activities for better project outcomes;
5. Assess the extent to which gender issues such as mainstreaming, analysis and outcomes (access, equity, empowerment and capacity building) are integrated in health service delivery;
6. Identify enabling factors and challenges to gender integration outcomes (access, equity between men and women and empowerment);
7. Establish factors that may lead to stigmatization of women, youth and adolescents who may be identified HIV positive;
8. Assess the extent to which parental care and support impact on the health of adolescents and youths;
9. Assess the preparedness of service providers at service points in terms of skills, attitude, morale, and other factors critical to provision of quality health services to women, youth, and adolescents;
10. Explore information about stigma, social norms, and subjective norms (i.e., what individuals think that other individuals think about them) and how those elements affect their healthcare seeking/disclosure behaviors;
11. Assess the extent to which the existing infrastructure at the service points facilitates provision of quality services to special groups like women, youth, and adolescents; and
12. Establish the availability of necessary tools and processes at the service sites for handling cases of GBV, and similar unwanted occurrences that promote the spread of HIV among women, the youth, and adolescents in the region.

To achieve these objectives, the study team used a two pronged approach which included:

1. A comprehensive literature review that explored factors related to GYSI in northern Uganda.

2. A series of qualitative individual interviews and FGD with key informants from the Lango sub-region.

The literature review was used to identify vulnerable sub-populations, factors that contribute to their vulnerability, and any available evidence-based interventions that have been implemented in the sub-region to address GYSI-related vulnerability. KIIs and FGDs were conducted to obtain more detailed insights on current practices and vulnerabilities, as well as enablers and barriers to health care seeking among the target population. The literature review and survey are each presented separately below including their methodology, findings, and conclusions/recommendations.

LITERATURE REVIEW

Methodology

A comprehensive list of search terms were compiled related to GYSI categories and northern Uganda from 2013-present (Box 1). An electronic database and conference search included PubMed, Cochrane Library, and Embase. Literature and abstracts were included if they: 1) were published in the past 5 years; 2) contained any information on gender dynamics, youth related strengths or vulnerabilities in regards to psychosocial, mental or physical health, or information on any other sub-population that experiences vulnerability in northern Uganda; or 3) provided similar national level data that included details for the northern regions. Literature and abstracts were excluded if they: 1) were published prior to 2013; or 2) did not provide data for the northern regions. The search encompassed northern Uganda and was not restricted to Lango sub-region given the dearth of studies in the sub-region. A Google search was also conducted to identify non-peer reviewed literature which used similar inclusion criteria. Key documents from the Government of Uganda (GoU) including the Ministry of Health (MoH) were also included.

BOX 1: Search Terms

1. Gender/women AND health service access/uptake AND Uganda
2. Youth/Adolescence/Young adults AND health service access/uptake AND Uganda
3. Gender/women AND Vulnerability AND Uganda
4. Youth/adolescence/young adults AND vulnerability AND Uganda

Literature Review Findings

Health is a human right and the Ugandan MoH is increasingly aware that all citizens should have unhindered access to health care.[1] Consequently, attention has been drawn to certain vulnerable categories of the population such as pregnant mothers, the elderly, children, PWD and young people. Uganda has made significant improvements in social services. However, the MoH notes that there are still major barriers to uptake of social services such as health, housing, education, water and sanitation and others. Barriers are attributed to demand side factors including the lack of power that women have to make decisions around finances, transport use, and health and social service access. The World Health Organization (WHO) affirms that marginalization serves to exclude certain populations in society from enjoying good health. According to the WHO, three of the most fatal communicable diseases- malaria, HIV and TB, disproportionately affect the world's most vulnerable groups like PWD, women living with HIV and AIDS, sex workers and refugees or internally displaced persons (IDPs).[2] Previous assessments in Uganda have demonstrated that vulnerable populations are deprived of services and economic opportunities. Such populations include orphans and vulnerable children (OVC), PWD, unemployed youth, displaced persons, and marginalized women. To overcome these challenges, Uganda has adopted a human rights-based approach to service delivery and has taken major steps to mainstream human rights and gender at various levels through building

[1] MOH (2015): Health Sector Development Plan 2015/16-2019/20
[2] WHO (2015): Human Rights and Health

capacity of service providers in programming and implementation, so as to address critical barriers to health care and health promotion services.[1]

Central to achieving measureable health improvements is identifying and addressing risks and vulnerabilities that impact service access and uptake, health and psychosocial status, and health care seeking behaviors of women and youth who are among the most vulnerable in the Lango sub-region. The concept of risk assumes there is always a chance that an adverse health related event will occur. Naturally, everyone is potentially at risk of poor physical, psychological and social health. However, some individuals and groups of people are more at risk of poor health at different times of their life than others. Therefore, social vulnerability is driven by multiple factors such as food and land tenure insecurity, income disparities, youth unemployment, GBV, education levels, traditional roles of women or gender dynamics within the community and households, cultural practices, climate change, social and economic marginalization, nature of employment and HIV status. Social vulnerability is also driven by physical abilities, poor access to credit and farm inputs. Ensuring the inclusion of voices of marginalized groups especially women, young people, people with disability, and PLHIV requires special effort and attention of health programmers.[3]

National Planning Frameworks that Address GYSI: The GoU is committed to addressing socio-cultural and gender factors that contribute to vulnerability of both men and women to ill health including HIV and AIDS.[4]The GoU has developed a National Strategic Framework (2015-2020) aimed at promoting a human rights approach to health service delivery. The country is focusing on critical areas to advance women's rights, which include reproductive health, girl child education, and social and economic empowerment of women. [5] The National HIV and AIDS Strategic Plan (NSP) 2015/16 -2019/20 focuses on mitigating underlying socio-cultural, gender and other factors that drive the HIV epidemic including the application of gender and human rights-based programming approaches for HIV prevention programs at national and lower levels. The National Gender Policy makes gender responsiveness mandatory for development practitioners. The National Health Sector Development Plan (2015/16) provides for the provision of free health services at the point of use, so as to reduce the financial barriers to service utilization.

The MoH and its partners also developed a "Sharpened Plan and Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH).[6]The plan forms the sector's overall approach to accelerated progress towards reduction of maternal mortality targets set in the HSDP. The plan states that the high RMNCAH burden is rooted in inequalities within the social determinants of RMNCAH over the life course of women. It advocates an increased focus on primary community-based healthcare that is rooted in prevention including revamping VHTs and the proposed community health extension workers (CHEWs).

[3] MOH (2015): Health Sector Development Plan 2015/16-2019/20
[4] UAC (2015): National HIV and AIDS Strategic Plan 2015/16-2019/2020: An AIDS Free Uganda, My Responsibility!
[5] MOH (2015): Health Sector Development Plan 2015/16-2019/20
[6] Uganda Gender Youth and Social Inclusion Analysis 2017

Uganda also has many laws and policies to promote the wellbeing of children. They include: The Children's Act, the Early Childhood Development (ECD) policy, the national OVC policy, the national child labor policy, the Action plan for Children with Disabilities, among others. A National Action Plan for Child Well-Being, 2016 – 2021 has been developed to provide a framework for the implementation of these policies. The Youth Livelihoods Program (YLP) is the main GoU program for tackling youth unemployment and improving productivity. The program, led by the MGLSD, targets poor and unemployed youth across Uganda. YLP is a community, demand-driven, program implemented with guidance from both the central and local governments. Despite all of the above described measures, there still exist many barriers to uptake of health care services.

Health Decision Making Participation: According to WHO, participation requires that all concerned stakeholders have ownership and control over the health care process in all phases of the program lifecycle including assessment, analysis, planning, implementation, monitoring and evaluation.[7]WHO asserts that participation goes well beyond consultation and that it should include explicit strategies to empower citizens, especially the most marginalized, so that their expectations are recognized by health programs. Overall, participation is important to ensure accountability as it provides the necessary checks and balances over the services provided and received by the community so as to ensure that those services are people-centered, acceptable and cater for the specific needs of the target population. WHO further affirms that when people are given the opportunity to participate in their own care, the outcomes are better and health systems become efficient.[7]

Through the Health Sector Development Plan (HSDP) 2015/16/-2019/20, the GoU recognizes the need to design and implement social protection systems according to the principle of social inclusion, by ensuring that there is non-discriminatory treatment and that measures are adopted to enable those suffering from structural discrimination like women, PWD, IDPs and PLHIV to enjoy full access to health care. Such measures, according to the MoH, include increasing financial risk protection of households who have health expenditures and addressing the key determinants of health through strengthening inter-sectoral collaboration and partnerships, among others.[8] According to Ministry of Gender, Labor and Social Development (MOGLSD), youth are among the most marginalized populations and their involvement in health decision making is considered merely that of a service beneficiary rather than an actively participating group.[9]On the other hand, the current trends show that the economic environment favors the participation of male youth while the female are largely involved in domestic and reproductive work. This is contrary to the principle of the 2030 agenda for sustainable development which is to ensure that no one is left behind in any manner of social development.

HIV Prevention: The national HIV prevalence is estimated at 7.3% with the northern region's prevalence estimated to stand at 8.3%. This is considered to be in the higher prevalence

[7] WHO (2017): Human rights and Health
[8] MOH (2015): Health Sector Development Plan 2015/16-2019/20
[9] MOGLSG (2001): The National Youth Policy

bracket, only second to the central region of the country.[10] Notably, women and girls carry the largest burden of HIV with the national prevalence estimated at 8.3% compared to 6.1% among men. The NSP 2015/16 -2019/20 was developed with HIV prevention as a cornerstone. The government promotes a combination of approaches to HIV prevention that targets different sub-populations. To improve access and efficiency of HIV testing services, a combination of health facility and community based approaches were adopted which include provider initiated HIV testing and counseling, client initiated testing and counseling, as well as index client contact tracing and outreach services.[11] All these approaches are intended to ensure that no one is left behind in the provision of HIV testing and counseling services. Special emphasis is placed on populations that have a relatively higher risk of contracting HIV. These groups of people are normally referred to as Key Populations (KP), who include Commercial Sex workers (CSWs) and their clients, long distance track drivers, uniformed service personnel, people living among fishing communities.[12] This category of people may be extended to include pregnant women, survivors of sexual violence; young people especially women and girls, emancipated minors, OVC, children out of school, PWD, IDPs and refugees. The prevalence of HIV among fishing communities averages between 23-35%, and the prevalence among CSWs is about 35% which is way above the national average of 7.3%.[13]

HIV prevention interventions include both biomedical and behavioral ones, as well as prevention and management of GBV which is believed to increase the risk of acquiring HIV. The GOU has placed special emphasis on elimination of mother to child transmission (MTCT) of HIV and improving maternal, newborn and adolescent health through routine HIV testing and counseling, behavior change communication and STI/Hepatitis B virus (HBV) screening and treatment, as well as prevention of unplanned pregnancies.[14]

Gender: Gender refers to socially constricted roles, behaviors, activities, expectations and opportunities considered appropriate in a particular social cultural context. Gender also refers to relationships between people and the distribution of power in those relationships.[15]Unequal gender dynamics result in a host of vulnerabilities for women including disproportionate rates of HIV, depression, and trauma.[16]According to the WHO, gender is a determinant of health inequalities where women are more susceptible to sexual violence.[17] In the Lango sub-region in 2016, 21.5% of women reported having ever experienced sexual violence compared to 4.3% of men.[18] According the MOH, GBV negatively affects retention and ART adherence leading to poor treatment outcomes.[19]

[10] MOH (2011): Uganda AIDS Indicator Survey 2011
[11] MOH (2016): Consolidated Guidelines for Prevention and Treatment of HIV in Uganda
[12] MSM are not formally recognized in Uganda, but research suggests that they may be a driver of the epidemic. This analysis did not specifically target MSM.
[13] UAC (2014): Multi-Sectoral HIV Response for MARPS in Uganda: Programming Framework 2014-2016
[14] MOH (2016): Consolidated Guidelines for Prevention and Treatment of HIV in Uganda
[15] WHO (2018): Gender and Health
[16]Spittal, PM., Malamba, SS., Ogwang, MD., et al (2018). CangoLyec (Healing the Elephant): Gender Differences in HIV Infection in Post-conflict Northern Uganda.J Acquir Immune DeficSyndr 2018;78:257–268.
[17] UBOS (2016): Uganda Demographic and Health Survey
[18] UDHS 2016
[19] MOH (2016): Consolidated Guidelines for Prevention and Treatment of HIV in Uganda

Gender and social norms in Uganda that promote child marriage and large families and unequal power relations, in part driven by unequal control of resources and earning power, and patrilineal customary norms further contribute to GBV and impact health and psychosocial vulnerabilities.[20] Data from northern Uganda show that the impacts from conflict and post-conflict settings worsen already existing gender inequalities. Violence experienced as part of political conflict influences intimate partner relations resulting in GBV, rape, and limited sexual decision making powers including the ability to refuse sex or ask a spouse or partner to use a condom. In the 2016 Uganda Demographic and Health Survey (UDHS), Lango had the lowest percentage of women who could say no if they did not want to have sex across the entire country (71.5%).[21] These findings are further supported by qualitative data which show that rigid gender norms in northern Uganda reinforce the notion that men possess authority while women are obedient.[22] Despite expressed commitment by the GoU to address GBV including introduction of various laws, policies and action plans,[23] more than 65% of ever married women in the northern region have experienced intimate partner violence (IPV).[24]

Unequal power dynamics also translates into decisions around financial spending. Out of all sub-regions, Lango has the lowest percentage of households where women are the deciders of how to use the cash that she has earned (25.7%) and is the sub-region with the second lowest percentage of women who have and use a bank account (5.6%) and use a mobile phone (19.2%). These power dynamics also often translate into the inability of women to make healthcare decisions. Research shows that even when HIV positive women have access to economic opportunities, gender norms that influence healthcare seeking behaviors often result in increased investments in caring for others in place of allocating funds for their own HIV treatment.[25]

There is a cascade of problems as a result of generally accepted gender socialization in many communities. In northern Uganda, gender norms accord men dominance over women, further perpetuating the problem of GBV. A multi-county study by WHO found that the proportion of ever partnered women who had experienced physical or sexual violence or both by an intimate partner in their life time ranged from 15% to 71%. Women who experience GBV often have difficulty using contraceptives effectively and often experience higher rates of unintended pregnancies, unsafe abortions and adolescent pregnancies.[26] Abuse during pregnancy poses risks to the mother and unborn baby.[27] Women who experience GBV are less likely to seek

[20] https://www.usaid.gov/sites/default/files/documents/1860/Gender_Social_Inclusion._Final_Report_08.23.17.pdf
[21] UBOS (2016) UDHS. https://dhsprogram.com/pubs/pdf/FR333/FR333.pdf
[22]Adams, MK., Salazar, E., Lundgren, R. (2013). Tell them you are planning for the future: Gender norms and family planning in adolescents in northern Uganda. International Journal of Gynecology and Obstetrics 123: e7–e10
[23] MOGLSD (2015): Standard Operating Procedures for the National Gender Based Violence Database
[24]Uoma, S., Turyasima, M., Acca, H., et al (2015). Obstacles to family planning use among rural women in Atiak Health Center IV, Amuru district, northern Uganda. East Afr Med J.; 92(8): 394–400.
[25]Dovell, K. and Thompson, K. (2017). Financial obligations and economic barriers to antiretroviral therapy experienced by HIV positive women who participated in a job-creation programme in northern Uganda. Cult Health Sex. 2016 June ; 18(6): 654–668.
[26] MOH (2015): Health Sector Development Plan 2015/16-2019/20
[27]Ronsmans et al (2006): Maternal Mortality: Who, When, Where, and Why.

healthcare for the trauma they experience and other conditions which many not be associated with the GBV.

The UDHS 2016 reported a fertility rate of 5.4 children per woman in Uganda. Some other sources suggest an even higher number (5.8) of children per woman. While there is a documented declining rate in fertility since the 1980s from 7.4 children per woman, the total fertility rate (TFR) in Uganda is 5.4 and still among the highest in the region. However, rural women in Uganda are more likely to produce nearly two additional children during their reproductive years than the urban women (5.9 vs 4.0).[28] There is a documented risk associated with more pregnancies and the GoU is committed to reducing fertility to 5.1 children per woman by 2020.[29]

In Uganda, 40% of the pregnancies are unplanned, and 40% of women give birth by the age of 18. Poor households are more likely to have larger families due to lack of information and access to family planning services. Only 41.3% if women in the Lango sub-region region reported using any modern family planning method compared to a national average of 47.1%. There is a 27.4% unmet need for family planning among women in the Lango sub-region.[30] This indicates that if contraceptive methods are made affordable and acceptable, there is a large pool of women who would choose to use them. The GoU's rights based approach to health care suggest that everyone is entitled to control over their own health including having access to confidential and respectful sexual and reproductive services.[31]

Youth and Adolescent Health: Almost 50% of the Ugandan population is under 15 years of age making up 17.0M of the 34.9M population of the country.[32]One quarter of the population (24.5%) are adolescents between 10-19 years of age. The MoH observes that the health of young people is affected by both personal and external conditions[33] and that decisions made during adolescence have a direct impact on current and future health; emphasizing the importance of timely interventions to reduce health risks. Young people in Uganda face immense health challenges and significantly contribute to overall population morbidity and mortality. While their health problems and needs are generally basic such as sexual and reproductive health, substance abuse and mental illness, many suffer from STIs and HIV infection, with females being more vulnerable than their male counterparts. The UDHS 2016 found that 27.9% of young women 15-19 years in the Lango sub-region had begun child bearing (vs. the national average of 24.8%).[34]

Appropriate policies have been developed to mainstream the needs of young people into all development programs. For instance, the MoH developed an Adolescent Health Policy that

[28] UBOS (2016): Uganda Demographic and Health Survey
[29] MOH (2015): Health Sector Development Plan 2015/16-2019/20
[30] UDHS 2016
[31] WHO (2015): Human Rights and Health
[32] UBOS (2014): National Population and Housing Census
[33] MOH (2012): Adolescent Health Policy Guidelines and Service Standards
[34] UBOS (2016): Uganda Demographic and Health Survey

aims to mainstream adolescent health concerns in the development process.[35] One of the objectives of the National Adolescent Health Policy is to create an enabling legal and social-cultural environment that promotes the provision of better health information services. However, the implementation of such policies remains a huge challenge due to structural barriers, health systems challenges, and culturally embedded norms. For instance, community level barriers include poverty, lack of relevant health information, unequal gender dynamics in sharing resources at the family level, negative cultural practices, lack of youth friendly services, inadequate health facilities, among others. To overcome these challenges, there is increasing national attention to strengthening health services for young people to promote uptake of existing services and encourage young people to adopt positive health behaviors.[36]

The Intersection of Gender and Youth: Gender inequalities and related structural arrangements have magnified the problem of the girl child. The impact is diverse, covering a wide range of complex repercussions, the outstanding being defilement[37], unwanted pregnancies, contraction of STIs and psychosocial as well as economic effects.[38] Girls are often the most vulnerable to cultural and gender norms which influences their health risks. The Lango sub-region of Northern Uganda has the youngest median age of first marriage in the country at 17.3 years. Early child marriage places girls at risk for adolescent pregnancy, which carries significant risk for both the young mother and baby including obstructive labor and low birth weight and death of the baby.[39]Over 10% of adolescent girls and young women (AGYW) in the mid-northern region have had sex with a partner ≥10 years or older in the past 12 months and less than half of AGYW used a condom at last intercourse. With a median age at first birth of 17.8 (the lowest in Uganda) and a total fertility rate of 6.3, over a quarter of all girls (15-19 years) have already begun having children.[4]

AGYW ages 15-24 experience significant HIV risk such as GBV including rape, cross-generational relationships, transactional sex, multiple sexual partners, poverty, illiteracy and drug use[40]contributing to an HIV prevalence rate of 6.7% among women ages 15-24 (vs. men 2.4%) in the mid-northern region[41] and the third lowest rates of viral suppression across the entire country.[42]

[35] MOH (2004): Uganda Adolescent Health Policy
[36]Namy et al (2017): Gender, Violence and Resilience among Ugandan Adolescents
[37] Defilement means having sex with a person under 18 years of age. This can be consensual or non-consensual.
[38] UBOS (2009): Gender productivity Survey
[39] UNFPA (2013). UNFPA's Adolescent Girls Initiative. Programme Document. Retrieved from, http://www.unfpa.org/webdav/site/global/shared/youth/UNFPA%20AGI%20programme%20document.pdf
USAID Multi-Sectoral Nutrition Strategy 2014-2025. 2014. Retrieved from, http://www.usaid.gov/nutrition-strategy
[40]Karamagi, E. Sensalire, S., Nabwire, J., et al. (2018). Quality improvement as a framework for behavior change interventions in HIV-predisposed communities: a case of adolescent girls and young women in northern Uganda. AIDS Res Ther (2018) 15:4.
[41] Uganda AIDS Indicator Survey, 2011. http://health.go.ug/docs/UAIS_2011_REPORT.pdf
[42] Uganda Population-based HIV impact assessment. UPHIA. 2016-2017. https://www.afro.who.int/sites/default/files/2017-08/UPHIA%20Uganda%20factsheet.pdf

Conclusion

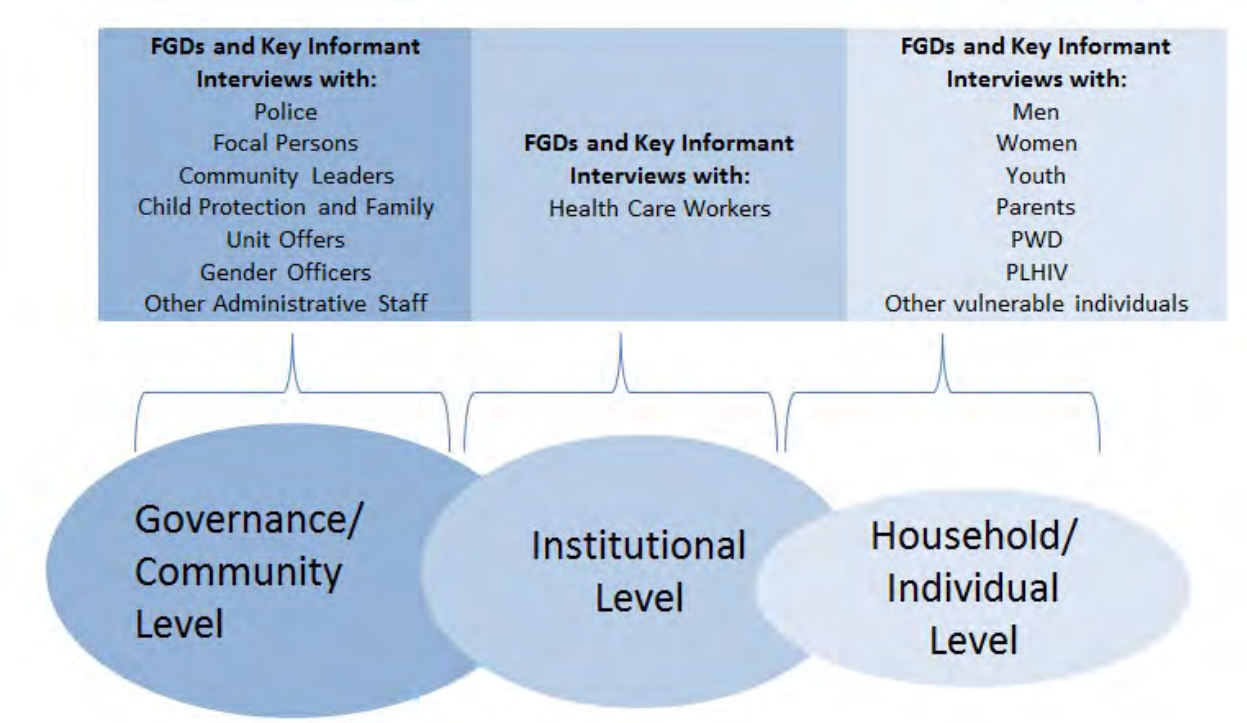
While the GoU has made significant strides to address health and social barriers among vulnerable populations through the development of laws, policies, and strategic plans; implementation at the service delivery level requires addressing deeply ingrained social cultural barriers, poverty, systems level barriers, and a host of other challenges. The literature is extremely sparse relative to Lango sub-region and no evidence-based interventions to address gender, youth and social inclusion were identified. Data show that women, girls, and youth living in the Lango sub-region are especially vulnerable to experiencing health and social service access barriers and experience higher rates of GBV, higher unintended pregnancy, lower use of modern family planning methods, and higher HIV rates than their national counterparts. Recommendations from the GYSI analysis below provide a framework to sustainably address these challenges.

GYSI SURVEY

Methodology

Theoretical Framework: The study team used the Social-Ecological Model (SEM) to frame survey development and study findings. The SEM provides a theoretical framework to understand multifaceted and interactive effects of personal and environmental factors that influence behavior. It also assists to classify behavioral and organizational factors that influence health promotion within an organization.[43] Figure 1depicts the SEM Framework utilized by the study team and the respondent categories within each level.

Figure 1:SEM Theoretical Framework for GYSI Analysis



Survey Tool Development: Survey tools were developed for each category of respondents described in Table 1 to elicit key information on factors around health seeking behaviors, enablers and barriers to access health services, various factors associated with vulnerability and how the factors could be addressed. See Annex I for the survey tools.

Key Informant Interviews: RHITES-N, Lango project staff provided names and contact information of potential key informants within the Lango sub-region. These include stakeholders from youth/adolescent peer groups, elected youth leaders, partners of adolescents, parents, adolescent/youth focal persons at health facilities, sexual and gender based

[43] https://www.unicef.org/cbsc/files/Module_1_SEM-C4D.docx

violence (SGBV) focal persons at facilities, in charges of health facilities, Assistant District Health Officers for MNCH, Probation and Child Welfare Officers, District Police Commanders and or Child and Family Protection Officers, religious leaders, cultural leaders and local council leaders amongst others.

Sampling Size and Procedure: The survey was conducted in five of the nine districts that make up the greater Lango sub-region of northern Uganda. The districts included Apac, Amolatar, Lira, Otuke, and Oyam. The districts were purposively selected to represent the different social-economic variations of the sub-region. The factors used for selecting the districts included the size of population, nature of health risk characteristics (e.g., existence of fishing communities and highway track stopovers). In order to provide a basis for comparison of target population findings, district and community leaders, and health care workers were also interviewed. A snowball approach to interviews was conducted to increase the breadth of data available from a variety of stakeholders, resulting in interviews with over twice the number of respondents than was initially planned(Table 1).

Table 1: Target and Realized Respondents

	Category of respondents	**No. Planned**	**No. Realized**
1	Young people (15-24 years)	13	48
2	Women	14	36
3	Men	11	48
4	People with disability	10	9
5	Vulnerable people	9	57
6	District and local leaders	51	43
7	Health care workers	25	29
	Total	**133**	**270**

Inclusion and Exclusion Criteria: All individuals that fell within the seven categories in the table above were identified within the five selected districts at the time of the interview, and were eligible to participate in the survey. All participants were required to provide written consent.

Ethical Considerations: Participation in the survey was voluntary and included an informed consent procedure. Eligible respondents were selected to participate after being informed about the purpose and objectives of the exercise and potential benefits and possible risks of participation. An information sheet was provided to all respondents with phone and email contacts for the lead team members conducting the survey. This was done in case the respondents had any questions during or following the interaction with the interview teams. The respondents were fully informed of the information being collected and the methodology for data collection. They were also informed of confidentiality measures undertaken during data collection and management. Finally, potential respondents were informed that participation was voluntary, and refusal to participate would in no way affect them and their future dealings with RHITE-N, Lango project. Interviewers were trained on how to identify individual respondents who may need further support on some of the issues that they shared. Being from the

respective communities, the interviewers were advised to make referrals for such individuals to organizations that provide the kind of services that would support them.

Confidentiality: Data collected at individual level was not communicated outside the data collection/coordination team. The raw data remained in custody of the Task Team and only generalized findings were shared for purposes of generating the report. Nominal information was not recorded during the interviews nor were any identification numbers (e.g. patient's number on medical card, or National ID number) that could allow tracing back to survey participants. To the extent possible, interviews were conducted in venues suggested by the respondents to maximize their privacy.

Ethics Approval: The survey protocol was submitted to and reviewed the JSI Institutional Review Board (IRB). The IRB specifically considered (i) the risks and anticipated benefits; (ii) the selection of participants; (iii) the procedures for securing and documenting informed consent; (iv) the safety of respondents; and (iv) the privacy and confidentiality of data. Based on the above considerations, approval was obtained on July 23, 2018.

Guiding Principles for Conducting the Survey: The process of conducting the survey was as important as the results generated. First, the study team took into account the USAID's Gender Equality and Female Empowerment Policy and recommendations stemming from the Gender and Social Inclusion Analysis: Uganda to frame findings and contribute to the recommendations. The survey was conducted under the guiding principle that gender mainstreaming is critical and requires a meaningful involvement of vulnerable people in decision making on matters that affect them. Other principles include a respect for participants, inclusion, trust, honesty and openness, compassion, shared responsibility and strict confidentiality by the survey teams, and fairness and justice to the respondents. In particular gender sensitive language was adapted, and information collected in matters that affect both men and women specifically, while exploring their relative access and utilization of health services.

Survey Limitations and Challenges: The survey was qualitative in nature and was conducted in five of the nine districts in the Lango sub-region. The sampling effect may have a bearing on the extent to which the findings could be over-generalized to the entire Lango sub-region. However, given the in-depth nature of interviews, the diversity of respondents and the consistency of the responses among multiple respondents from the different districts, the study team concludes that the results are largely reflective of the gender, youth and social inclusion situation in the entire sub-region.

The RHITES-N, Lango management team has a well-coordinated network of affiliates in the entire region. This greatly facilitated the process of reaching out to the target population. However, despite having clearance from the district authorities including the Chief Administrative Officers and District Health Officers, some public health workers were often not comfortable engaging with the research team on how they interact with the target populations in decisions related to seeking health care services. Private health providers were

more difficult to access as they required a more sophisticated approval processes; however, the study team was still able to speak with 2 private providers.[44] An additional challenge involved obtaining parental consent for some of the minor respondents, some of who were mobilized to meet the research teams away from their homes. In these cases, the VHT members and youth leaders who invited the youth provided consent for them to participate in the survey.

Quality Control: Data for this survey was collected by teams that comprised of individuals experienced in qualitative data collection. To be consistent with the gender mainstreaming principles, the team included both men and women from different age brackets. The data collectors were supported by a supervisor for purposes of quality control and efficiency. The data collectors were persons who were natives of the Lango sub-region and had first level knowledge of the socio-cultural dynamics of the region, including competency in the local language. In order to ensure quality of the data collected, the responses were tape-recorded and transcribed after the interview ended. The team was supported by two external consultants who had significant experience in conducting descriptive surveys.

Data Analysis: Transcription data was analyzed using NVivo 11 software. Both axial and open coding of the transcript text allowed for deconstruction of the text and led to the emergence of common themes. A skeleton coding frame was set up using the key themes identified. Initial transcripts were coded manually by the two external consultants and then coded in NVivo by a third study team member to ensure inter-coder reliability. Data findings and recommendations were framed by each survey population at the according SEM level.

Findings

Inclusion of Gender, Youth, and other Vulnerable Groups

Governance/Community: Local governments oversee the implementation of national policies as enshrined in the health policies, the national development plan and the national constitution. In alignment with our literature review findings, stakeholders reported that most of these documents have been adapted to address the needs associated with vulnerable populations. Despite the inclusion of vulnerable groups within policies, there remain significant and multi-faceted gaps and challenges to implementing the inclusion aspects of policies at the service delivery level which are further described below.

Service Delivery: It is apparent that inclusion is the function of health care delivery systems; however, respondents alluded to the fact that there were health significant systems barriers that affected service utilization. These barriers include a lack of availability of specific services for various vulnerable groups, like pregnant women with physical disabilities, people who have hearing impairments. Infrastructure that did not allow for privacy was also a significant concern voiced by pregnant women and by youth. Respondents also commonly mentioned poor provider attitudes, lack of available essential medicines, and inability to pay for medicines out of pocket as additional barriers.

[44] Most often private business owners are not actually working at the private facility. Private facility staff who are employed by the private business owner are not empowered to consent to interview in surveys.

Household/Individual: Household and individual level factors significantly contribute to an exclusion of women, youth, and other vulnerable groups in health and social service uptake. Throughout the interviews, respondents reported male dominance, lack of financial resources, lengthy travel (including the inability to pay for it) to the health facility, and a lack of motivation as dominant barriers to accessing care. Expectations about health service experiences also limited service uptake including poor attitudes from HCW, a lack of appropriate medical supplies and infrastructure to appropriately treat PWD and laboring women, and insufficient drug supplies.

Surveys pulled critical information from each level in regards to the key enablers, and barriers that influence service uptake. In the analysis, a number of factors were identified that strengthen the ability of local governments and communities, institutions, and households/individuals to provide care for the populations of interest. In the following subsections we highlight the contributions, concerns and limitations regarding the inclusion of each of the key groups of interest in view of the different units of analysis including governance/community, institutional, household/individual levels as described in Table 2.

Table 2: Enablers, Barriers, and Key Practices to Inclusion

	Enablers	**Barriers**	**Key interventions /practices**
Governance/Community	– Laws and policies that support the health of vulnerable groups – Budget and resource allocation – Implementation of policies and plans within the community – Knowledge, cultural norms, practices and beliefs attitudes that support inclusion	– Inadequate financial and other resources for implementation of policies and plans – Negative attitudes and lack of commitment to enforcement – Negative cultural beliefs, practices, values and norms regarding care-seeking for certain conditions	– Central and local governments and development partners have in place programs, plans and policies for guiding quality health care services to all population sub-groups – Community mobilization approaches that sensitize and disseminate information about availability of health services and appropriate health behaviors/habits

Institutional	– Service availability (e.g., supplied and skilled to provide maternity care) – Adequate size of health workforce – Central location so extensive travel not required – Reliable access to essential medicines – Economic empowerment opportunities for women	– Perceived low quality of services in respect to space, equipment, human resource skills and knowledge – Poor and/or discriminatory treatment from HCW – Lack of access to essential medicines and supplies – Location requires travel – Long wait times – HCW shortages	– Despite the current guidance for inclusion of vulnerable populations in health programs and policies, systems and structures for health service delivery, there are still significant service delivery weaknesses
Household/Individual	– Knowledge relating to disease identification, service availability, – Women empowered to make decisions and have access to financial resources – Economic capacity to afford costs of care – Male figure perceives value in wife and children accessing healthcare	– Negative attitudes and wrong perceptions about health services offered – Lack of knowledge about available health service availability – Dependence on male figure for health decision making and health spending – Lack of available finances for care-seeking (including travel) – Fear of social stigma and poor treatment from HCW – Lack of privacy and confidentiality	– Targeted behavior change communication – Service delivery through community based health providers and structures – Differentiated service delivery for various population groups including youth that increases access to health services using innovative strategies such as couple/joint HIV testing services (HTS), home visiting and drug distribution

Governance/Community Factors that Influence GYSI

Presence of VHT as sensitization agents to health issues and as awareness raisers of health service availability was the principle means through which the community gained health knowledge and learned about health service access. Other than ad hoc information accessed via the presence of non-governmental organizations (NGOs), VHT were the only recognized source of health information available within communities to the larger population. Youth who attended school also pointed out that their teachers were important providers of health education and provided linkages to health facilities when they became ill.

"VHTs around the villages are trained to sensitize others about available services and also tell them about a particular date to come for health related issue." (Man, Lira District)

"Even at school, the teachers are always teaching us how to live a healthy life… being respectful youth and avoiding bad peers." (Youth, Oyam District)

"When at school and I am sick, the teachers see to it that I get treatment." (Youth, Amolatar District)

Institutional Factors that Influence GYSI

At minimum, the health care system has physical infrastructure, medical and support staff, medical equipment and other supplies, technical service sections/departments for different health services provided etc. Health facilities provide a range of health services including HIV/AIDS services, malaria management, TB, reproductive health and family planning, safe male circumcision (SMC) services, among others. Key themes emerged around factors that influence GYSI within health facilities.

Basic Infrastructure and supplies: Health workers acknowledged the challenges of inadequate infrastructure, supplies and equipment, including personal protective equipment to treat TB patients.

"Our unit is very small with high population coming here for services, the drugs we get are not enough to serve all the clients and like I told you that I normally go to Amolatar. When I go to Amolatar I borrow other things for my maternity. Maternity being an essential service I go and borrow these things so that am in position to help the mothers who come to deliver at the facility*". (Public Health Workers)*

"The infrastructure is a problem; we don't have stools and couches or beds for operational procedures for the insertion of IUDs. The crawling ones (physically handicapped individuals) will be carried to the bed. If at all we help a lame person to get family planning services and if the beds and couches are there, we can just carry them on the beds and couches and provide for them the services. For the people with disabilities we need well organized beds because generally in this facility we only have the normal beds". (GBV, Lira District)

"We have a very big challenge because of the relocation of the Regional Referral Hospital which took place on the 14th July 2018. Our deliveries have increased. All the TB clients are being sent to our facility here and yet the protective gear for health workers is not in place". (HCW)

Interviews with women and youth also commonly noted that they might be turned away if they did not bring gloves for the HCW to use during their consult.

> "Some young people when they go to the health centers the nurses say to them that if you don't have gloves I will not work on you and this scares the young people from going to the health centers" (Adolescent, Lira District)

Staff Shortages: HCW and informants at the individual/household level reported that staff shortages contribute to long wait times, staff burn-out, and inhibit service uptake.

> "At times the facility is left with few staff and if patients come in a huge number, work becomes very difficult for the few who are at the health centre". (HCW, Apac District)

Some patients noted that long waiting times, and perceived preferential treatment of some patients discourages the use of health centers.

> "At the health facility, there are delays in accessing services which forces you to just stay at home the next time you are sick". (Adolescent, Lira District)

> "Some of us go very early at the health centre but there are other people who are friends and relatives of the health workers who just come and get us waiting on the line and by pass to see the health workers before us seeing the health worker and yet we who come early would come from home even without taking breakfast. This makes someone who came early to walk away from the health centre without getting treatment saying there is no need to wait for all those hours if the health workers don't honor the time they have spent waiting on the line". (Adolescent, Lira District)

Poor Treatment from HCW: Health workers were reported to have poor attitudes and biases towards patients including children who were not clean, resulting in avoidance, shame and fear and poor treatment from parents who delayed or avoided bringing their children into health services. Youth also described avoiding health services as a result of poor treatment from HCW and one youth also described sexual harassment from a HCW.

> "Things like nurses and midwives being arrogant, rude and abusive to pregnant mothers. You may decide to go to the health facility and meet harsh treatment from these health workers. This can make you not to come back again". (Women, Oyam District)

> "Even the health workers themselves are not hospitable to the youth they can either abuse us or even speaks rudely to us. This can make us shy away in most cases and as a result complicating the situation". (Youth, Oyam District)

> "As a girl, you have some problems which you can't discuss with the male health workers and some time, they take advances over your situation to ask for sexual favors." (Youth, Oyam District)

Staff Skills: Health workers were worried about their lack of capacity to handle people with disabilities especially those with hearing and speech impairments.

> "We lack skills because all of us are not trained to handle people with these disabilities, some are deaf, some are blind and some are lame. Talking to them is not easy; if a

> mother comes here and they cannot talk it's very difficult to communicate with them and it's actually very embarrassing to us to fail to communicate with the patients". (HCW FGD)

Lack of staff skills to provide youth friendly services was also identified as a barrier to service uptake.

> "The challenge is at the health facility, in situations where they don't have the youth corners, then it becomes very hard for us, the youth, to express ourselves of what is disturbing us". (Youth, Oyam District)

> "Sometimes when you go to the health centre to find out our (HIV) status, those who are there ask very difficult questions. They even say we are not morally upright and that we have been having a lot of sex and now we are in hurrying to find out our status". (Youth, Apac district)

Household/Individual Factors that Influence GYSI

Men as Household Decision Makers: In this setting, men play a significant role in influencing health seeking behaviors of the household members, both positively and negatively. Family cooperation and consultation from men was presented by men as an important condition for health seeking. If the man values health seeking behaviors, healthy decisions for the family may be made. However, multiple informants described men as barriers to family health seeking.

> "The problem comes when the sickness is now severe and needs referral; the man will now start looking at the cost involved and may not want to release the money. It is now the woman to find a way out to the referred place". (Women, Amolatar District)

> "Men do not cooperate when children are sick and we want to take them to the hospital on the day like tomorrow. The next day when you ask him to take you and the child to the hospital he will refuse to take you there, and will go and do his own things. The sick child is left suffering". (Women, Apac District)

There were however, often situations where cooperation between family members and mutual support for each other was described and included making collective decisions. In households where there was "decision space" for health care there were often discussions about the appropriateness of the choice(s) within the context of family available financial resources and values orientation. In these discussions, women tend to be influenced by the husbands' willingness and ability to pay for the treatment service(s) since, in most households these decisions are largely rendered by men. In these cases, women tend to respect the views of their spouses and will consult them on their options to access health care. Joint decision making may delay the process, but may be more effective when both individuals agree on the same decision.

> "If I really there is any sickness in my home, I agree with my wife and we go to the hospital and if they find that we are HIV positive then I have to support my wife and

start taking the ARVs or take the required treatment for any disease the health workers find in us." (Male participant, Amolatar district)

The men feel that they are the custodians of well- being of their families in many aspects including healthcare. Men indicated that health in the home is very important not only for the couple but for the whole family.

> "On my side as the head of the household, I will ensure that all my children sleep under a mosquito net and that is the best way I can monitor the health of the people in my home to ensure that any child does not get malaria." (Male, Amolatar district).

Some male participants indicated that they go the "extra mile" to promote health by supporting their family members to access treatment at the hospital. They also preside over health in their homes including encouraging personal hygiene, keeping the home clean, and constructing sanitation facilities. They also encourage family members to undertake preventative measures such as sleeping under mosquito nets.

> "You should make sure that you home surrounding is totally very clean. There should be latrine, kitchen, and shelter for bathing even the water being used at home should be clean." (Male, Otuke district)

> "For a man to have a healthy family, he should put much effort in making sure that there are latrines at home, shelter should be there as well as rubbish pit so as to prevent the outbreak of some diseases that may cause some problems." (Male, Oyam district)

> "Me, as the man of the home, I ensure that my home is clean the road leading to my home is clean and there should also be transport at my home such that in case of sickness we can reach the hospital easily" (Male, Oyam district).

Men as Resource Providers: Men argued that health seeking behavior patterns are determined by the availability of resources in the form of money to transport the sick, and pay for services, including drugs and supplies.

> I don't have the money for transport and treatment at the health facility, so how do I take my family member for treatment because our health facilities are in far from our homes, sometimes a distance of like 18 kilometers. (Male, Lira District).

> "Our children do not have good clothes so we are ashamed to take them to the health centre". (Male, Lira District)

> "Many times our children and our spouses are too dirty and we fear to take them there because we do not buy soap at home." (Male, Lira District)

Several men maintained that long distances affect health seeking behaviors– suggesting it is too far a walk and/or speculate that there are no drugs available at the facility. Others do not go to

a facility because they are unlikely to find enough or qualified/appropriate health workers, coupled with the overcrowding of other patients.

> Going to the health facility and we line up the whole day, only to be told that there are no drugs and that the officer in charge is not available and will come after two days, demoralizes us and we resort to self-treatment whether herbs or tablets." (Male, Amolatar district)

Men as Non-users and Defaulters: There was a predominant theme that men are generally the last to seek services when they are sick. This is especially true with HIV related services, where men do not readily attend HIV counseling and testing appointments. When men are enrolled in ART, they tend to default on their medications. Alcohol consumption and poverty were largely cited as the reasons for non-adherence.

> "Men are impatient; when they go the health they want immediate treatment. When they see many people there, they fear and shy away and go for self-medication this is dangerous". (Male, Lira District)

> "Me, I am a Person Living with HIV, a farmer and at the same time a fisherman. I want to talk about my health as far as eating food in my home is concerned. I am a married man but most of the times I default taking my drugs because my wife is serial drunkard, she cannot even cook for me food because she is most of the times drunk. This makes me at times fail to take my drugs because I cannot take ARVs on an empty stomach since taking drugs on an empty stomach will make my condition worse. So I prefer not to take the drugs if am hungry because most of the times I feel am not healthy". (PLHIV, Apac District)

There was also concern that men undertake risky behaviors such as smoking, alcohol consumption, having multiple sex partners and then fail in their responsibilities for caring for their families. Adult males argued that younger men and youth were the primary treatment defaulters.

> "Some men also drink too much as a result they may not even get any time to talk and discuss issues to do with health they always leave everything in the hands of their women". (Male, Otuke District)

Barriers beyond Gender for Men: Based on exploration of male views provided during FGDs, the analysis identified diverse factors that affected care seeking decisions beyond those directly associated with gender. They included value for farm work, social stigma associated with disease, poverty, and resignation to die due to HIV-positive status. These individual level barriers have far reaching implications among household members that these men head, ultimately negatively impacting health seeking behaviors for the entire family.

WOMEN

In general, health care is a disproportionate responsibility of women who play a central role as caregivers for other family members. Despite their dependence on the male head of household to make decisions and provide financial support, women were largely noted throughout interviews as the principal catalyst for all family members to seek healthcare.

Women as Individuals: Women indicated that they were not confident or "smart enough" to influence health workers to provide them with needed services. Some women experienced blame by the health workers for not being clean and/or for not coming to the clinic with their husbands. They expressed mistreatment by nurses during child delivery and other routine health services. They expressed concern that due to their socioeconomic position, they do not receive supportive treatment during service delivery.

> "The problem comes from higher level health facilities; they always look at your appearance if they think you may be having money, and then they will attend to you very fast. But if you don't seem to have money, they will hesitate to attend to you also you may not have the money to even go to the health facility in case you are sick. Most ladies don't have their own money that they can pick to go to the health facility when they are not feeling fine.. (FGD woman, Oyam district)

Women also highlighted health systems barriers that include lack of available essential medicines and the common practice of requesting patients to purchase the medicines from elsewhere. Women resented being referred to the private sector to buy drugs because often, they are not able to afford the cost.

> "Poverty; when we go to the hospital the health workers just prescribes the drugs for us to go and buy and for some of us who don't have money we fail to buy the drugs". (FGD Woman, Lira District)

> "For us here you can come to the health centre and the health workers tell you that there are not drugs and they only prescribe the drugs for you to go and buy. When you reach home the man might not buy your idea of going to buy drugs from the clinic. He tells you there is no money saying that is your child; get a way out to treat the child.(FGD Woman, Oyam District)

Poverty: Poverty was identified as a significant barrier for women on multiple levels. Lack of financial resources interfered with basic elements, such as the inability to purchase soap to clean themselves and their children prior to visiting the health facility. Lack of soap was a theme that emerged throughout interviews with men, women, and youth. Women often voiced feeling ashamed arriving because of smelling poorly, or appearing dirty. Poverty also influenced the inability of women to pay for transport to the facility as well as their inability to pay for drugs prescribed by the HCW.

> "Too much responsibilities for the single mothers like looking for food for children even if you have some money and you are sick you cannot use that money for going to the

hospital and yet your children don't have food to eat, I decide to buy food for feeding my children instead of using that money to go with to the hospital". (FGD Woman, Lira District)

Some of us when we go to the health centre and our clothes are not clean the health workers despise us because we are dirty and yet some of us at times don't even have money to but soap". (FGD Woman, Oyam District)

"Also because the men do not buy for us soap at home, most times we are very dirty and our clothes are dirty, we cannot go to the health centre because health workers do not work on people who have not washed their clothes with soap and also have not bathed with soap". (Woman, Apac District)

Domestic Violence and Family Discord: Domestic violence and family discord themes were noted to include prohibitive behaviors from husbands that resulted in denial of women to participate in economic empowerment and health related activities and services. However, several women voiced that female economic empowerment activities are critical to enabling health seeking behaviors.

"If there is any project that will come and help us women; some of our men even if we make money the little money we get the man take it away from us to drink alcohol. In this place we have a market and health centre, there is no money for us to use as capital for us to do business". (FGD Woman, Oyam District)

"It is only business that can enable women to improve health care seeking pattern because as a woman, you will have your personal money to cater for emergencies like sicknesses but not waiting from a man only." (FGD Woman, Oyam District)

In the Lango sub-region, agriculture (crop cultivation) is the dominant economic activity, where women are the key source of labor. The reality is that men generally work less on the farm, but control the products of the labor of their wives; they sell off farm produce and use the income as they wish. Meanwhile, women are preoccupied with the demands of farming and neglect health seeking behaviors. Among many women who were interviewed, it was clear that men inhibit or block healthcare access for their families. As this analysis confirmed, GBV may result from conflict over the use of household resources and income including decisions to seek health services.

"Busy seasons are not the best for health seeking. Busy seasons include farm work during harvesting and planting seasons." (FGD Woman, Apac-District)

"The men in our lives do not look after us well in our homes. The leave all the responsibilities on us, e.g. looking for food, cooking it, looking for soap for the whole family, looking after the family, digging in the gardens, taking the children to the health centres. All these responsibilities make us weak." (Woman, Apac District)

"We are farmers, when it does not rain then we get very poor crop harvest that means we cannot sell our crops because when we sell the crops we get the money. We use this money for looking after our families. Like when the child is sick I can sell a basin of our groundnuts and use the money for buying any prescribed drug which is not available at the health centre most times". (FGD Woman, Apac District)

"Fear; the women fear the men, when you tell the men you are going to the hospital, they shout at us" (FGD Woman-Apac-District)

The implication of this reality is that women (especially housewives) are significantly challenged to seek health care at their own discretion.

Views towards Family Planning: All groups were asked about their feelings towards family planning services. There were mixed opinions expressed among and between groups with women having more favorable feelings towards family planning but expressing concerns about potential side effects, including heavy bleeding. Some men expressed concern that use of family planning was an indication that one's spouse was having extra-marital affairs or that use of family planning was only appropriate for CSW. Both men and women expressed concern that using family planning may go against biblical teachings. However, both men and women also expressed that family planning is important so that one can have the financial resources to care for the already present children, including the ability to pay for them to go to school.

"People think that for ladies who are seeking family planning services may be sex workers who are fearing to get pregnant." (Male, Ayei Landing Site)

"People think the idea of family planning is making women to cheat on their husbands as they feel they may not get pregnant even if they have sex outside their marriage." (Male, Ayei Landing Site)

"Some family planning methods are really causing some diseases to our women like cervical cancer that is why I really don't encourage the use of family planning in my home." (Male, Ayei)

"I have seen it can give you time to take care of your children through education, feeding and medical services as well so it's a good idea to go for family planning." (Woman, Amolatar District)

Barriers beyond Gender for Women: Based on exploration of female views provided during FGDs and individual interviews, there were numerous institutional-level factors that also inhibited health and social service access. Women were reluctant to visit lower level health facilities when they knew that they would likely be referred and knowing that they would not be able to afford the cost of travel to reach the referral point and the cost of care upon arrival. Women also expressed concerns about the limited scope of health services available at facilities and the lack of drugs, supplies, health workers and the inadequate infrastructure. These issues were often raised around labor and delivery due to inability to receive life-saving blood transfusions, in the case of postpartum hemorrhage. They also described a lack of equipment such as

maternal/delivery beds that result in mothers delivering on the floor. Other deterrents to assessing the health center were frequent drug stock outs and the subsequent requirement to purchase drugs from pharmacies when one lacks the financial resources, a lack of space to allow for privacy and confidentiality, long waiting times, and mistreatment from HCW.

YOUTH

Poverty: Overwhelmingly, the principal challenge to seeking health and social services among youth was attributed to poverty. Youth expressed that their parents could not give them money to pay for health services. They also voiced fears that if they were to visit the health facility, they would be asked for money to pay for the visit or to pay for drugs, which they would be unable to do.

> "As a young person, I may be very sick, and when I get diagnosed with a fatal sickness I become very fearful and emotional I begin to think of death any time because I do not have the money to go to the regional referral hospital or the main referral hospital Mulago in Kampala. Sometimes we do not have clean clothes to wear for hospital visitations. This is because our fathers at home do not buy soap for washing and bathing for the family". (FGDYouth, Amolatar-District)

> "Sometimes we children of ages 15 – 17 years, when we go to the health centres, the nurses ask for gloves saying it is out of stock. They need to wear gloves before they work on us, she will say, "give me some money to buy gloves, if you do not have the money, she will again say, I cannot work on for I do not have gloves to use. Next time when even one is very sick, they not go to hospital because they do not have money to buy gloves to be examined by the health worker." (Youth, Apac District)

Poor Treatment from HCW: Poor treatment by healthcare workers was the second principal factor that inhibited youth from seeking health services. Youth frequently stated that HCW can be rude and insulting, discriminate against those who don't speak English, or provide services that lack integrity. Youth stated that some facilities were not sufficiently skilled to provide services for the special needs of youth.

> "At times for us young girls when we get our boyfriend and now decides to live with that boy as your husband, when we go to the health centre to test for HIV the boy can give the health worker some little money and the health worker will give a wrong result that the boy is not HIV positive even if the boy is HIV positive and this is scaring the young people from going to the health centre". (Adolescent, Lira District)

> "There are some health workers who are not friendly to the patients and at times other even despise patients and this scares many people from going to the hospital" (Adolescent, Lira District)

> "Sometimes when you are coughing and go to the hospital, the health worker will say, there is no medicine even when there is medicine in the store because she is corrupt and wants money. When I go back home and the cough gets very bad I will fear to go

back to the health centre because the health centre does not have medicine and I do not have the money to buy medicine from the drug shop." (Adolescent, Lira District)

Individual Factors: Health care seeking among young persons was also found to be linked to personal image, economic factors, and perceived quality of health care including treatment from HCW. Throughout interviews, youth expressed concerns regarding damage to their personal image if they were identified as being diagnosed with a socially stigmatizing health condition, such as STI, HIV or TB.

> "Peer pressure; if I share with a friend that am going to the health centre to test, a friend can tell me that what if you get that you are HIV positive what will you do? This kind of question can make me scared from going to the health centre". (FGD, Youth, Oyam District)

> If you go to the health centre to test for HIV and get a health worker who knows you… when you test positive, they tell other people that this person is sick. They just declare your results to other people (FGD Youth, Lira District)

There was significant concern expressed that some young people, boys in particular, engage in harmful alcohol consumption, which reduces their ability to make healthy decisions.

> "There are some young boys who take a lot of alcohol and this makes them fail to go to the health centre in case of sickness or even to know their health status and they get so busy at their work and later on realize that their health is not okay. These include those who sell in markets and at the road side, people in long distance relationships, soldiers, school drop outs". (FGD male, Otuke District)

PEOPLE WITH DISABILITIES

Institutional Barriers: Data from discussions and interviews involving PWD as well as evidence from interviews with HCW reveal a number of health seeking barriers. At the institutional level these included communication barriers with HCW for deaf and mute patients, inadequate infrastructure and equipment such as wheelchair ramps, examination and delivery beds, and toilets. Poor treatment from HCW, and experiences being subjected to long lines and waits despite their physical challenges were further cited as significant issues.

> "There are some people who cannot talk and when they come for services here it is not easy to communicate with them. For instance, one day a patient who cannot talk came to this facility and just telling him to go and buy the syringe is huge problem. If the deaf and dumb client is supposed to come back for another appointment at the health centre is normally very difficult to communicate this. So the thing we need is training on sign language so that we can be in position to communicate with these people when they come for health services here". (Public Health Workers, Apac District)

> "…and then for women who come for maternity, actually we need to help them. The kind of the delivery bed in place at the moment at the health facility is not conducive for

them and I don't know what kind of delivery bed should be provided for them; may be one that they can easily climb. So for now the people with disability deliver on the floor and this makes them feel not loved or cared for". (Apac District)

Individual Barriers: At the individual level, PWD often cited discrimination, not only from HCW, but also from the community at large which posed significant challenges.

> "People with disabilities are facing a lot of stigma. Many people in the community do not even want to greet a disabled person not to talk of helping them. This condition makes it difficult for them to adapt the healthy behavior patterns. (Oyam district)

> "It is we, the PWDs, with many challenges in trying to improve our lives in a healthy way. When we go to the health centre we are not taken care of. They take so long to work on us, and many times we are completely ignored. Sometimes or most times we cannot struggle with the health people on the lines to get medical examinations of even the prescribed medicine." (Amolatar District)

The key finding was that most people with disabilities felt they were neglected at household, community and health facility levels. As a result of this perceived social dejection, some have utilized alcohol to address or mask their frustrations with life. While the health care seeking barriers appear to be similar to those of other vulnerable groups, PWD experience unique institutional barriers related to their disabilities.

PLHIV

Institutional Barriers: Health facility/institutional related factors that impact health care seeking decisions for PLHIV remained similar as with other population sub groups. They included drug stock outs especially required for managing opportunistic infections, required travel to health facilities and the associated travel costs and failure to raise the money due to poverty, negative attitudes from health workers, rude health workers, a long waiting time at the health facilities.

> "For us PLHIV, when we come to the facility like this the health worker can only check your chest and they will tell you to go and buy drugs from the clinic and if you don't have the money it becomes very difficult for us to buy the drugs hence failing to adhere to our treatment which can even result to death" (PLHIV, Apac District)

Negative attitudes towards PLHIV were found to significantly affect health service utilization. Interviews with district officials in the region suggest there are more positive attitudes towards PLHIV as opposed to past years. This analysis noted however that the PLHIV still experience significant stigma from the community. PLHIV also seem to self-stigmatize as evidenced from reports of those who said they have to hide when they are going to take their ART drugs. Some PLHIV, especially men, fear to disclose their status. Failure to disclose leads to challenges to initiate treatment and be retained in care, including PMTCT.

"There is a lot of stigma from people in the community; as you pass by, they would be telling their friend that you see, that person is HIV positive this is really making it hard for us to go for ART due to fear of stigma." (Muntu Sub-county)

"Sometimes when we go to the health centre our neighbors follow us with their eyes when we go back to our villages they tell everyone that we are HIV positive and they have seen getting ART. This discourages other people to come for HIV treatment and testing." (Olilim Sub-county)

Efforts to improve disclosure would include support mechanisms to enable couples to share their HIV status. From all focus group discussions, people fear attending HIV counseling and testing, and most of those who test HIV positive expressed concerns that they would be labeled sexually promiscuous by their community and/or partners. Individuals who are married and diagnosed as HIV-positive, and women in particular, experience increased risk to experience domestic violence. On a positive note, health workers and other stakeholder interviews suggest there is a slow but noticeable attitude change towards this demographic.

Individual Barriers: Individual level barriers included feelings of desperation and self-denial reflected in increased alcohol consumption. Fears around experiences of stigma were expressed through lack of ART adherence for fear of being recognized and concerns about one's physical appearance revealing one's HIV-positive status. Individuals also expressed concerns about the inability to be able to provide for their family and household food insecurity. As a consequence this affected the ability to consume the recommended meals and contributed to ART non-adherence. In summary, PLHIV expressed a sense of hopelessness and this was compounded by the absence of psychosocial support from one's social network.

"Sometimes the youth fear to disclose the sicknesses disturbing them for various reasons especially if the case is complicated and too hard for them to mention to the health workers". (FGD Youth, Oyam District)

"Most of us PLHIV drink a lot of alcohol and we fail to eat food". (FGD, PLHIV, Apac District)

"The life of taking ARVs at home is not easy because of the stigma and discrimination which is still very rampant in our community." (FGD, PLHIV, Apac District)

Attitudes and Perceptions about HCT Utilization: The predominate view across groups was that HIV testing is important and appreciated. There were however, those who felt it was unnecessary as it evokes feelings of hopelessness and desperation when the test results are positive. Those who supported the practice of HIV testing stated it allows those who test positive the opportunities to change their sexual behaviors and prolongs their life through positive living. Conversely those who test negative, it affords the opportunity to observe safe sex practices. Other benefits of testing cited largely by women were the opportunity to deliver HIV negative children as result on enrolling in PMTCT.

Despite the largely favorable attitudes towards testing, young persons expressed concerns that they may be unable to find a spouse if they are diagnosed with HIV. Men noted that they would

prefer to assume or guess their own HIV status based upon their partner's status, rather than initiate the HIV test on their own. This reinforces the common belief that men delay accessing health care services.

HEALTH SYSTEMS SOLUTIONS

Sensitization and Outreach: According to interviews conducted with health facility workers and local government civil servants, in a bid to realize equitable access for far-off communities, outreach services are provided to reach distant communities. This includes mobile outreach health services which have been carried out to increase access to health education, malaria care, HCT, SMC, and other services. Further to this effort has been the creation of community based structures spotlighted by the creation of VHT whose main mandate is create awareness about health service availability and provide treatment within their capacity and to provide advice on their identification of the health problem.

Presence of Relevant Political Structures: Political structures which can be utilized to articulate gender and youth issues in health such as the youth and women's councils provide platforms through which gender and youth issues are articulated. In line with their mandates, the council members serve as voices of their constituencies, and engage in advocacy work for addressing constraints of access to health services for youth and women and other disadvantaged groups.

CONCLUSIONS

Central to the discussion of vulnerability are the cultural norms and values that underpin patriarchal systems. It should be noted, in Uganda especially in rural settings there is still male dominance in regard to access, use, control and ownership of household resources. This means a woman should not own land, and cannot sell land, even if they do own it. Culturally, land is owned by the men, and daughters are rarely bequeathed with land. In some households, daughters inherit land as a group, not individually. They are expected to use such land, but cannot sell it. On the other hand, men easily sell off matrimonial land, and no one in the community recognizes the need for the wife's consent. The effect of this is skewed gender division of control over land, agricultural produce and income, and unfair gender division of labor and family provisioning at household level.

Although in Uganda there are laws governing family resource control and ownership, implementation of these laws on the ground remains poor. Given this background there are means for rural semi illiterate woman to spend money even if from the proceeds of her agricultural produce without the husband's approval. However, when this happens, it provides fertile ground for physical violence.

This analysis explores health-care-seeking decisions and influencers for various population sub groups including men, women, youth, PWD, and PLHIV. Discussions revealed complex issues that present significant barriers that negatively affect health service utilization. The decision to go or not go for health services was found to be a function of several factors. Most factors reported by different groups overlapped. Generally, the severity or urgency of the health service required and the economic capability of the care-seeker to pay for services are key determinants of the decision to seek health services among all demographic groups. The supply

side factors (health care worker attitude, distance to facility, availability of drugs) were also found to be important drivers of health care seeking.

Women, youth, and all economically dependent groups' decision to seek health care were dependent on availability of funds required in the process of seeking care. Women in particular had to consider whether the male partner approved of the decision to seek care, if he was willing to provide the necessary financial and logistical support, and whether their domestic responsibilities were taken care of. For instance, women would not go to a health facility when there was a possibility of facility admission, if they had no clear arrangements /assistance to take care of children, husband and other household responsibilities including care for domestic animals. Male partners also had to understand when a child was ill and needed care before they were willing to provide financial and other support to enable them to receive treatment.

Health Provider Perspectives: The analysis also delved into issues of health provider skills and competencies for handling conditions of different population groups. While heath service providers indicated they provide health services to all without discrimination in line with the national constitution, the quality of health services was largely expressed as inadequate. The implication of this is that individuals avoid or delay seeking healthcare until they can no longer avoid it. Despite the claim that health facilities serve all vulnerable populations, without discrimination, there were obvious gaps in regards to meeting the basic health needs of PWD, women in labor, and PLHIV. Identified gaps included lack of user-friendly infrastructure and equipment such as ramps, delivery and examination beds; health provider skills gaps for handling and communicating with PWD; and inadequate service space to allow for confidentiality and privacy. Other service delivery challenges were drug stock outs, inadequate blood supply, and HR staff shortages, among others.

Perceptions of Health Risks and Vulnerability: The common view across the analysis sub groups appeared to be that individuals in every category are vulnerable as long as there is no money to facilitate health facility and meet the medical care costs. Notwithstanding this general view, women were considered among the most vulnerable since they shoulder the burden of health care-seeking and they tend to have more health care needs than men. Youth also depend largely on their parents were also found to be vulnerable, as their decision to seek care (including male circumcision)still requires the approval of parents, particularly the father. Lack of available youth friendly services further deters youth from accessing youth services. Other groups included among the vulnerable were; street boys, men in challenging trades such as urban hustling and informal sector, disabled persons, men with multiple sexual partners, alcoholics, truck drivers, musicians, boda boda riders, fishermen, and the elderly.

RECOMMENDATIONS

The following recommendations (Table 3) have been identified through compiling data from the literature review and the GYSI survey. They are accordingly separated into recommendations at the Community, Institutional (health facility), and Household/Individual levels. A rationale is provided for each recommendation along with next steps for the RHITES-N, Lango team that is required in order to carry out the recommendation. The special interest groups have been identified for purposes of monitoring the activities and outputs.

Table 3: Summary of Recommendations

	Target population	Recommendation	Rationale	RHITES-N, Lango Next Steps
Community	Women	Multi-media promotion of family planning services specially targeting local leaders and women organizations	Sensitization may dispel myths and increase awareness in regards to service access.	• Facilitate sensitization meetings for religious leaders on family planning at sub-county levels • Facilitate sensitization meetings for local leaders on family planning • Facilitate sensitization meeting for women's (see below) groups on family planning • Facilitate sensitization meetings for men's groups on family planning
	Women	Link with existing women groups and women councils at the district and lower levels to facilitate health education	Women's groups may serve as an important opportunity for women's empowerment via income generation including increased ability to pay for transport and health service access (including essential medicines) by women. The groups may work as entry point to disseminate health education and link women to health services.	• Work with CDOs to map existing women groups in respective districts and sub-countries • Facilitate District Health Education Teams and VHTs to enrage the women groups on health matters in addition to their primary causes • Work with District councils to specifically target female counselors and women leaders at all levels on matters related to health

	Target population	Recommendation	Rationale	RHITES-N, Lango Next Steps
	Administrative	Support the Districts to establish quotas for excluded groups to benefit from services and economic opportunities, e.g. special targets for women, PWDs, youth, etc.	Quotas will provide important benchmarks by which interventions can be measured against to ensure that new vulnerable populations are reached.	• Support the District Health Teams in the Planning processes to establish realistic targets for the diffident special interest groups like women, PWD • Facilitate the District Health Teams in monitoring service delivery to such special interest groups
	All	Build VHT skills to mobilize communities to enhance service demand.	VHTs can increase momentum among community members to enhance service demand and address myths related to some services, particularly FP.	• Conduct survey among DHOs to take stock of all communities who have had VHTs trained in the past by different partners • Conduct meetings with HFs to conduct work planning that harmonizes the operations of the VHTs in their respective communities • Update/adapt any relevant curricula/tools and deliver to VHT as needed
	Youths	Support the districts to implement youth friendly service options for young people as outlined in the Adolescent Health Policy which include a multi-faceted approach to adolescent health including in schools, at clinical level and at community setting	Adolescent-friendly services can increase service uptake, improve health seeking behaviors, and help to dispel stigma, myths associated with various conditions	• Meet with DHOs to determine needed strengthening activities for youth Focal Persons at the respective health facilities • Provide training/on the job mentoring to youth focal persons • Support health facilities to promote youth friendly services that meet the RH needs of young people including increasing service awareness and needed infrastructure changes
	Men	Support District Health Service teams to strengthen male engagement in health promotions including through men's groups. .	Men are the gatekeepers of resources at family level and their attitudes towards health impact the entire family	• Support CDOs to strengthen existing men's groups with male leaders that sensitize other men in the community around the importance of health seeking behaviors for the entire family • Facilitate VHTs to organize male groups in their respective catchment areas to promote family health

	Target population	Recommendation	Rationale	RHITES-N, Lango Next Steps
	All	Expand on current outreach efforts to reach more vulnerable populations especially in hard to reach locations like landing sites and very remote communities	When marginalized individuals work in groups, the power in numbers helps them to be self-empowered at the individual and community levels. In this way they are capable of fending off socially instigated stigma and discrimination. Once empowered, such people are also able to seek health care services and support each other in the face of community based stigma and discrimination.	• Work with CDOs to take survey existing groups of PLHIV, CSWs and other special interest and marginalized groups • Facilitate the mobilization of such groups where they do not yet exist • Through such groups, work with District Health Education Teams and VHTs to provide information packages to address health needs of such marginalized groups
	Youths	Build skills of teachers to integrate health education in the classroom, and develop referral pathways between schools and facilities for preventive and routine healthcare.	Schools are a significant social magnet that attracts big numbers of young people in their adolescent years. Schools provide an enormous opportunity to reach youth with health information that can facilitate behavior change.	• Work with DHEs to strengthen school based education and health promotion for young people • Support DHEs to promote the role of senior men and senior women teachers so as to support learners with their health related needs some of which may not be clinical in nature • Establish referral pathways between nearby HF and schools
	Youths and women	Collaborate with cultural leaders to mobilize communities for norms change on matters related to health, family planning use, and early marriages	Health behaviors patterns are engraved in cultural norms like the preference for early marriages for girls. In order to shift norms, buy-in from community gatekeepers is required.	• Engage cultural leaders through the Lango Cultural Institution and conduct a series of sensitization meetings on a broad range of public health issues affecting young people, women and PLHIV like reproductive health, STI, family planning, maternal and neo-natal health.

	Target population	Recommendation	Rationale	RHITES-N, Lango Next Steps
Institutional	Women and men	Revitalize the GBV Focal persons at the health facility level to effectively increase provider skills to screen for, recognize, treat, counsel and refer GBV cases.	Patients who report to health facilitates with domestic violence related trauma require skilled providers on staff who can meet their unique health and psychosocial needs to reduce vulnerability.	• Work with DHOs and HFs to facilitate more than one staff at each health facility to be skilled in handling GBV survivors, preferably a male and female staff. • Develop referral pathways between HFs and available police, legal, and psychosocial services in cases of sexual violence and suspected child abuse.[45]
	PWDs	Enhance HCW skills gaps to provide care for PWD, particularly those with hearing impairment.	Building HCW skills to provide quality services for PWD may increase health service demand.	Work with DHOs to facilitate training of selected HCWs in basic sign language in areas that are known to have higher numbers of deaf patients.
	All	Facilitate availability of medical products and technologies so as to ensure gender equitable access to vaccines and medicines	The system for supply of medical consumables especially in the public section should be aligned with gender specific profiling so as to respond to the needs of the sub-pupations.	Work with DHOs and health facilities to facilitate the ordering of medical supplies that address the predominant needs of women, men, young people and PWDs.
	Youth	Promote school-based health education through the senior women and male teachers	Health education in schools may increase service demand and improve health seeking behaviors not only among the learners but also their families.	Work with DEOs to facilitate refresher skills building for senior men and senior women teachers at sub-county levels

[45] JSI has tools that can be implemented to assist with this process, as needed among children. https://aidsfree.usaid.gov/resources/prc-companion-guide

	Target population	Recommendation	Rationale	RHITES-N, Lango Next Steps
	All	Support service utilization by minimizing supply side barriers like the attitudes of some health care workers towards their patients, drug stock-outs, lack of privacy in maternity wings, etc.	Service related barriers compound demand barriers and make it even harder for individuals to make decisions to seek health care	• Work with DHOs to organize customer care re-orientation for HCWs and support them to realign service delivery with national quality standards • As feasible, identify some HFs that are in need of urgent refurbishment like provision of curtain in critical units like maternity wings, and support such HFs to secure such small capital inputs
	Youth	Support health facilities to promote youth friendly services to meet the reproductive needs and information gaps in a sustainable way	Young people find it difficult to seek health care alongside other people especially when the problems are reproductive health related.	• Identify staff in select HF who are interested in becoming youth friendly providers • Conduct staff training/mentoring • Make needed operational changes for youth-friendly hours, needed infrastructure changes • Involve youth to design, implement and monitor services • Conduct community sensitization including in schools to raise awareness about youth friendly services
	Women and men	Promote gender responsive health service delivery to reduce health inequalities through delivering integrated, safe, effective and acceptable interventions that focus on promotion of, prevention and curative care from community to tertiary level.	Some of the challenges faced by individuals to receive adequate health care are associated with health seeking delays. Such delays can be attributed to not knowing what symptoms require seeking health services leading to unnecessary morbidity and mortality.	• Work with DHOs to facilitate HFs to obtain national guidelines and service standards for the delivery of integrated health care • As appropriate, facilitate team-based refresher workshops for health facility staff on guidelines and standards

	Target population	Recommendation	Rationale	RHITES-N, Lango Next Steps
	All	Strengthen existing HF Management Teams and support the constitution of p community advisory boards (CABs) to create avenues to report poor treatment at HF including strengthening the MoH hotline for community members to report issues. Also consider conducting periodic exit surveys.	Provider attitudes are a significant deterrent for women and youth to access health services. Creating reporting avenues may help improve provider treatment.	• Meet with DHOs to establish a schedule to institutionalize quarterly meetings of the HF Management Team and CABs • Co-develop and implement roadmap to strengthen MoH hotline • Co-develop and implement exit surveys
	Youth	Support parents through interventions that will enable them to keep their children in school for longer so as to minimize health risks including HIV , STIs and early marriages and pregnancies	Extending school enrollment may reduce early marriage and other vulnerabilities associated with early school departure.	Work with DHEs to facilitate girl education campaigns by targeting parents through their associations like school management committees and Parent Teacher Associations (PTAs)
	All	Support collection of data on social inclusion indicators for progressive improvement in targeting excluded categories and for tracking impacts of the programs on their development outcomes.	More accurate data on how vulnerable groups are treated and accessing services will allow RHITES-N Lango to target and tweak interventions to ensure services are available, affordable and accessible to all.	• Ensure that all data from the project is disaggregated • Share data with facilities to identify service gaps and develop plans to ensure social inclusion in service provision.

	Target population	Recommendation	Rationale	RHITES-N, Lango Next Steps
Household/Individual	Men	Increase men's budgeting skills so they can plan with their families to appropriate budget for household healthcare needs.	The predominantly patriarchal system dictates that men own most of the family resources	• Work with CDOs, religious and cultural leaders to promote the value of male engagement in health decision making through skills building in budgeting for health care needs of their families • Work with CDOs and existing men groups to facilitate meetings on health matters including budgeting for health care .
	Men and women	Address mental health and help seeking behaviors for mental health symptoms.		• Works CDOs and DHOs as well other partners involved in promoting mental health to educate the masses about mental health. • Train PHC and HIV providers to integrate basic mental health, therapeutic interventions and referral (stepped care) into routine services.[46]
		Address harmful substance use.	Excessive consumption of alcohol contributes to poor health seeking behaviors at the individual and family level, and negatively impacts self-care behaviors including adherence and retention.	• Collaborate with CDOs and DHOs as well other partners involved in harmful alcohol and substance use to develop coordinated approach including referral pathways. • Train PHC and HIV providers to integrate basic alcohol screening, therapeutic interventions and referral (stepped care) into routine services.[47]

[46] JSI has tools that can be quickly adapted to accomplish this. https://www.sciencedirect.com/science/article/pii/S1055329015002241
[47] JSI has tools that can be quickly adapted to accomplish this. https://www.sciencedirect.com/science/article/pii/S1055329015002241

	Target population	Recommendation	Rationale	RHITES-N, Lango Next Steps
	All	Promote use of soap for hand washing among all households in the region	Most of the common ailments are as a result of poor hand hygiene.	• Conduct hands on support to environmental health staff and VHTs to equip them with skills to "trigger" women and youth who come to seek health care and or their attendants for Hand washing with soap/ash

Annex I: GYSI Data Collection Tool

USAID RHITES-North, Lango: Gender, Youth and Social Inclusion (GYSI) Analysis

Background:

The objective is this Analysis is to document current practices, enablers and barriers for healthy behaviors among women, men, youth and marginalized populations of the 9 districts that make up the greater Lango sub-region of Northern Uganda. The intended outcome of this Analysis is to have innovative approaches that will improve access to quality health care among these groups of people, based on local needs. The Analysis will be situated in the Health Belief and the Social Behavior Change Models.

The analysis will document social-cultural, economic, and structural enablers and barriers to healthy behaviors as experienced by the different target populations.

The analysis will target the following populations:

1. Women and men of all ages;
2. Young people 15-24, and 25-34;
3. People with disability and chronic conditions;
4. Vulnerable populations like fishing communities, PLHIV, internally displaced and refugee communities, people in complex trades like CSWs, urban area hustlers;
5. People with disabilities; and
6. Health care providers both in public and private sector (including NGOs).

In order to triangulate the opinions of the target population, critical stakeholders in healthcare delivery will also be interviewed. These will include:

1. Local government officials like Health and Social Services Secretaries, LC Chairpersons 1-5, Women Chairpersons; and
2. Opinion leaders and influencers including religious leaders, community elders, etc.

A. General questions (targeting stakeholders)

1. How do people participate in decision making related to health care provision in their respective localities?
2. On what basis do people in your locality make decisions to seek health care?
3. What facilitates people in your locality to seek health care?
4. What challenges do people in your locality often have in seeking health care?
5. Which sub-populations normally face the biggest challenges?
6. What role does knowledge of availability of services play in facilitating health care seeking behaviors for the different sub-population?
7. How do you feel about people who disclose their HIV status? (**PROBE** for perceptions about HIV positive people in the community)
8. How are PLHIV in your locality perceived by their respective communities?
9. How do people in your community think about others who seek for FP services?
10. How do people in your community think about others who seek for HIV testing services?
10. What have you seen or heard that have made a difference in how you feel about FP services? (**PROBE** for messages, materials on the radio, posters, branding, etc.)
11. What have you seen or heard that has impacted on the way you think about HIV testing services?

B. Young people

1. How do young people participate in decision making related to health care provision in their respective localities?
2. What challenges do young people often face in adapting healthy behavior patterns?
3. What types of young people face the biggest challenges in seeking health care? (RE: young people in schools, street children, displaced persons, younger persons in challenging trades, non-traditional individuals, emancipated young people like young girls with babies, young people with some form of disabilities, etc.)
4. What challenges do young people often face in making decisions to seek for health care?
5. Who often supports young people to seek health care?
6. What do you think would enable young people to improve health care seeking patterns?
7. What situations often discourage young people from seeking health care services and adapt healthy behavior patterns?
8. Are there specific conditions in which young people find themselves that make it difficult to them to adapt healthy behavior patterns?
9. What is the role of significant others in facilitating young people to seek care?
10. How does having knowledge about specific services help young people in making decisions to seek for the services?
11. How do you feel about people who disclose their HIV status? (**PROBE** for perceptions about HIV positive people in the community)
12. How are PLHIV in your locality perceived by their respective communities?
13. How do people in your community think about others who seek for FP services?
14. How do people in your community think about others who seek for HIV testing services?
12. What have you seen or heard that have made a difference in how you feel about FP services? (**PROBE** for messages, materials on the radio, posters, branding, etc.)
13. What have you seen or heard that has impacted on the way you think about HIV testing services?

C. Women

1. How do women participate in decision making related to health care provision in their respective localities?
2. What challenges do women often face in adapting healthy behavior patterns?
3. What types of women face the biggest challenges in seeking health care? (RE: more educated, less educated, rural dwellers, married women, unmarried women, women employed in the informal sector, women in challenging trades like street vending, CSWs, women with disabilities, young women with children, incarcerated women, etc.)
4. What challenges do women often face in making decisions to seek for health care?
5. Who often supports women to seek health care?
6. What do you think would enable women to improve health care seeking patterns?
7. What situations often discourage women from seeking health care services and adapt healthy behavior patterns?
8. Are there specific conditions in which women find themselves that make it difficult to them to adapt healthy behavior patterns?
9. What is the role of significant others in facilitating women to seek care?
10. How does having knowledge about specific services help women in making decisions to seek for the services?
15. How do you feel about people who disclose their HIV status? (**PROBE** for perceptions about HIV positive people in the community)
16. How are PLHIV in your locality perceived by their respective communities?
17. How do people in your community think about others who seek for FP services?
18. How do people in your community think about others who seek for HIV testing services?
14. What have you seen or heard that have made a difference in how you feel about FP services? (**PROBE** for messages, materials on the radio, posters, branding, etc.)
15. What have you seen or heard that has impacted on the way you think about HIV testing services?

D. Men

1. How do men participate in decision making related to health care provision in their respective localities?
2. What challenges do men often face in adapting healthy behavior patterns?
3. What types of men face the biggest challenges in seeking health care? (RE: young men in schools, street boys, displaced men, men challenging trades like urban hustling, non-traditional individuals, men with some form of disabilities, etc.)
4. What challenges do men often face in making decisions to seek for health care?
5. Who often supports men to seek health care?
6. What do you think would enable men to improve health care seeking patterns?
7. What situations often discourage men from seeking health care services and adapt healthy behavior patterns?
8. Are there specific conditions in which men find themselves that make it difficult to them to adapt healthy behavior patterns?
9. What is the role of significant others in facilitating men to seek care?
10. What is the role of men facilitating their partners/spouses to seek health care?
11. What kind of role, if any, do men play to create barriers for their partners/spouses/children to seek health care?
12. What are some challenges to men accompanying their partners/spouses or children to health care services?
13. How does having knowledge about specific services help men in making decisions to seek for the services?
14. How do you feel about people who disclose their HIV status? (**PROBE** for perceptions about HIV positive people in the community)
15. Howa re PLHIV in your locality perceived by their respective communities?
16. How do people in your community think about others who seek for FP services?
17. How do people in your community think about others who seek for HIV testing services?
16. What have you seen or heard that have made a difference in how you feel about FP services? (**PROBE** for messages, materials on the radio, posters, branding, etc.).
17. What have you seen or heard that has impacted on the way you think about HIV testing services?

E. People with Disability (PWD)

1. How do PWD participate in decision making related to health care provision in their respective localities?
2. What challenges do PWD often face in adapting healthy behavior patterns?
3. What types of PWD face the biggest challenges in seeking health care? (RE: hearing impaired, physically disabled, etc.)
4. What challenges do PWD often face in making decisions to seek for health care?
5. Who often supports PWD to seek health care?
6. What do you think would enable PWD to improve health care seeking patterns?
7. What situations often discourage PWD from seeking health care services and adapt healthy behavior patterns?
8. Are there specific conditions in which PWD find themselves that make it difficult to them to adapt healthy behavior patterns?
9. What is the role of significant others in facilitating PWD to seek care?
10. How does having knowledge about specific services help PWD in making decisions to seek for the services?
11. How do you feel about people who disclose their HIV status? (**PROBE** for perceptions about HIV positive people in the community)
12. How are PLHIV in your locality perceived by their respective communities?
13. How do people in your community think about others who seek for FP services?
14. How do people in your community think about others who seek for HIV testing services?
15. What have you seen or heard that have made a difference in how you feel about FP services? (**PROBE** for messages, materials on the radio, posters, branding, etc.)
16. What have you seen or heard that has impacted on the way you think about HIV testing services?

F. Vulnerable groups (fishing community residents, IDPs/Refugees, people in complex trades like CSWs, urban area hustlers, etc.)

1. How do vulnerable people participate in decision making related to health care provision in their respective localities?
2. What challenges do vulnerable people often face in adapting healthy behavior patterns?
3. What types of vulnerable people face the biggest challenges in seeking health care?
4. What challenges do vulnerable people often face in making decisions to seek for health care?
5. Who often supports vulnerable people to seek health care?
6. What do you think would enable vulnerable people to improve health care seeking patterns?
7. What situations often discourage vulnerable people from seeking health care services and adapt healthy behavior patterns?
8. Are there specific conditions in which vulnerable people find themselves that make it difficult to them to adapt healthy behavior patterns?
9. What is the role of significant others in facilitating vulnerable people to seek care?
10. How does having knowledge about specific services help vulnerable people in making decisions to seek for the services?
11. How do you feel about people who disclose their HIV status? (**PROBE** for perceptions about HIV positive people in the community)
12. How are PLHIV in your locality perceived by their respective communities?
13. How do people in your community think about others who seek for FP services?
14. How do people in your community think about others who seek for HIV testing services?
15. What have you seen or heard that have made a difference in how you feel about FP services? (**PROBE** for messages, materials on the radio, posters, branding, etc.).
16. What have you seen or heard that has impacted on the way you think about HIV testing services?

G. Health care providers

1. What facilitates you in targeting those individuals who are in most need of your services?
2. What policies and guidelines are in place at your HF that will enable you to provide timely services to the different sub-populations (women, men, young people, PWDs, KPs)?
3. What special skills do you need in order to provide care to special populations like PWD, KPs?
4. What challenges do you normally face in providing care to the different sub-populations?
5. Does your HF has teams that can attend to PWD?
6. Does your HF have infrastructure that can facilitate PWD to access care?
7. Does your HF have equipment and supplies to address the needs of the target population at all times?