GOOD PRACTICES IN SEXUAL REPRODUCTIVE HEALTH INTERVENTIONS FOR ADOLESCENT COMMERCIAL SEX WORKERS INUGANDA (ACSWs)

UYDEL
UGANDA YOUTH DEVELOPMENT LINK
2013
GOOD PRACTICES IN SEXUAL REPRODUCTIVE HEALTH INTERVENTIONS FOR

ADOLESCENT COMMERCIAL SEX WORKERS IN UGANDA

UGANDA YOUTH DEVELOPMENT LINK

2013
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<td>ACSWs</td>
<td>Adolescent Commercial Sex Workers</td>
</tr>
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<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual Reproductive Health</td>
</tr>
<tr>
<td>AFS</td>
<td>Adolescent Friendly Services</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavioural Change Communication</td>
</tr>
<tr>
<td>FGDs</td>
<td>Focus Group Discussions</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMP</td>
<td>Health Matters Project</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informants’ interviews</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual Reproductive Health</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>UYDEL</td>
<td>Uganda Youth Development Link</td>
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EXECUTIVE SUMMARY

This report highlights the good practices, strategies, tools, lessons learnt and operational methods that guaranteed the efficiency and sustainability of the Health Matters project for Adolescent Commercial sex workers in four divisions of Central, Rubaga, Kawempe and Makindye in Kampala City, Uganda from 1st June 2010 to 30th May 2013.

The project contributed to the reduction of incidences of unwanted pregnancies Sexually Transmitted Diseases (STIs) including HIV among Adolescent commercial sex workers (male and female) through increased access to high quality ASRH youth friendly services and information to ACSWs (Male and Female) in the 4 divisions of Kampala City.

The project addressed the challenges faced by adolescent commercial sex workers and young people in slums such as high rates of teenage pregnancies, unsafe abortions, high rates of STI and HIV/AIDS infections, limited access to family planning services and limited awareness about adolescent sexual reproductive health issues.

The major finding of the study revealed that working with adolescent commercial sex workers with multiple sexual reproductive needs requires one to have a comprehensive and holistic approach that addresses access to correct and culturally sensitive information on ASRH to enable them make informed choices/decisions about their lives. It is also important to include socio-economic support services for the ACSWs to reduce their vulnerability and dependency on commercial sex work to address their basic needs and other survival needs without exposing them to HIV infection and other risks involved in engaging in Commercial sex work.
ACKNOWLEDGEMENTS

UYDEL Management and the Health Matters Project Team would like to acknowledge the authors of this Good Practice Report Ms. Anna Nabulya and Ms. Nambatya Susanne.

We would like to convey our sincere thanks to all those that have made the documentation of Good Practices for the Health Matters Project a success. Our thanks go to Mr. Rogers Kasirye the Executive Director of UYDEL for his technical assistance and experiences about the project. We are grateful to Ms. Jacqueline Nassaka the Project Co-ordinator and the Health Matters Project Staff for their unwavering support during the good practices documentation exercise for their insights and experiences about the project.

We would like to extend our heartfelt thanks to the project beneficiaries, community leaders and partner organizations and institutions that unreservedly shared their experiences and provided valuable insights into their work with ACSWs and community members. Most importantly, we would like to appreciate the beneficiaries of the project, the adolescent commercial sex workers who unreservedly accepted to share their experiences into the services they received from the project and the challenging contexts they live in. We are also grateful to all other people who shared their views and opinions with the team.
Chapter One

INTRODUCTION

This report provides information about the good practice intervention adapted during the implementation of the Health Matters Project implemented by Uganda Youth Development Link in the 4 Divisions of Kampala from 1st June 2010 to 30th May 2013.

1.1. Contextual and background information

Uganda’s population has seen a marked growth since 1959 when it stood at 6.5 million; reaching 33.8 million in 2010 and is now projected to increase to 91.3 million by 2050. The State of Uganda Population Report 2012 reveals that there are 6.5 million Ugandans in the age group 18-30 years and these constitute 21.3% of the population. This age group is projected to grow to 7.7 million young people in 2015.

A preliminary study by the Crane Survey 2012, estimates the Conservation Population size of Female Sex Workers in Uganda to be 13,000 (95% CI: 10,000 - 16,000) and the Conventional population size of Female Sex Workers is 26,000 (95% CI: 18,000 - 35,000).

Young women are particularly vulnerable to consequences of early pregnancy, unsafe abortion and unsafe sex including STI/HIV infection. The current key findings of the 2011 Uganda AIDS Indicator Survey (UAIS) shows that youth aged 18 - 24, 60% of women and 47% of men had sex before age 18 and that in Uganda 3.7% of young women and men age 15-24 are HIV-positive. A study conducted by MoH and ORC Macro in 2006 indicated that 63% of girls and 47% of boys had had sex before the age of 18 while 15% of young people aged 15 - 24 had had sex before the age of 15. According to Darabi et al., (2008), the incidence of STI infections among young people in Uganda is high. 18% of adolescent females and 6% of adolescent males (15 - 19 years) reported having ever had an STI or experiencing a specific STI symptom. About 14% (females) and 34% (males) of sexually active adolescents do not know where to go for treatment. According to the Uganda Adolescent Survey (S. Neema, 2006), 20% of sexually active adolescent women had ever had an STI. Moreover, pregnancy among adolescents is rife with over 55% of all 15 - 19 adolescents who have ever had sex having been pregnant. This is consistent with findings from a study conducted by Panos (2010) that about 68% of adolescents who participated in the study indicated that teenage pregnancies were common while 63% indicated that abortion was common among young people. According to a study by Uganda Aids Commission and its partners 2009, commercial sex workers are among the population with high HIV prevalence rates.

Access to adolescent sexual reproductive health services in Uganda remains woefully inadequate. For instance, about 29% of adolescents out of school have access to STI counseling testing, 26% have access to family planning services, 8% STI treatment while about 2% have access to antiretroviral therapy (Panos 2010). Adolescents, both unmarried and married, face many sexual and reproductive health risks stemming from early, unprotected, and unwanted sexual activity. Key factors underlying this issue are lack of access to sexuality education, and to accessible, affordable, and appropriate contraception. There is an urgent need to implement programmes to meet the contraception needs of adolescents, while dismantling the current barriers to adolescents from accessing services.

1.2 Policy Environment for sexual reproductive health

Sexual and reproductive health and reproductive rights do not represent a new set of rights but are rights already recognized implicitly or explicitly in national laws, international human rights documents and other relevant United Nations consensus documents.
Uganda Government is committed to the improvement of the quality of life of adolescents. This commitment is reflected in many several documents (see Annex 3). However, despite the existence of the various policy frameworks and wonderful documents for the improvement of sexual reproductive health to adolescents in Uganda, many largely remain on papers and gather dust on shelves; and young people in urban slums remain greatly unreached by these services.

1.3. Background to the Health Matters Project

The Health Matters Project for Adolescent Commercial Sex Workers was implemented by Uganda Youth Development Link in the four divisions of Kampala City from 1st June 2010 to 31st May 2013. The aim of the project was to contribute to a better quality of ARH of ACSWs by reducing the incidences of unwanted pregnancies, Sexually Transmitted Diseases (STIs) including HIV through increasing access to high quality ASRH youth friendly services in 4 divisions of Kampala City. The project was aimed at addressing challenges that are faced by adolescent sex workers and young people in slums such as high rates of teenage pregnancies, unsafe abortions, high rates of STI and HIV/AIDS infections, limited access to family planning services and limited awareness about adolescent sexual reproductive health issues.

The project specific objectives were:-

i. To increase community awareness on ARH and rights, quality reproductive health care and treatment, for the prevention of unwanted pregnancy and HIV/AIDS infection among for ACSWs in four (4) divisions of Kampala City.

ii. To increase access and utilization of youth friendly reproductive health information and services for 720 ACSWs through high quality outreach service arrangements.

iii. Most important to withdraw, rehabilitate and equip 720 ACSWs with vocational, business, and life skills education as an alternative means of reducing their vulnerability and promoting alternative positive survival options.

Distribution of ACSWs by gender for the two project phases in 3 years

<table>
<thead>
<tr>
<th>Project phases</th>
<th>Planned Target (#)</th>
<th>Right target reached for the project intervention</th>
<th>Disaggregation by gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>June 2010 - May 2011</td>
<td>320</td>
<td>344</td>
<td>32</td>
</tr>
<tr>
<td>June 2011 - May 2012</td>
<td>200</td>
<td>177</td>
<td>8</td>
</tr>
<tr>
<td>June 2012 - May 2013</td>
<td>200</td>
<td>227</td>
<td>13</td>
</tr>
<tr>
<td>Totals</td>
<td>720</td>
<td>748</td>
<td>53</td>
</tr>
</tbody>
</table>

HMP ACHIEVEMENTS AGAINST PLANNED TARGETS, JUNE 2010 – MAY 2013

<table>
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<tr>
<th>Output indicator</th>
<th>Planned targets</th>
<th>Achievements</th>
</tr>
</thead>
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<tr>
<td>Awareness raising on ASRH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish static and mobile outreach sites</td>
<td>2 static outreach posts and 2 mobile outreach sites</td>
<td>3 static outreach posts (Nateete, Kamwokya and Masooli) and 7 mobile outreach sites established (Kalerwe, Katanga, Mulago, Kibuye, Makindye, Kajungi, Nakulabye and Bwaise)</td>
</tr>
<tr>
<td>Conduct consultative meeting with local leaders and owners of commercial enterprises where CSW is practiced.</td>
<td>130 local leaders</td>
<td>129 local leaders oriented and consulted</td>
</tr>
<tr>
<td>Intervention</td>
<td>Activity</td>
<td>Result</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Conduct dialogues with youth on ASRH</td>
<td>90 dialogues (targeting 720 young people)</td>
<td>63 community youth dialogues conducted (reached 1,394 young people in 57 communities)</td>
</tr>
<tr>
<td>Train peer educators</td>
<td>120 young people</td>
<td>169 girls (79 from Rubaga division and 90 from central division) were trained and supported to mobilize and educate young people on SRH issues</td>
</tr>
<tr>
<td>Conduct community education using drama on ASRH</td>
<td>72 community drama shows conducted (in slum communities in Rubaga, Makindye, Central and Kawempe divisions)</td>
<td>72 community drama shows were conducted in 36 slum communities of Rubaga, Central, Kawempe and Makindye divisions</td>
</tr>
<tr>
<td>Promote indoor and outdoor recreation activities for ACSWs</td>
<td>6 different indoor and outdoor games were promoted for positive recreation</td>
<td>845 young people participated</td>
</tr>
<tr>
<td>Dissemination of IEC materials on ARH</td>
<td>600 copies</td>
<td>1,360 copies of information materials collected (posters, brochures, stickers, banners, T-shirts with ARH messages)</td>
</tr>
</tbody>
</table>

### Access and utilization of ASRH services

<table>
<thead>
<tr>
<th>Service</th>
<th>Activity</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual counseling on ASRH</td>
<td>720 adolescents and youth</td>
<td>1,896 young people (39 male and 1,857 Female) were counseled</td>
</tr>
<tr>
<td>Treatment of Sexually Transmitted infections</td>
<td>720 young people engaged in risky sexual behavior particularly commercial sex</td>
<td>1,993 clients treated commonly for syphilis, gonorrhea and candidiasis (80 male and 1,913 female)</td>
</tr>
<tr>
<td>Pregnant tests</td>
<td>400 young people</td>
<td>283 young people and 14 young people were pregnant</td>
</tr>
<tr>
<td>Family Planning (FP) information and services</td>
<td>500 young people</td>
<td>291 girls (185 accessed pills, 106 accessed Depo Provera injection)</td>
</tr>
<tr>
<td>Promotion and distribution of condoms for duo protection</td>
<td>720 young people</td>
<td>1,541 young people (137 male, 1,404 females accessed condoms)</td>
</tr>
<tr>
<td>Referrals for Anti-Retroviral Therapy (ART and other RH) services</td>
<td>150 young people</td>
<td>90 young people referred (post abortion care – 12, ART-45, PMTCT -3, Ante-natal care 12, 1 for X-ray with severe abdominal pains and male circumcision -17)</td>
</tr>
<tr>
<td>HIV Counseling and Testing (HCT)</td>
<td>720 young people</td>
<td>1,449 young people (1,095 female and 354 male) utilized HIV counseling and testing and Twenty nine (29) HIV Counseling and Testing sessions were conducted</td>
</tr>
</tbody>
</table>

### Withdraw and rehabilitate ACSWs including vocational skills training

<table>
<thead>
<tr>
<th>Service</th>
<th>Activity</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and home visits of beneficiaries.</td>
<td>520 young people</td>
<td>553 young people were assessed and their profile documented</td>
</tr>
<tr>
<td>Life planning skills training (street smart)</td>
<td>520 young people</td>
<td>618 young people trained (67 boys, 551 girls)</td>
</tr>
<tr>
<td>Placement for vocational skills training</td>
<td>520 young people</td>
<td>553 young people completed, 63 still on training and 40 dropped out</td>
</tr>
<tr>
<td>Trained in business skills training</td>
<td>200 young people</td>
<td>275 young people trained in business skills training</td>
</tr>
<tr>
<td>Follow-up of ACSWs benefiting from vocational skills training</td>
<td>520 young people</td>
<td>263 young people have been followed up</td>
</tr>
<tr>
<td>Resettlement and graduation of beneficiaries</td>
<td>520 young people</td>
<td>263 young people resettled and graduated</td>
</tr>
</tbody>
</table>

### Project management

<table>
<thead>
<tr>
<th>Service</th>
<th>Activity</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring and support supervision activities</td>
<td>24 support supervision visits</td>
<td>26 visits were made to youth centers and outreach sites</td>
</tr>
<tr>
<td>Review meetings for peer educators</td>
<td>12 meetings</td>
<td>12 review meetings were held to review progress and re – energize peer education</td>
</tr>
</tbody>
</table>
Chapter Two

GOOD PRACTICE REVIEW FRAMEWORK

2.1 INTRODUCTION

A Good Practice is a management idea which asserts that there is a technique, method, process, activity, incentive or reward that is more effective at delivering a particular outcome than any other technique, method, process, etc.

Good practices can also be defined as the most efficient (least amount of effort) and effective (best results) way of accomplishing a task, based on repeatable procedures that have proven themselves over time for large numbers of people.

A good practice:-

♦ Be it small or large may contribute partially or in full to the sustainability and relevance of interventions by any organization and project implementations, it is sustainably, ethical and relevant.

♦ It poses the quality of being efficient during implementation, potentially usefulness and has been tried and seen to be working and useful in stimulating new ideas and guidance in helping in prevention, withdrawal and reintegration.

2.2 THE PURPOSE OF THE GOOD PRACTICE DOCUMENTATION

The good practice documentation aimed at helping the Health Matters project team to review strategies and practices utilized during the implementation of the project to ensure that they were: evidence-based; met a meaningful threshold of effectiveness i.e conforms to prevention science and standards; are generalizable and; provide actionable information to help practitioners implement/replicate practices.

2.3 THE GOOD PRACTICE FRAMEWORK

The Good Practice Framework focused on reviewing the:-

♦ Methods (procedures and means of implementation of the Health Matters Project)
♦ Innovation s( new inventions)
♦ Experiences (resulting know how)
♦ Approaches (ways of doing it.)
♦ Practices (performing these activities)

The study team reviewed the:-

♦ Conception, design and planning of the Health Matters Project
♦ Implementation, factors at play and attribution
♦ Relevancy and lessons learnt from the activity at macro, meso and micro levels, time, resources,
♦ Practices, tools levels of replicable, and human resource development
Sustainability into the general project plan and processes
◊ Staff capacity and engagement
◊ Infrastructure
◊ Recruitment incentives to CSWs
◊ Building relationships with clients
◊ Creativity
◊ Fidelity/monitoring

Scope of work Activities/expectation
The study team was expected to: identify and document good practices in the field of Adolescent Sexual reproductive Health of youth involved in commercial sex work utilized/ adapted in the implementation of the Health Matters Project and; Review and document good practices developed by other social actors in the Sexual Reproductive health.

Final output
The final output identified: basics in reintegration patterns; and described some model SRH good practices for ACSWs and; Is pragmatic and ready-to-use for professionals in the field of ASRH, highlighting recommendations, concrete examples or testimonies.

Methodology
The qualitative component consisted of reviewing HMP project programmatic and evaluation reports; Interviews, observations and focus group discussions were held with the project beneficiaries and key partners/ social actors/ networks/ project staff to get feedback about the best practices identified; Review of literature on SRH best practices and policies in Uganda and made recommendations about new innovations; and Documentation of case studies and, most significant change stories and lessons learnt during the implementation of the Health Matters project

The study team also used purposeful sampling to identify the subjects to be interviewed on the recommendation of the project coorNighttors, staff and other key stakeholders both for face to face Interviews and the focus group discussions. This was also supplemented with snow balling especially when it comes to children who may know other beneficiaries but not know/remembered by the project staff.

Ethical Considerations
The good practices review of the HMP Project posed no known risks to the Human Subjects that were involved. The study team sought informed consent verbally from the participants that were interviewed and engaged in the Focus Group Discussions, and No personal identifiers will be collected. Where pictures were taken and the success stories and case studies, written, informed consent was given to the study team

Sample size
The sample size was 247 ACSWs and 15 Project staff for the face to face interviews and 2 groups of 10 to 15 participants for the focus group discussions and 10 key stakeholders/ partners were interviewed and contacted for focus group discussion in the project area.
Data collection

Data Collection was undertaken using Desk reviews, Face to face interviews, observation, and Focus group discussions as discussed below:

Desk review:

Reading the preliminary information, project reports and policies, and identify activities for follow up for in depth information and design of the evaluation questionnaire

Face to face interviews were conducted by 2 Project Co-ordinators, 13 project staff, 247 project beneficiaries, 5 partner organizations and with 10 key community informants to understand why certain interventions are considered good practices.

Focus group discussion were also held with project coorNighttors, project staff, 2 groups of project beneficiaries each group with 10 - 15 people.

The Key areas of focus for the interviews and focus group discussions included:-

- Activities and processes (nature of activities - vocational, life skills etc., business training, reintegration, community awareness, etc)
- Achievements and successes, numbers, gender, conditions, why, factors for its success and challenges
- Sustainability, relevancy of the good practice
- Why it is considered a good practice.
- Lessons learned and why group considers it as good practice
- Challenges and recommendations for improvement

Validation meeting:

These were achieved at 2 levels:-

- The First Level was done in the field with Project CoorNighttors, key staff and informants and young people.
- The Second level was done at the validation workshop, for verification of data and information with project staff and beneficiaries organized by the study team to seek comments and agreements on the good practices.
This Chapter provides a detailed analysis of the good practices identified and utilized by the Project team in the implementation of the Health Matters project which aimed at contributing to a better quality of ARH of ACSWs by reducing the incidences of unwanted pregnancies, Sexually Transmitted Diseases (STIs) including HIV through increasing access to high quality ASRH youth friendly services in 4 divisions of Kampala City from June 2010 to May 2013.

After conducting interviews, focus group discussions and consultations with the Project staff, Project Beneficiaries (both direct and indirect), Key informants, community members and partner organizations, the study team identified five key good practices utilized by the project team to reach out to the Adolescent Commercial Sex Workers with Youth Friendly Sexual Reproductive Health Services. These included: Youth Friendly Sexual Reproductive Health Services (YFS), Vocational Skills Training, Psychosocial Support, Partnership and Collaboration and Capacity Building. The details of each of these Good Practices are discussed in the tables below.

<table>
<thead>
<tr>
<th>Title: Youth Friendly Sexual Reproductive Health Services (AFS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location/ geographical coverage:</strong></td>
</tr>
<tr>
<td>☑️ UYDEL youth Drop - in centre and mobile outreach posts in kibuye, Kajubi and Nanteete, Rubaga Division, Kampala district</td>
</tr>
<tr>
<td>☑️ UYDEL youth Drop - in centre and mobile outreach posts in Kifumbira and Kamwokya, Central Division, Kampala district</td>
</tr>
<tr>
<td>☑️ UYDEL Mobile post in Kalerwe Katanga, mulago II, in Kawempe division.</td>
</tr>
<tr>
<td>☑️ UYDEL mobile outreach post in kibuye and Mubarak in Makindye Division.</td>
</tr>
<tr>
<td>☑️ UYDEL youth rehabilitation and vocational skills centre, Masooli, Wakiso District</td>
</tr>
<tr>
<td><strong>Summary:</strong></td>
</tr>
<tr>
<td>Youth friendly Sexual Reproductive health services (YFS) are defined as those programs, interventions and services that have policies, procedures, practices and other attributes that attract young men and women of ages 10-24 years. These interventions provide the young men and women with a comfortable and appropriate setting, meet their needs, and are able to retain them for follow-up and repeat visits. They are designed to apply to all of UYDEL’s services delivered to adolescents and young people at the drop-in centres and outreach posts/ sites and; represent minimum expectations of the ways in which UYDEL staff will behave and operate.</td>
</tr>
</tbody>
</table>

| Summary: |
| Youth Friendly Sexual Reproductive Health Services:- |
| ☑️ ensure transparency and honesty, |
| ☑️ are relevant and voluntary |
| ☑️ ensure a safe, welcoming and encouraging environment for participation |
| ☑️ ensure equality of opportunity |
| ☑️ are effective and confident |
| ☑️ ensure that participation promotes the safety and protection of youth |
| ☑️ ensure follow up and evaluation |

In the HMP Project, the Youth Friendly Sexual Reproductive Health Services were used to:-

| ☑️ establish a safe and meaningful environment for the participation of ACSWs and minimize the risk to their involvement in participatory practice. |
| ☑️ inform training and other approaches to competencies that ensure that staffs working with ACSWs have the attitudes, skills and confidence required to deliver the Adolescent Friendly Services (staff preparedness). |
| ☑️ assist UYDEL staff in assessing their practice in Adolescent Friendly Services and identifying improvements. |
| ☑️ provide a basis for accountability and challenge if Adolescent Friendly Services fall below a certain standard |
| ☑️ share UYDELS’ understanding of meaningful ACSWs participation with organizations and other partners. |
| ☑️ review and evaluate current practice and identify goals for the future |

Youth Friendly Sexual Reproductive Health drop-in centre and outreach posts were established to provide Sexual and Reproductive Health (SRH) information and services to the vulnerable and disadvantaged street and slum adolescents aged 10 – 24 years engaging in commercial sex work and those being trafficked into the urban slums. The ASCW were provided with counseling and supplies such as condoms to help girls and boys prevent pregnancy and infection such as HIV that are transmitted by sexual contact.

During the interviews with the ACSWs, the young people told us that what they like most about the Youth Friendly Drop-in Centres and outreach posts is that the service providers are friendly and helpful. They shared that the drop-in centres and outreach posts are comfortable places to go to with friends, participate in health talks and watch movies about life skills and STIs including HIV and AIDS.

The biggest strength of the Youth Friendly SRH Drop-in centres and the UYDEL rehabilitation and vocational skills centre were the combination of providing sexual and reproductive health services to ACSWs and teaching them various vocational skills courses as safer alternatives to attaining employments and starting their own businesses so that they can earn money and be independent.
UYDEL provided a minimum package of YFS which included: Information and counseling on sexuality, safer sex, and reproduction cycles; HIV Counseling and referral for testing and care; STI diagnosis and treatment; short-term family planning method with emphasis on dual provision, including emergency contraception; pregnancy tests; Counseling on unsafe abortions and post abortion-care; Counseling on sexual and gender based violence; and referral when necessary especially for antenatal and postnatal services, PMTCT and ART services; and long –term contraception methods as shown in the graphs and charts below:-

### Stakeholders and Partners:

<table>
<thead>
<tr>
<th>Stakeholders and Partners:</th>
<th>Roles and Responsibilities</th>
</tr>
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<tbody>
<tr>
<td><strong>Stakeholder and Partner</strong></td>
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<tr>
<td>Development Partners</td>
<td>Provision of funding and technical support for ASRH</td>
</tr>
<tr>
<td>Government agencies and institutions</td>
<td>Integration of ASRH in various sectors like education, health among others; coordination of SRH service provider and enforcement and revision of legislations and policies in regard to SRH</td>
</tr>
<tr>
<td>Parents</td>
<td>Mentorship and education of Adolescents about SRH</td>
</tr>
<tr>
<td><strong>Peer Educators</strong></td>
<td>Mobilization and referral of fellow peers for SRH services and provision of information and condoms to fellow peers</td>
</tr>
<tr>
<td><strong>Civil Society Organization (CSO)</strong></td>
<td>Provision of direct assistance to ACSWs, provision of information and SRH services, lobby and advocate for the SRH Rights of ACSWs</td>
</tr>
</tbody>
</table>
Mobile Outreach visits
- Static drop-in centres
- Rehabilitation and Vocational skills centre

Basing on the indicators below from our sample of the 247 ACSWs’s assessed the need for the provision of Youth friendly services at drop-in centres and Outreach Posts was fully justifiable.
- 80% of the sampled ACSWs admitted that they were sexually active meaning that they were vulnerable to engaging in risky behaviors such as unprotected sex and therefore the need for family planning services such as the condoms.
- 90% had one or more sexual partners justifying the need for counseling and guidance and family planning services for safer living.
- 39% had ever been forced into sex by their friends/peers, employers, other relatives, community members, strangers, boyfriend/girlfriend, ACSW partner, teachers and husbands (with whom they are cohabiting) and therefore, the importance of counseling and guidance, HCT, referrals, Pregnancy tests, STI treatment and treatment of other infections
- 53% had ever suffered STI’s, 19.8 had untreated STI’s, 32.4% had current signs at the time of recruitment under the project
- 24% had never tested for HIV at the time of recruitment under the project for the youth friendly services at the drop-in-centers and outreach posts
- 13.8% had ever carried out abortion at the time of recruitment and therefore the need for referral for post abortion care
- Only 0.8% could get secure a payment of 20,000 UShs for CSW and therefore a need for vocational skills training to empower such ACSW’s.

The youth Friendly Services ensured consistent, high quality youth participation and practice throughout UYDEL’s programmes. They aimed to provide a framework that gives guidance and direction to UYDEL staff in continuously improving their participatory practice.

Improved health status of Adolescent Commercial Sex Workers as a result of increased comprehensive knowledge of sexual Reproductive health including HIV/ AIDS/STI through Behavior Change Communications and distribution of condoms and family planning services

Increased access to HIV counseling and testing through provision of mobile testing health tents and facilities.

Stakeholder involvement to build community trust and secure community support

Adolescent participation and engagement beyond tokenistic participation and from the onset of an emergency is critical to building adolescent trust and increasing demand for services

The interventions were responsive to the different needs of the ACSWs, including married/ unmarried ACSWs; and / out of school adolescent

Through networking and referrals to other service providers, the ACSWs were linked to clinical SRH services. These included protection, life skills, , vocational and livelihood skills training among other relevant services

Qualified and dedicated ASRH staff, including health service providers was crucial to good quality service provision. The project staff recruited had appropriate professional backgrounds and UYDEL management invested in staff awareness and ongoing trainings and support for the project staff in ASRH and professional standards.

The provision of comprehensive SRH services for the Adolescent Commercial Sex Workers at the youth drop-in centres and mobile outreach posts increased service utilization. Integration of SRH services including sexuality education, skills building to negotiate safe sexual practices, family planning, HIV and referral for comprehensive abortion care where legal, improved use among the ACSWs for whom access to the these services is a challenge

Outreach visits and provision of free SRH services and information were essential and necessary to reaching adolescents in hard to reach areas

To improve service delivery and access to SRH services and information at the drop-in centres and outreach posts, the project team in consultation with the ACSWs and other community stakeholders, developed the Youth –friendly SRH services checklist below:-

<table>
<thead>
<tr>
<th>UYDEL Drop-in centre Kamwokya, Kampala District</th>
<th>UYDEL Drop-in Centre Nateete, Kampala District</th>
<th>UYDEL Drop-in Centre Makindye, Kampala District</th>
<th>UYDEL Rehabilitation and Vocational Skills Centre Masooli, Wakiso District</th>
<th>Outreach Posts and sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convenient working hours</td>
<td>Convenient Locations</td>
<td>Convenient Locations</td>
<td>Services provided from Bars, hotels, peer houses and in the communities where the ACSWs operate and reside</td>
<td>Services located in community settings</td>
</tr>
<tr>
<td>Open daily from 9.00 am to 5.00pm</td>
<td>All these centres are located in the slum areas where the ACSWs can easily go without incurring high travel costs</td>
<td>Located in Wakiso District and away from the slum areas and ideal for effective rehabilitation and close follow of clients</td>
<td>4 days - 8 days a month. 2 - 4hrs</td>
<td></td>
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</tbody>
</table>

Interventions for ACSWs - 2013: A UYDEL Publication
<table>
<thead>
<tr>
<th>Innovation and Success Factors:</th>
<th>Adequate Space and sufficient privacy</th>
<th>Comfortable Surroundings</th>
<th>Necessary referrals available</th>
<th>Affordable fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nateete, Kamwokya and Makindye centres have:</td>
<td>♦ At least three (3) service providers attached to each drop in centre which has made short waiting times for clients.</td>
<td>♦ UYDEL offers ASRH services that are acceptable, accessible and appropriate for youth in the community.</td>
<td>♦ This has been done through partnerships/collaboration - MOU were signed with relevant stakeholders, namely KCCA health clinics, Kasangati health centre and NGOs to deliver and manage health care services to adolescents.</td>
<td>Services are cost free and all the referral health service arrangement done – services are freely given.</td>
</tr>
<tr>
<td>♦ Health workers are informed and in contact with referral facilities which made referrals of young people easy and fast.</td>
<td>♦ Young people consult service providers without any appointment through centre visits, or phone call.</td>
<td>♦ Health promoting materials distributed to community stakeholders.</td>
<td>♦ Referral facilities are designated in close proximity of beneficiaries/clients.</td>
<td>Small contributions towards food, basic needs and training materials are made by some of the NGOs and parents that can afford</td>
</tr>
<tr>
<td>♦ Young people consult service providers without any appointment through centre visits, or phone call.</td>
<td>♦ Have ample space and service units/ rooms for treatment, counseling, vocational skills classes are separated.</td>
<td>♦ Drop-in centres situated in areas where young people reside/ within reach of young people.</td>
<td>♦ Necessary referrals available</td>
<td>Services are cost free and all the referral health service arrangement done – services are freely given.</td>
</tr>
<tr>
<td>♦ All centres have an outside compound fairly enough for young people to play outdoor games.</td>
<td></td>
<td>♦ 40 Peer educators attached to the various community drop-in centres and posts.</td>
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<tr>
<td></td>
<td></td>
<td>♦ Involved in awareness raising activities e.g. MDD.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>♦ 40 Peer educators attached to the various community drop-in centres and posts.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>♦ Involved in awareness raising activities e.g. MDD.</td>
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<tr>
<td></td>
<td></td>
<td>♦ 10 Peer educators attached to the various community drop-in centres and posts.</td>
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<tr>
<td></td>
<td></td>
<td>♦ Involved in awareness raising activities e.g. MDD.</td>
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<td>♦ 40 Peer educators attached to the various community drop-in centres and posts.</td>
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<td></td>
<td></td>
<td>♦ This centre is UYDEL Property on 7 acres. It has a big play ground for young people (football, netball, basketball; it has 8 big vocational classes, 4 dormitories for temporary shelter, a sick bay, dining, main hall, stores among others space</td>
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<td></td>
<td></td>
<td>♦ The centre has 17 staff</td>
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<td></td>
<td></td>
<td>♦ Staffs are informed and in contact with referral facilities which made referrals of young people easy and fast.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>♦ Young people consult service providers without any appointment through centre visits, or phone call</td>
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<td></td>
<td></td>
<td>Extra space was created by the provision of tents to accommodate the number of children accessing services at mobile posts.</td>
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<tr>
<td></td>
<td></td>
<td>Structure accepted and volunteered by the community stakeholders and beneficiaries e.g. bar/hotel owner in kibuye, and Katanga.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Peer educators attached to the community mobile outreach posts next to the areas of their residence.</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>♦ Treatment given to both male and female.</td>
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<tr>
<td></td>
<td></td>
<td>♦ Youth dialogues held on engendered sexual reproductive health.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Ongoing appropriate referral done.</td>
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</table>

Interventions for ACSWs - 2013; A UYDEL Publication
<table>
<thead>
<tr>
<th>Innovation and Success Factors:</th>
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<tbody>
<tr>
<td><strong>Drop-in clients welcome</strong></td>
<td>◆ Posts on the walls, availability of enough chairs at the centre. ◆ Cleanliness of the centre. ◆ Service facilities acceptable and accessible by youth in the community.</td>
<td></td>
</tr>
<tr>
<td><strong>Publicity and recruitment that inform and reassure youth</strong></td>
<td>Consultations and orientation meetings of community leaders, peer educators, parents, stakeholders on the project roll out.</td>
<td></td>
</tr>
<tr>
<td><strong>Respect for ACSWs</strong></td>
<td>◆ UYDEL child protection policy is available and adhered to by service providers upon recruitment which emphasises respect for beneficiaries for example; the health services provider understand a situation from a youth’s point of view with respect ,sensitivity and professionally and not with any bias. ◆ Treat clients with equal care. ◆ ACSWs clients are repetitively taught about their rights and responsibilities as clients.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-judgmental attitude</strong></td>
<td>◆ All adolescent are handled equally regardless of gender, ethnicity, religion, disability, Social status or any other reason. ◆ Reach out to those who are most vulnerable and those who lack services ◆ Effective because they are delivered by trained and Motivated health care providers who abide by professional ethics. ◆ Data tools capture both gender issues.</td>
<td></td>
</tr>
<tr>
<td><strong>Privacy and confidentiality honored</strong></td>
<td>Children are worked on in closed doors ◆ Client file/medical records are put under lock.</td>
<td></td>
</tr>
<tr>
<td><strong>Peer Counseling available</strong></td>
<td>◆ Age-tailored messages ◆ Service providers take into account the special needs ACSWs ◆ Involvement of peer service providers in the program.</td>
<td></td>
</tr>
</tbody>
</table>
**Same-sex providers when possible**
- Yes, both male and female social workers were recruited and have been attending/serving beneficiaries professionally. (10 female & 4 male).
- More gender representation among Masooli staff.

**Strict confidentiality maintained**
- Beneficiaries/ client handled one by one. For example; treatment, individual counseling.
- Individual beneficiary information profiled in one file.
- Beneficiary files are kept under lock and key.

**Staff trained in youth-friendly health services characteristics**
- Technically competent and motivated to handle adolescents issues, i.e. Knowledgeable of normal adolescent development, ASRH needs and YFS services to offer them.
- They practically use ASRH adolescent policies/guidelines/standards from MOH in their service delivery.
- Demonstrate respect and concern for young people
- Have the skills to diagnose and treat common conditions
- Have access to the correct drugs and supplies
- Know where to refer youth
- Respect the confidentiality and privacy.

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**The Diagram below shows the Youth –Friendly SRH drop-in centres and outreach post Facility Assessment and Quality Improvement Process utilized by the project team**

1. **Facility identified for AFS Intervention**
2. **Assessment to determine baseline and interventions required to improve quality for AFS**
3. **Results of the assessment are used to develop an action plan to improve the quality of service rendered**
4. **Technical assistance is provided to the facility to implement its action plans**
5. **Certification tool is applied to quantify the extent to which services are Adolescent-friendly**
6. **Facility assessment tool reapplied to assess the impact of program interventions**

---

**Constraints:**
Establishment of quality Youth Friendly SRH drop-in centres and outreach posts is quite expensive as it requires training and/or hiring of professionals, equipment that will make the service environment comfortable for the ACSWs, and provision of a one-stop centre where the ACSWs can access a comprehensive package of ASRH services thus the need to plan for allocation of enough resources and/or partnering with various service providers to provide these services at the one-stop centre

**Lessons Learned:**
- There is a dire need for incorporation of both traditional and innovative methods of communication to reach boys and girls with SRH information. For example the use of films, music, dance and drama, debates, dialogues, informational leaflets/brochures/posters, radio shows, among others
- Refresher trainings, structures supervision, recognition and on-going mentorship to service providers and staff are essential for improved delivery of quality ASRH services to ACSWs
- Involvement of relevant stakeholders (Parents, community leaders, health practitioners and social workers) and Adolescent girls and boys in the design, implementation, monitoring and evaluation of SRH projects for Adolescent Commercial Sex Workers
- Targeting different outlets and utilization of outreach sites for delivery of SRH Services and information is essential for successful response to ACSWs’ SRH needs

**Sustainability:**
- Refresher trainings, structures supervision, recognition and on-going mentorship to service providers and staff are essential elements that foster sustainability of services.
- Involvement of relevant stakeholders (Parents, community leaders, health practitioners and social workers) and Adolescent girls and boys in the design, implementation, monitoring and evaluation of SRH projects for Adolescent Commercial Sex Workers
- There is need to strengthen linkages and referral for SRH and coorNightte with related sectors, including protection, education and livelihoods for a holistic, multi-sectoral response to SRH issues for adolescents

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Interventions for ACSWs - 2013; A UYDEL Publication
<table>
<thead>
<tr>
<th>Up-scaling:</th>
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| ♦ The future projects and or interventions need to increase support for holistic, comprehensive and flexible ASRH services for ACSWs  
♦ Documentation and dissemination of good practices, lesson learned and success stories in Delivery of SRH services and information to adolescents  
♦ There is need to invest more in strengthening the capacities and competences of the service providers to effectively address and respond to the SRH needs of Adolescent Commercial Sex Workers |

<table>
<thead>
<tr>
<th>Conclusion:</th>
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<tbody>
<tr>
<td>Adolescent Commercial Sex workers have a right to accurate, appropriate and understandable information delivered through counseling and through educational activities and materials that are available at the Youth Friendly Drop-in centres and outreach posts. Easing access to Youth Friendly Adolescent Sexual and Reproductive Health services and information helps Adolescent Commercial Sex Workers stay in rehabilitation programs and /or school, delay child bearing, have healthier children and earn a better income that benefits themselves, their families and their communities</td>
</tr>
</tbody>
</table>
Vocational skills Education and training is an essential component of strategies to reduce and prevent adolescent engagement in commercial sex work. Many of these adolescents dropped out of school early due to high school fees, death of parents and teenage pregnancies among others and thus lack the necessary employable skills and / or skills needed for them to start a small business locally. The vocational training was done within 6 to 12 months in a range of vocation including: Electronic, Welding, Catering, Motorbike Mechanics, Tailoring, Hairdressing and carpentry.

While under going training the ACSWs benefited from psychosocial support and after training some were placed with existing local businesses for internship, other found employment and some started their own small businesses locally.

**Stakeholder and Partner**

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<td>Development Partners</td>
<td>♦ Provision of financial and technical resources for vocational skills training</td>
</tr>
</tbody>
</table>
| Government agencies and institutions | ♦ Designing of vocational curriculum for ACSWs  
♦ Designing, Revision and enforcement of policies and legislations on vocational skills training and employment of Adolescent  
♦ Budget and allocate resources for vocational skills training  
♦ Monitor and supervise vocational skills training institutions and rehabilitation centres  
♦ Link trainees to other government programmes like the youth fund and community development driven fund to access income and grants to start their own business |
| Parents                  | ♦ Provision of Psychosocial support with the family  
♦ Mentorship and follow up of ACSWS during and after training  
♦ Provision of start- up capital and kits to the ACSWs |
Community members
- Mentorship and follow up of the ACSWs
- Social Inclusion
- Identification and Referral of ACSWs to the UYDEL drop-in centres and outreach posts

Peer Educators
- Provision of peer support during and after vocational skills training
- Identification, mobilization and referral of the ACSWs to the UYDEL drop-in centres and outreach posts for vocational skills training

Stakeholders and Partners:
Local Artisans/ Vocational Skills Instructors
- Provision of vocational skills training and mentorship to the ACSWs
- Link ACSWs to internship placement and employment opportunities
- Monitor and supervise trainees while in internship

Civil Society Organization (CSO)
- Identification, assessment and referral of ACSWs for vocational skills training
- Conduct vocational skills training at drop-in centres and outreach posts
- Provision of psychosocial support to trainees
- Build capacity of the Vocational skills trainers
- Conduct Research on vocational skills training for evidence – based planning
- Documentation of good practices
- Link trainees to micro finance services and other government programmes to access loans and grants to start-up their own business

Method used:
- Identification and Assessment of ACSW
- Needs Assessment
- Market Surveys
- Training for Trainers
- Identification, orientation and signing MOUs with Vocational instructors and local Artisans
- Provision of career counseling and guidance to the ACSWs before enrolment in vocational training/ business skills training
- Training of ACSWs in Vocational Skills
- Internship after six months to nine months in training
- Start-up capital and support
- Follow up and continuous Mentorship
- Recovery and Reintegration

The project aimed at reducing poverty through the provision of income generation activities, skills development and vocational skills training. Referring to our sample of 247 beneficiaries, 97.2% were early school dropouts and the highest level of education attained was Primary education as illustrated below.

![Chart showing highest level of education attained](image)

Validation:
The reasons for school drop out were as follows: 68.8% said they lacked school fees and requirements, 17.4% said the loss of their parents who were the breadwinners, 7.3% said the parents refused to pay their school fees, 1.2% said the poor performance in school, 0.4% were convinced by peers to leave school, 0.8% said they needed to work, 3.2% said pregnancy, 0.4% said they were looking after a sick parent and 0.4% did not answer.

![Chart showing age group of young people](image)
<table>
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<td>As mentioned earlier under Adolescent friendly services, Only 0.8% could get secure a payment of 20,000 UShs for CSW after completion of the sexual intercourse. And Since most of the ACSWs (as illustrated below) were possibly falling under 18 years of age and therefore still considered as children by law, there was need to empower them with vocational skills such that they can be able to support themselves with non exploitative jobs in future. Important to note however is that, 21.9% of the ACSWs said they did CSW only as an economic activity given the challenges associated with CSW such as, non payment, contraction of STI’s, unwanted pregnancy, physical injury, forced sex, clients refusal to use condoms and violence of the clients. The reasons for school drop out were as follows: 68.8% said they lacked school fees and requirements, 17.4% said the loss of their parents who were the breadwinners, 7.3% said the parents refused to pay their school fees, 1.2% said the poor performance in school, 0.4% were convinced by peers to leave school, 0.8% said they needed to work, 3.2% said pregnancy, 0.4% said they were looking after a sick parent and 0.4% did not answer. As mentioned earlier under Adolescent friendly services, Only 0.8% could get secure a payment of 20,000 UShs for CSW after completion of the sexual intercourse. And Since most of the ACSWs (as illustrated below) were possibly falling under 18 years of age and therefore still considered as children by law, there was need to empower them with vocational skills such that they can be able to support themselves with non exploitative jobs in future. Important to note however is that, 21.9% of the ACSWs said they did CSW only as an economic activity given the challenges associated with CSW such as, non payment, contraction of STI’s, unwanted pregnancy, physical injury, forced sex, clients refusal to use condoms and violence of the clients.</td>
</tr>
</tbody>
</table>

| Impact: |
| Removed engagement by the ACSWs in risky behavior for survival and earning income to meet basic needs as the possibilities for returning in commercial sex work and other risky behaviors were reduced or completely erased |
| Acquisition of specific employable, entrepreneurship and business skills |
| ACSWs accessed and completed vocational skills training and have improved employment prospects |
| After vocational skills training and rehabilitation, the ACSWs were reunited with their families, parents, friends and/or resettled independently for some cases |
| ACSWs were integrated and reintegrated into the labour market |
| ACSWs were also supported to be reintegrated into their communities |

| Innovation and Success Factors: |
| Provision of free/ no cost vocational skills training, training materials and start –up kits and a certificate after the completion of vocational skills training by the ACSWs were some of the factors that led to positive results in the implementation of the Health Matters’ Project |
| Linked vocational skills to the local labor market demands in the areas where the ACSWs reside, plan to work, and/or where they will be reintegrated after training |
| The training in Business and entrepreneurship skills enabled the ACSWs to draw up business plans and possible budgets this enabled some to start up their own small business locally thus creating jobs as they employed fellow peers and provided a means for them to support their families and contribute to the economic development of their communities. |
| Follow up and mentorship support was provided to the ACSWs in either setting up businesses or seeking employment. |

| Constraints: |
| Identifying sustainable financing for provision of start-up capital and kits |
| Some of the ACSWs did not know how to read and write making it difficult for the project team to enroll them into some of the vocational skills like catering, tailoring and electronics that require some level of educational achievement |

| Lessons Learned: |
| The provision of short, need tailored, practical training is essential to prevent drop-out and attract the ACSWs who have been out of school for a long time to stay and complete vocational skills training |
| Provision of start- up kits/ capital and/or linking the ACSWs to micro-finance services and grants is important |
| Market Analysis and information on current demand for skills is crucial for adjusting training |

| Sustainability: |
| Partnership to improve access to vocational training and employment |
| Presence of a permanent vocational and Rehabilitation youth center at Masooli could guarantee the continuity of vocational skills education by the organization |
| The presence of trained instructors who love their job and are committed to helping the ACSWs realize their potential and guaranteed the possibility of continued training of the ACSWs even without expecting any pay. |
| Supervision of instructors ensures effectiveness of service delivery |
| The presence of the former beneficiaries / trainees as instructors in the community depending on the skills acquired while at UYDEL acts as a pool of vocational skills knowledge and practice for other ACSWs who might want to learn |

| Up-scaling: |
| Encourage formation of Peer support group/ solidarity groups among the ACSWs as this will provide a platform for independence, peer mentorship and self-motivation, creating a network that can be sustained once the project ends |
| Market Analysis and assessment of goods and clients and opportunities for growth is vital as these will enable the training to focus on the demanded skills and expertise and not on the traditional methods of vocational training that may no longer be competitive |
| Continued Mentorship and follow up are vital elements for success and effectiveness |
| Provision of additional training including pre- and post training, business training, literacy and numeracy and more targeted training |
| Training of trainers is vital for acquisition of demanded skills to be passed on to the ACSWs |
| Provision of start-up capital to enable the ACSWs establish their own business |
| linking ACSWs to micro-finance services and or grants remains critical |
| Partnership to improve access to vocational training and employment |

| Conclusion: |
| Vocational Education and Training plays a key role in the process of economic reintegration of the Adolescent commercial sex workers as it gives them a renewed sense of hope for the future. |
### Psychosocial support

Psychosocial support is a scale of care and support which influences both the individual and the social environment in which people live and range from care and support offered by caregivers, family members, friends, neighbors, teachers, health workers, and community members on a daily basis but also extends to care and support offered by specialized psychological and social services. Psychosocial support addresses a person’s emotional, social, mental and spiritual needs—essential elements of positive human development. It builds internal and external resources for children and their families to cope with adversity.

The Health Matters project team adapted Psychosocial support interventions in the delivery of sexual and reproductive health services for Adolescent Commercial sex workers (ACSWs) aged 15 – 24 years because they wanted to place the adolescents in a stable and supportive family, community and peer environments. Beyond physical and material support, Adolescent Commercial Sex Workers (ACSWs) also require psychosocial support and this form of support yielded significant sustainable results as majority had been subjected to trauma resulting for example from the need to survive under harsh and inhumane abusive and exploitative conditions.

The Psychosocial support was based on the Stages of Change model which describes five stages of readiness (see Figure below) - Precontemplation, Contemplation, Preparation, Action, and Maintenance - and provides a framework for understanding behavior change (DiClemente and Prochaska, 1998).

For most ACSWs, behavior change occurs gradually over time, with the person progressing from being uninterested, unaware, or unwilling to make a change (precontemplation), to considering a change (contemplation), to deciding and preparing to make a change (preparation). This is followed by definitive action, and attempts to maintain the new behavior over time (maintenance). ACSWs can progress in both directions in the stages of change. Most ACSWs will "recycle" through the stages of change several times before the change becomes fully established (Zimmerman et al., 2000).

The fact that commercial Sex work is illegal in Uganda, majority of the ACSWs faced stigma and discrimination and sometimes feelings of suicide. Some of the ACSWs experienced multiple traumas such as illness and death of peers and parents and some were forced to carry out crude abortions and or bear children whose fathers were not known, violence and exploitation, stigma and discrimination, isolation and loneliness, and lack of adult support and guidance. For ACSWs infected with HIV and AIDS, who must adhere to TB treatment, long-term prophylaxis or antiretroviral therapy, on-going counseling was critical in enhancing adherence to treatment regimens.

For both the ACSWs and their families, psychosocial support assisted them in making informed decisions, coping better with situations, and dealing more effectively with discrimination. It improved the quality of their lives; supported families to provide for adolescents’ physical, economic, educational, health and social needs; and helped the ACSWs build resilience.

**ACSWs were provided with:**

- general psychosocial counseling, adjustment / family/relationship counseling, parenting support, anger management,
- basic life skills (re)training,
- involvement in community support services, self-help or chronic disease/illness support groups
- healthy/fitness and exercise regimes,
- drug and alcohol prevention,
- life skills,
- business counseling, and economic assistance to start up small businesses
- attendant care, home support and
- Temporary shelter

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**FIGURE: THE STAGES OF CHANGE CONTINUUM**

Source: Adapted from DiClemente and Prochaska, 1998
For most ACSWs, behavior change occurs gradually over time, with the person progressing from being uninterested, unaware, or unwilling to make a change (precontemplation), to considering a change (contemplation), to deciding and preparing to make a change (preparation). This is followed by definitive action, and attempts to maintain the new behavior over time (maintenance). ACSWs can progress in both directions in the stages of change. Most ACSWs will “recycle” through the stages of change several times before the change becomes fully established (Zimmerman et al., 2000).

**STAGES-OF-CHANGE CHARACTERISTICS AND STRATEGIES**

<table>
<thead>
<tr>
<th>STAGE</th>
<th>CHARACTERISTICS</th>
<th>STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>The person is not even considering changing. They may be “in denial” about their</td>
<td>✗ Educate on risks versus benefits and positive outcomes related</td>
</tr>
<tr>
<td></td>
<td>health problem, or not consider it serious. They may have tried unsuccessfully</td>
<td>to change so many times that they have given up.</td>
</tr>
<tr>
<td>Contemplation</td>
<td>The person is ambivalent about changing. During this stage, the person weighs</td>
<td>✗ Identify barriers and misconceptions</td>
</tr>
<tr>
<td></td>
<td>benefits versus costs or barriers (e.g., time, expense, bother, fear).</td>
<td>✗ Address concerns</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✗ Identify support systems</td>
</tr>
<tr>
<td>Preparation</td>
<td>The person is prepared to experiment with small changes.</td>
<td>✗ Develop realistic goals and timeline for change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✗ Provide positive reinforcement</td>
</tr>
<tr>
<td>Action</td>
<td>The person takes definitive action to change behavior.</td>
<td>✗ Provide positive reinforcement</td>
</tr>
<tr>
<td>Maintenance and Relapse</td>
<td>The person strives to maintain the new behavior over the long term.</td>
<td>✗ Provide encouragement and support</td>
</tr>
<tr>
<td>Prevention</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Zimmerman et al., 2000; Tabor and Lopez, 2004

The fact that commercial Sex work is illegal in Uganda, majority of the ACSWs faced stigma and discrimination and sometimes feelings of suicide. Some of the ACSWs experienced multiple traumas such as illness and death of peers and parents and some were forced to carry out crude abortions and or bear children whose fathers were not known, violence and exploitation, stigma and discrimination, isolation and loneliness, and lack of adult support and guidance. For ACSWs infected with HIV and AIDS, who must adhere to TB treatment, long-term prophylaxis or antiretroviral therapy, on-going counseling was critical in enhancing adherence to treatment regimens.

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- attendant care, home support and
- Temporary shelter

**PSYCHOSOCIAL SUPPORT AND CARE (June 2010 to May 2013)**

<table>
<thead>
<tr>
<th>Psychosocial support and care</th>
<th>Male (# reached)</th>
<th>Female (# reached)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Music, dance and drama</td>
<td>116</td>
<td>1800</td>
<td>1,916</td>
</tr>
<tr>
<td>Youth dialogues</td>
<td>54</td>
<td>1340</td>
<td>1,394</td>
</tr>
<tr>
<td>Indoor and outdoor games</td>
<td>0</td>
<td>845</td>
<td>845</td>
</tr>
<tr>
<td>Individual counseling</td>
<td>39</td>
<td>1857</td>
<td>1,896</td>
</tr>
<tr>
<td>Group counseling (BCC)</td>
<td>22</td>
<td>1500</td>
<td>1,522</td>
</tr>
<tr>
<td>Total</td>
<td>231</td>
<td>7,342</td>
<td>7,573</td>
</tr>
</tbody>
</table>
### Summary:

#### Psychosocial support and Care (% reached)

- **Female**: 97%
- **Male**: 3%

#### Psychosocial services offered to males

- **Music, Dance and Drama (MDD)**: 17%
- **Youth dialogue**: 50%
- **Individual Counseling**: 23%
- **Group Counseling (BCC)**: 10%

#### Psychosocial services offered to females

- **Music, Dance and Drama (MDD)**: 25%
- **Youth dialogue**: 20%
- **Individual Counseling**: 25%
- **Group Counseling (BCC)**: 12%
- **Indoor and outdoor games**: 18%

#### Life Skills

- **June 2010 - May 2013**
  - **Business skills training**: Male: 100, Female: 200
  - **Peer education**: Male: 50, Female: 150
  - **Smart street training**: Male: 300, Female: 400

### Stakeholders and Partners

#### Roles and responsibilities

- **Families and communities**: Best placed to provide psychosocial support to ACSWs with the home and community environment

- **Community support systems such as peer support groups, parent support groups, health services, and sports clubs**: Provide for the needs of individual adolescents and affected family members. Psychosocial support services that address the specific needs of vulnerable groups can be especially important (e.g., women, children, etc.)

- **Hospital or clinic or Health Centre Ills and IVs**: Support of nurses, physicians and other health care personnel who may be seeing large numbers of clients. Assist health workers to cope with issues related to HIV/AIDS.

- **Peer groups (including Adolescent commercial sex workers, Trafficked Young people, young people involved in drug abuse)**: Provide psychosocial support

- **Government sectors and agencies, Civil society organizations**: Provide a comprehensive support system linking and coorNightling existing psychosocial services with each other and to health services thus maximizing all resources

### Method used:

- **Peer Educators**
- **Parent Support Groups**
- **Home visits**
- **Individual and Group Counseling**
- **Music, dance and drama**
- **Youth dialogues**
- **Indoor educative games**
- **Outdoor games**

### Validation:

Experiencing difficulty or disturbing events while engaging in commercial sex work can significantly impact the social and emotional wellbeing of an adolescent. The ACSWs that benefited from the Sexual and Reproductive Health Services under the Health Matters project suffered unspeakable acts of abuse, exploitation and degradation. Some were raped, assaulted and horribly violated and others were psychologically abused.
The table below shows the different types of violence/exploitation faced by a sample of 247 young people that benefited from the ASRH services and information at the UYDEL drop-in centres and outreach posts:

<table>
<thead>
<tr>
<th>Type of violence/abuse/exploitation</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never abused</td>
<td>73</td>
<td>29.6%</td>
</tr>
<tr>
<td>Sexually abused</td>
<td>34</td>
<td>13.8%</td>
</tr>
<tr>
<td>Physically beaten/abused</td>
<td>77</td>
<td>31.2%</td>
</tr>
<tr>
<td>Denied food/other needs</td>
<td>10</td>
<td>4.0%</td>
</tr>
<tr>
<td>Chased out of home</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Emotionally/psychologically abused</td>
<td>28</td>
<td>11.3%</td>
</tr>
<tr>
<td>Sexually and emotionally abused</td>
<td>6</td>
<td>2.4%</td>
</tr>
<tr>
<td>Physically, emotionally and sexually abused</td>
<td>46</td>
<td>2.4%</td>
</tr>
<tr>
<td>Non response</td>
<td>12</td>
<td>4.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>247</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Depression, Anxiety and hostility were some of the symptoms frequently detected among ACSWs. Majority showed little or no interest in things, hopeless about the future, depressed, and had suicidal thoughts. Some were fearful, tense, restless and nervous. Many engaged in frequent fights, insults, arguments, temper outbursts and were irritated easily by their fellow peers while at the UYDEL centres.

Psychosocial support provided ACSWs with an opportunity to: develop to their fullest potential; participate in social life, be self-reliant, develop self-confidence and empowerment; address discrimination, social integration, encourage fair play and channeling energy away from potential destructive behavior like abuse of alcohol and drugs; and supported the physical and psychological rehabilitation and social reintegration of ACSWs.

There fore, Early and adequate psychosocial support can: help the ACSWs cope better and become reconciled to everyday life; prevent distress and suffering developing into something more severe; help the ACSWs to resume their normal lives and; meet community-identified needs.

**Validation:**

- Increased sense of security and confidence among the ACSWs as indicated by reaching out and making friends, or at least participating in Youth Centre activities (Prosocial Behavior) like outdoor games (Sports), Group counseling sessions, Music, Dance and Drama, Debates and SRH Health Weeks
- Positive Peer guidance, mentorship and support
- Improved problem solving skills from participating in regular, organized group activities like debates, group counseling, life skills and Behavioural change sessions
- Increased self control and Prosocial behavior (reduced aggression, reduced rates of crime and fighting and increased cooperation
- Through the Prevention Smart Parent Support Groups - greater awareness of parents about their own children’s individual strengths and needs; improved parenting skills; and more communication and dialogues between Parents and children

**Social Wellbeing**

- Improved ability to assume Leadership roles and positions (Peer Educators, Head prefects, Sports leaders, Class monitors, etc.)
- Improved social skills, social responsibility and social conformity as evidenced by positive social functioning behavior
- Improved abilities to make friends
- Improved good values as shown by the willing and respectful participation in appropriate household responsibilities, vocational skills training, children’s dialogue and other activities at the UYDEL Youth centres
- Contributing to the family and living up to their family expectations as some go back to school and or start to work and save some money to support their basic needs and those of their families
- The families have put in place safety nets to protect the young adolescents from further abuse and exploitation
- Improved networking and social cohesion between the participating adolescents and adolescents outside the project hence reduced stigma and discrimination

**Skills and Knowledge**

- Acquisition of Knowledge and skills related to Sexual and Reproductive Health, Life skills, HIV prevention, risk and protective factors, nutrition, hygiene, alcohol and drug abuse prevention, and child rights and responsibilities
- Increased learning and creativity of the adolescents about SRH issues and other crosscutting issues like HIV and AIDS, drug and substance abuse, child protection and child rights, hygiene
- Teaching fellow peers about SRH issues and other crosscutting issues like HIV and AIDS, drug and substance abuse, child protection and child rights, hygiene

**Physical wellbeing**

- ACSWs have greater awareness of SRH information and services and effectively respond to their SRH needs, physical health and psychological wellbeing
- ACSWs being healthy, clean and strong and having enough food to eat

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**Impact:**

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**Interventions for ACSWs - 2013; A UYDEL Publication**
### Innovation and Success Factors:

The Project team utilized a Rights-based approach in the delivery of the psychosocial care and support services. Too detailed and not explained have few answers not all listed is helpful it makes it wordy This focused on:
- Strengthening families, communities and social institutions (like the health facilities and the UYDEL drop-in centres) as and dialogues to reduce stigma and enhance collective problem-solving and behavioral change
- Providing equal opportunities to both males and females to increase their skills and capabilities, and
- Ensuring that the health service providers and social workers have appropriate training and educational support to address unique vulnerabilities of girls
- Development of guiding principles in providing psychosocial support to ACSWs which helped to reduce the risk of harm and promoted community based interventions. Principles and values included: do no harm; informed consent; confidentiality; non-discrimination; Participation; gender sensitivity; Respect for views of ACSWs; and working with families and communities

### Constraints:

Some of the barriers and challenges for developing effective psychosocial support structures included:
- Lack of knowledge about how to integrate an adolescent-centered approach in psychosocial support services
- Case workers sometimes suffering from secondary trauma from working intensely with abused adolescents and lacking support mechanisms
- Role and value of the routine, lower-level caregivers not being recognized, and excessive emphasis put on counselors, who spend much less time with the adolescents
- Lack of awareness among caregivers and communities on sexuality and sexual reproductive health
- Low levels of awareness on the concept of adolescent resiliency
- Difficulty in finding adequate support within the community and family to care for ACSWs in need, coupled with lack of resources to keep ACSWs in institutional care for lengthy periods of time
- Difficulty in providing quality psychological interventions, due to lack of therapists and high cost of therapy
- Lack of public awareness about existing psychosocial support services for adolescents commercial sex workers
- Inadequate dialogue between groups working on trafficking and sexual exploitation and groups working on other sexuality-related areas such as HIV/AIDS and sexual minority issues.

### Lessons Learned:

- Indoor and outdoor games such as sports, music dance and drama help ACSWs to relax and most especially build a sense of belonging and ownership of the services offered to them
- Psychosocial support should not be a stand-alone activity but was part of the comprehensive, integrated rehabilitation package for the ACSWs as they access SRH services and information at the UYDEL drop-in centres and outreach sites what about referral. Psychosocial support should not be a stand-alone activity but was part of the comprehensive, integrated rehabilitation package for the ACSWs as they access SRH services and information at the UYDEL drop-in centres and outreach sites
- Offer psychosocial support trainings to staff so as to be able to handle problems of young people.
- Provide necessary support to staff so as to be able to handle problems of young people
- Monitor and document the success of all the psychosocial support activities e.g., youth dialogues, indoor games, sports, MDD etc.

### Sustainability:

- Availability of staff that are trained in psychosocial support.
- Presence of trained peer educators who are key in encouraging and counseling fellow peers
- Empowerment of the community members through parent support groups to handle psychosocial issues of adolescents

### Up-scaling:

- Building community capacities to provide counseling and support will ensure sustainability, continuity of interventions and community development
- Strengthen peer support groups and team activities such as indoor games, outdoor games (sports), music, dance and drama, BCC sessions to promote co-operation among ACSWs and dependence on one another
- Create new opportunities for expression especially through drawing and writing (visual expressions) to promote self-confidence among young people
- Conduct inter-sex games and sports competition
- Encourage staff to support each other and to discuss among themselves strategies for assisting young people
- Conduct continuous and regular Behavioral Change Communication sessions
- Support parents, families and communities with activities to address stress
- Recognize, encourage and reward young people - through words, small tokens or gifts, trips for adventure (e.g., the zoo, Uganda museum) and or celebrations such as Christmas and retreats

### Conclusion:

Psychosocial support is vital in enhancing the capacities of ACSWs and should be an integral part of all SRH Programs and/ or projects targeting ACSWs. It helps the ACSWs, their families and communities to heal the psychological wounds and rebuild social structures after abuse and exploitation. Psychosocial rehabilitation interventions aim to change your perceptions of injury, pain, future losses and life changes which can undermine recovery and resilience. They aim to help alleviate anxiety associated with accepting an injury and the recovery process and assist in maintaining or improving wellbeing. Psychosocial interventions help address issues which can undermine and act as barriers to progressing rehabilitation.
Title: Partnership and Collaboration

**Location/ geographical coverage:**
- UYDEL Drop-in centre Kamwokya, Kampala District
- UYDEL Drop-in Centre Nateete, Kampala District
- UYDEL Drop-in Centre Makindye, Kampala District
- UYDEL Rehabilitation and Vocational Skills Centre Masooli, Wakiso District
- UYDEL outreach posts

**Summary:** Collaboration is a process where people with diverse interests share knowledge and resources to improve outcomes and/or enhance decisions. Partnerships often result from collaborative efforts. Partnership is a relationship where people work together to achieve goals that are meaningful to all parties. Partnerships were established for strategic planning, service co-ordination, information sharing, service/programme delivery, or capacity building. Some of the partnerships focused on health, law enforcement, ASRH Advocacy and lobbying at policy and practice level, education, internship placement and start-up capital and grants. These partnerships were utilized to implement the various aspects of the Health Matters project based on each partner’s strengths and value added to the project.

<table>
<thead>
<tr>
<th>Stakeholder and Partner</th>
<th>Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development Partners</td>
<td>Allocate Financial resources</td>
</tr>
<tr>
<td></td>
<td>Technical assistance</td>
</tr>
<tr>
<td></td>
<td>Knowledge building</td>
</tr>
<tr>
<td></td>
<td>Monitoring and evaluation of implementations</td>
</tr>
<tr>
<td></td>
<td>Identifying opportunities for cooperation</td>
</tr>
<tr>
<td></td>
<td>Bringing together the tripartite partners (communities, beneficiaries and government) in social dialogue</td>
</tr>
<tr>
<td>Government agencies and institutions</td>
<td>Advocate for legal and policy enforcement</td>
</tr>
<tr>
<td>Ministry of Health - Adolescent Health technical working group,</td>
<td>Facilitate research and documentation of good practices</td>
</tr>
<tr>
<td>MOGLSD</td>
<td>Mobilization of resources to support ASRH services</td>
</tr>
<tr>
<td>District health officer (DHO),</td>
<td>Strengthen community structures such that parents can play their role</td>
</tr>
<tr>
<td>Ministry of Gender Labour and Social Development</td>
<td>Integrate the concept of ASRH into the school curriculum</td>
</tr>
<tr>
<td>Kampala city council clinics-Kawempe, busabala, Kitebi, Komamboga</td>
<td>Private-Public partnership in ASRH service delivery</td>
</tr>
<tr>
<td>Child and protection unit/ Probation officers Police</td>
<td>Come up with regional action plans for ASRH services</td>
</tr>
<tr>
<td>Parents, siblings and care givers</td>
<td>Holding the government accountable for all the ASRH policies in place and those that they ratified to</td>
</tr>
<tr>
<td>Community members (Local Leaders, opinion leaders, religious leaders, teachers, business community)</td>
<td>Recognizing and adhering to the ASRH rights</td>
</tr>
<tr>
<td></td>
<td>Reporting and referral of cases of ASRH rights abuses</td>
</tr>
<tr>
<td></td>
<td>Holding Civil Society Organizations accountable for the ASRH services they offer</td>
</tr>
<tr>
<td></td>
<td>Utilization of the ASRH services</td>
</tr>
<tr>
<td></td>
<td>Provision of direct assistance, mentoring and follow up of rehabilitated ACSWs</td>
</tr>
<tr>
<td>Peer Educators and beneficiaries</td>
<td>Holding the government accountable for all the ASRH policies in place and those that they ratified to</td>
</tr>
<tr>
<td></td>
<td>Recognizing and adhering to the ASRH rights</td>
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<td>Reporting and referral of cases of ASRH rights abuses</td>
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<tr>
<td></td>
<td>Holding Civil Society Organizations accountable for the ASRH services they offer</td>
</tr>
<tr>
<td></td>
<td>Utilization of the ASRH services</td>
</tr>
<tr>
<td>Local Artisans/ Vocational Skills Instructors</td>
<td>Holding the government accountable for all the ASRH policies in place and those that they ratified to</td>
</tr>
<tr>
<td></td>
<td>Recognizing and adhering to the ASRH rights</td>
</tr>
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<td></td>
<td>Reporting and referral of cases of ASRH rights abuses</td>
</tr>
<tr>
<td></td>
<td>Holding Civil Society Organizations accountable for the ASRH services they offer</td>
</tr>
</tbody>
</table>
### Validation:

- Identification and mobilization of potential interested partners through networking opportunities, including: External events, Contacts in the field, Existing projects and partnerships, Social networking
- Recommendation letters- Point of contact for stakeholders
- Shared networking sites
- Consultation and orientation meetings with stakeholders.
- Formalized partnership document such as a Memorandum of Understanding (MOU)
- Community dialogues
- Organized Learning and experience sharing visits
- Participation in the network Meetings
- Organized Joint trainings activities/opportunities
- Conduct Joint activities/services e.g. Naguru centre
- Created for a at community and District level for sharing experience, reports and information
- Referral for services

Partnerships and collaborations were important because they help:
- Solve the multiple problems faced by the ACSWs
- Leverage funds and resources
- Meet the objectives and expectations of the ACSWs
- There is shared support among the partners
- Engage people in the management of their interests, needs, services or product

![Partnerships and Collaboration](image)

- Out of a sample of 247 young people, 77 were referred by the former beneficiaries, 38 by peer educators, 31 by community members, 8 by health workers, 18 by local leaders, 39 by social workers, 26 by the current beneficiaries, 6 by peers (friends), 2 by parents, 1 by sibling, 1 by relative

### Impact:

**Through Partnerships and collaboration:-**
- Increased institutional knowledge, publicity and growth
- Ensured active participation of all stakeholders. For example development of UYDEL strategic Plan.
- Fostered the exchange of knowledge and expertise between all the stakeholders of the project
- cross-site learning information and reports shared
- Easy access to working guidelines from the MOH for example ASRH minimum service guidelines, implementation guidelines on Male Engagement in reproductive health.
- UYDEL has been recommended for project intervention. for example MOGLSD
- Presented increased opportunities for dialogue on priorities ASRH issues( We have been able to identify and incorporate key action points into the project design and implementation)
- Reduced costs of procuring condoms and printing IEC Materials new and own -mobilized Information and education materials and condoms materials especially from the MOH and MOGLSD.
- Ensured high-quality implementation with full support of key stakeholders. For example Naguru teenage centre which increased beneficiary accessibility and utilization of ASRH comprehensive services.
- Cross-site learning visits (KCCA health clinics).
- The Multiple problems of the ACSWs and other needs that UYDEL could not meet were addressed and solved e.g. Medical care, ART care and support, STI diagnosis and treatment, HCT and safe medical male circumcision among others
- There was increased local commitment to getting results, as responsibilities for decision-making and management were shared by all the stakeholders and partners
| Impact:                                                                 |
| ♦ Increased awareness and response towards sexual reproductive health issues by both men and women |
| ♦ The UYDEL team were able to bring together/ pool resources for example expertise from the medical facilities and health centre IVs, informational leaflets and manuals, facilitators for some of the behavioral change sessions among others |
| ♦ Duplication of services and resources was minimized and a more- well connected, cohesive approach was created |
| ♦ The SRH need and issues affecting the ACSWs were identified using different perspectives and stakeholders |
| ♦ The project team built the local skills, leadership capacity and institutional development |
| ♦ Trust and understanding were built among the different stakeholders and partners |
| ♦ Improved referral of ACSWs to quality and efficient ASRH care, support and information |

| Innovation and Success Factors: |
| The following steps were taken by the project team to form partnerships and collaborations with the different stakeholders and partners: |
| ♦ Identification of Partners with SRH programmes and other related projects focusing on Adolescents (Service mapping) |
| ♦ Consultative and orientation meetings with the key identified stakeholders/ partners at the inception of the project were vital for success as this formed the first dialogues and line of discussion for the partnerships to be formed |
| ♦ Elements of strength and quality of each partner/ stakeholder were identified and assessed |
| ♦ Respect, trust and added-value were emphasized by the partnerships |
| ♦ Treating the partners and key stakeholders as equals, working with them and involving them at every step of the way in our decision making increased collaboration and trust and thus encouraged their participation in the project |
| ♦ Organizational strategic Plan which embraces partnership and Networking. |
| ♦ UYDEL Commitment in building national and International networks. |
| ♦ Been able to capture and write good success stories using UYDEL guidelines. |
| ♦ Facilitate organizational learning; to strengthen partnerships and team building; to support advocacy efforts; or to influence an organization’s culture. |
| ♦ Collection and analysis strengthened UYDEL - organization’s own credibility, legitimacy and its |
| ♦ Accountability to the people and communities it works with. |
| ♦ Children are giving anonymous feedback during the quarterly meetings; and any rising issues were keenly followed up. |

| Constraints: |
| ♦ How to partner with other organization, institutions, groups and agencies to effectively address ASRH issues among the ACSWs will effectively maximizing resource sharing among the partners and stakeholders |
| ♦ Formal/Written commitments like MOUs are not embraced by many CSOs/ institutions. |

| Lessons Learned: |
| ♦ Partnership were critical in fostering organizational professional development opportunities |
| ♦ Partnership were key in managing service quality improvement and learning |
| ♦ Collaboration enhanced the capacity of the people and organization to achieve goals through synergy effects, brought about by the efficient and effective combination of complementary skills and strengths. As well as of the human, material, and financial resources between the parties engaged in a partnership |

| Sustainability: |
| ♦ Continue embracing the already existing networks by involving them in UYDEL programs as well as identify more Relevant national and international partnerships/networks |

| Up-scaling: |
| ♦ Continue embracing the already existing networks as well as identify more additional strategic national and international partnerships/networks. |
| ♦ Apply / Support partnership funding since it also avoid duplication of services |
| ♦ Actively participation in the Partnership online, in print and via social media. |
| ♦ Renew UYDEL participation in the Partnership annually. |

| Conclusion: |
| The fact that we are living in an era of diminishing resources and increasing competition for funds partnership and networking should be embraced/ seen as desirable because it improves services and because it is a more cost-effective way of using limited resources. It also encourages efficient, effective and ethical operations to best meet community needs. |
 According to UYDEL, Capacity building was defined as the ability for the project team, beneficiaries, stakeholders and the communities as a whole to manage the implementation of the Health Matters’ Project successfully. Capacity building aimed at:
- Institutional and policy framework development: putting in place policies and regulatory guidelines to create an enabling environment for the organization at all levels to enhance their capacities
- Organizational development: elaboration of management structures, processes and procedures, not only within organizations but also the management of relations between the different organizations and sectors (Public, private and community)
- Human Resource Development: equipping individuals with the understanding, skills and access to information, knowledge and training that enables them to perform effectively.

Capacity building in terms of trainings for staff, peer educators, Beneficiaries, parents, and community leaders was done to build competences and capacities in ASRH and other components necessary for the effective implementation of the Health Matters Project. The table below shows the types of trainings done for each group.

<table>
<thead>
<tr>
<th>Nature of participants</th>
<th>Types/Nature of Trainings received by each of the participants</th>
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<tbody>
<tr>
<td><strong>Project Staff</strong></td>
<td>- Alcohol and drug abuse prevention</td>
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<td>- Prevention and Health promotion through Sports</td>
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<td>- Peer to Peer Support</td>
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<td>- Prevent Smart Parents</td>
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<td>- Motivational Interview</td>
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<td>- Handling Relapse and trauma of victims</td>
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<td>- Self Care</td>
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<td>- Social Communication</td>
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<td>- Project Proposal writing</td>
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<td>- Organizing effective workshops</td>
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<td>- Business and Entrepreneurship Skills</td>
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<td>- Adolescent Sexual Reproductive Health</td>
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<td>- Youth Friendly Services</td>
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<td>- Protecting Human Rights Subjects in research</td>
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<td>- Participatory Inquiry in Practice</td>
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<td>- Project Goals, objectives and activities and results</td>
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<td>- Home visits</td>
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<td>- Resettlement and reintegration</td>
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<td>- Data Collection, entry, analysis and effective utilization</td>
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<td>- Monitoring and Evaluation</td>
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<td>- Village Savings and Loan Associations</td>
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<td>- Counseling</td>
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<td>- Knowledge Management and learning</td>
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<td>- Strategic Planning and development</td>
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<td>- Child Trafficking</td>
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<td>- Worst Forms of Child Labour</td>
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<td>- Male Engagement</td>
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<td>- Gender mainstreaming</td>
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<td>- Commercial Sexual Exploitation of children</td>
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<td>- Gender Based Violence</td>
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<td>- Human Resource Management</td>
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<td>- Financial Management</td>
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<td>- Documentation of good practices and report writing</td>
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<td>- Street Smart Behavioral Change Module</td>
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<td>- Performance Appraisal and Evaluation</td>
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<td>- Professional Behavior</td>
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<td>- Child Friendly Approaches and Promotion of Resilience</td>
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<td>- Sister to Sister Intervention</td>
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<td>- Child Protection and Child Participation</td>
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<td>- Business skills training and management</td>
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<td><strong>Peer Educators</strong></td>
<td>- Peer Education</td>
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<td>- Report Writing</td>
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<td>- Business and Entrepreneurship Skills</td>
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<td>- Hygiene and Sanitation</td>
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<td>- STI Prevention</td>
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<td>- Correct and consistent Condom use</td>
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<td>- HIV Prevention, care and support</td>
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<td>- Family Planning</td>
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<td>- HIV Counseling and Testing</td>
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<td>- Nutrition</td>
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<td>- Safe Medical Male Circumcision</td>
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<td>- Alcohol, Drug and Substance Abuse</td>
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<td>- Life skills</td>
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<td>- Street Smart Behavioral Change Module</td>
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<td>- Risk Assessment and protective factors</td>
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<td>- Community mobilization and referral</td>
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<td>- Positive Living</td>
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<td>- Menstruation</td>
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<td>- Menstrual Hygiene</td>
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<td>- Dangers of Early and Un wanted pregnancy</td>
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<td>- Pregnancy and Antenatal care</td>
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<td>- Sex and Sexuality</td>
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<td>- Early Sexual Behavior</td>
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<td>- Healthy Relationships</td>
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<td>- Relationships building</td>
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<td>- Importance of physical exercise</td>
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<td>- Growth and Development</td>
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<td>- Gender issues and young people</td>
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<td></td>
<td>- Reproductive Health Cancers (RHC)</td>
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<td></td>
<td>- Treatment and drug adherence</td>
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<td>- Reproductive Health Rights</td>
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<td>- Communication and counseling skills</td>
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<td>- Self Esteem</td>
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<td>- Project Goals, objectives and activities and results</td>
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</table>
## Summary:

<table>
<thead>
<tr>
<th>Nature of participants</th>
<th>Types/Nature of Trainings received by each of the participants</th>
</tr>
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</table>
| **Beneficiaries**      | - Business and Entrepreneurship Skills  
                        - Hygiene and Sanitation  
                        - STI Prevention  
                        - Correct and consistent Condom use  
                        - HIV Prevention, care and support  
                        - HIV Counseling and Testing  
                        - Parenting skills  
                        - Family Planning  
                        - Nutrition  
                        - Safe Medical Male Circumcision  
                        - Talent Development (Music, Dance and Drama, in door and out games, debate)  
                        - Leadership skills  
                        - Alcohol, Drug and Substance Abuse  
                        - Life skills  
                        - Street Smart Behavioral Change Module  
                        - Risk Assessment and Protective factors  
                        - Jewelry Making  
                        - Project Goals, objectives and activities and results  
                        - Positive Living  
                        - Menstruation  
                        - Menstrual Hygiene  
                        - Dangers of Early and Un wanted pregnancy  
                        - Pregnancy and Antenatal care  
                        - Sex and Sexuality  
                        - Early Sexual Behavior  
                        - Healthy Relationships  
                        - Relationships building  
                        - Importance of physical exercise  
                        - Growth and Development  
                        - Gender issues and young people  
                        - Reproductive Health Cancers (RHC)  
                        - Treatment and drug adherence  
                        - Reproductive Health Rights  
                        - Self Esteem |
| **Parents**            | - Prevention Smart Parents  
                        - Psychosocial Supports  
                        - Project Goals, objectives and activities and results  
                        - Child Friendly Approaches and Promotion of Resilience  
                        - Child-parent communication. |
| **Community Leaders**  | - Psychosocial support  
                        - Adolescent Sexual Reproductive Health  
                        - Project Goals, objectives and activities and results  
                        - Community Child protection mechanism  
                        - Community mobilization and referral  
                        - Stigma and discrimination  
                        - Child Friendly Approaches and Promotion of Resilience  
                        - Project planning processes  
                        - Partnerships and collaboration |
| **Civil Society Organizations working with Commercial Sex workers and vulnerable young people** | - Alcohol and drug abuse prevention  
                        - Prevention and Health promotion through Sports  
                        - Peer to Peer Support  
                        - Prevent Smart Parents  
                        - Motivational Interviewing  
                        - Project Goals, objectives and activities and results |
| **UYDEL Board of Directors** | - Governance  
                        - Resource Mobilization  
                        - Prevention and Health Promotion through Sports  
                        - Prevention Smart Parents  
                        - Peer to Peer Support  
                        - Financial Management  
                        - Strategic Planning |

### Stakeholders and Partners:

**Development Partners**
- Training Needs Assessments  
- Identify Training Participants  
- Organize Training Materials  
- Conduct Training  
- Pre and post Evaluation of Training  
- Monitoring translation of knowledge into practice  
- Funding for Capacity Building  
- Provision of continuous Technical support and mentorship  
- Link UYDEL to Trainings and learning opportunities  
- Research and documentation of good practices, lesson learned and success stories and dissemination
<table>
<thead>
<tr>
<th>Stakeholders and Partners:</th>
<th>Training Needs Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government agencies and institutions:</td>
<td>Identify Training Participants</td>
</tr>
<tr>
<td>Ministry of Health - Adolescent Health technical working group.</td>
<td>Organize Training Materials</td>
</tr>
<tr>
<td>District health officer (DHO),</td>
<td>Conduct Training</td>
</tr>
<tr>
<td>Ministry of Gender Labour and Social Development</td>
<td>Pre and post Evaluation of Training</td>
</tr>
<tr>
<td>Kampala City Council Authority Clinics- Kawempe, busabala, Kitebi, Komamboga</td>
<td>Monitoring translation of knowledge into practice</td>
</tr>
<tr>
<td>Child and Protection Unit / Probation Officers - Police</td>
<td>Provision of continuous Technical support and mentorship</td>
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<td>Link UYDEL to Trainings and learning opportunities</td>
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<tr>
<td>Parents, siblings and care givers</td>
<td>Develop, monitoring and evaluation for adherence to standards and legislations</td>
</tr>
<tr>
<td>Community members (Local Leaders, opinion leaders, religious leaders, teachers, business community</td>
<td>Development of Service Indicators</td>
</tr>
<tr>
<td>Peer Educators and beneficiaries</td>
<td>Research and documentation of good practices, lesson learned and success stories and dissemination</td>
</tr>
<tr>
<td>Local Artisans/ Vocational Skills Instructors</td>
<td>Community policing</td>
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<td>Child rights protection</td>
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Interventions for ACSWs - 2013; A UYDEL Publication
<table>
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<tr>
<th><strong>Method used:</strong></th>
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| ♦ Organizational capacity Assessment  
♦ Community and Beneficiary capacity assessment  
♦ Participatory evaluation and self-assessment  
♦ Identification of training needs, resources and priorities  
♦ Identification of trainers and facilitators  
♦ Development and identification of training curriculums, methodologies, training tools and materials  
♦ Conduct trainings/ Training of trainers  
♦ Dialogues  
♦ Role Play/ story telling and testimonies  
♦ Trainings  
♦ Debates  
♦ Facilitation and presentation  
♦ Case studies  
♦ Learning visits to youth centres  
♦ Health Retreats | ♦ Participation in onsite activities  
♦ Spot Check visits  
♦ Observation  
♦ Exchange and learning visits to other stakeholders  
♦ Pre and post training evaluations  
♦ Follow up and mentorship  
♦ Feedback meetings  
♦ Desk review and analysis of existing literature  
♦ Monthly, quarterly and annual reviews  
♦ Joint support Supervision and monitoring  
♦ Outsource technical assistance and expertise (Networking)  
♦ Building upon existing strategies, tools and structures  
♦ Monitoring and Evaluation |

| **Capacity building aimed at:** |  
| ♦ Identifying the critical challenges in ASRH service delivery  
♦ Examining ways in which capacities of various stakeholders could be built and improved and  
♦ Identifying modalities of support that UYDEL and its partners can provide |

Of the 247 project beneficiaries sampled, 208 beneficiaries equivalent to 84.2% were slum dwellers affected by the problems associated with the slum communities such as poor sanitation and hygiene, risky behaviors such as theft, alcohol and drug abuse, rape, defilement, robbery and bribery, sexual exploitation and abuse among others. Thus the need to build the capacity of different stakeholders in these slum communities and the beneficiaries to effectively respond, detect and prevent the occurrence of some of these problems in their communities.

| **Validation:** |  
| ♦ A total of 34 young people who had ever carried out abortion at the time of identification, when asked how the abortion was done, 0.4% said they drunk oral solution, 0.4% said they introduced an object in the vagina, 6.5% said they took medical drugs, 2.4% said they had a miscarriage and 4.5% said they used local herbs. When asked who aided the abortion, 5.3% of young people said a medical personnel, 0.4% said Traditional Birth Attendants, 2.4% said friends, 2.8% self and 0.8% herbalist. The fact that abortion is illegal in Uganda, the afore-given evidence of its existence with all the stakeholders involved provoked the organization under the Health Matters Project to build the capacity of all stakeholder’s through various trainings such as Family Planning, Dangers of early and unwanted pregnancies, post and pre-abortion care among others to enhance behavioral change. |

It was also noted that:
♦ Young people started commercial sex work as early as 11 years old thus need for life skills training to make informed choices
♦ 40.9% of the young people tagged their involvement in commercial sex to “meeting the required basic needs” thus the need for positive survival skills, business skills training, vocational skills training, condom negotiation and linking them to micro-finance services and grants.
♦ 52.2% of the young people at least had a CSW partner thus the need for training in fidelity, HIV Prevention, condom use, and HIV counseling and testing among others
♦ 44.5% were using drugs and alcohol thus the need for training in drug prevention, peer to peer support, street smart, prevention smart parents and life skills
♦ 69.2% of the young people had lost one or both parents thus the need to training their caregivers in parenting skills and prevention smart parenting
♦ 44.5% of the young people had one meal a day, 34.4% had two meals a day, 19.8% had three meals a day and 0.4% sometimes none thus the need for nutrition training especially for those that were pregnant and on HIV Therapy

| **Impact:** |  
| ♦ Improved reporting and documentation of project achievements (result-oriented and impact reporting)  
♦ Encouraged staff to increase on male participation of young people at the community centre level in order to address issues of gender inequity, to challenge gender norms; namely masculinity and femininity to achieve positive outcomes related to adolescent health and well-being. |
### Interventions

- Supported staff to improve on the drawing of activity work plans with smart objectives, expected outputs, programme/schedule of work plan and concretized concepts.
- Monitored staff compliance with child protection standards/policies as well as the impact of the child Protection procedures.
- Reinforced staff to capture disaggregated data of ACSWs beneficiaries.
- Supported staff in incorporating changes in participation and Empowerment of beneficiaries, for example by increasing the space for children’s participation in decision making at centre and society levels and inclusion of gender in all aspects of the project implementation.
- Strengthened staff compliance and progress towards fulfilling their duties

### Innovation and Success Factors

- Integration of all stakeholders (private, public and community) influenced the performance of specific Capacity building activities such trainings of staff and tailoring training to address specific needs.
- Capacity assessments done enabled the project team to design needs tailor-made trainings for each stakeholders.
- Inclusion of activities like sports, health retreats, music, dance and drama, and culturally sensitive vocational skills that attracted Male Involvement in ASRH issues.
- Regular Data collection and analysis strengthened UYDEL -organization’s own credibility, legitimacy and its accountability to the people and communities it works with.
- Encouraged Anonymous beneficiary feedback during the quarterly peer meetings & any rising issues were keenly followed up.
- Utilization of participatory learning methods that helped the different stakeholders actively contribute to teaching and learning, rather than being passive recipients of information from experts.
- Integration of gender that aimed at closing the gaps between women and men to create an enabling environment for women to participate in capacity building and to incorporate gender perspectives when planning these trainings.
- Continuous and strategic facilitation of organizational learning; to strengthen partnerships and team building; to support advocacy efforts; or to influence an organization’s culture.
- Monitoring and evaluation of the capacity building trainings was relevant to measure success and provided important information input for corrective action and optimization of the capacity building strategy, its components and activities.

### Constraints

- Lack of sufficient know-how about the chances and risks of engaging in capacity building.
- Difficulty in translation of knowledge and skills acquired by the different groups into practice.
- Inadequate financial support to procure enough materials and hire expertise for continuous skills building of all the stakeholders.
- Capacity building takes a long time and requires long term commitment for those involved.

### Lessons Learned

- Working together with local actors and individuals provided important insight into cultural issues and helped to identify key factors for success of a particular Intervention. For example the use of various local languages when conducting trainings and educational sessions.
- Capacity Assessment is essential for prioritization of capacity building activities and development of a capacity building plan that are an integral part of the existing structures.
- Community educational efforts should begin within the family unit and address the social determinants of children’s vulnerabilities. Such as poverty and cultural norms.
- Organizational capacity to attract and retain a staff body and individual staff of the calibre or potential calibre necessary for running programmes effectively.

### Sustainability

- Capacity building/ training is embedded in the long-term organizational strategy and is not treated as ‘just an element’ or program and project, which came to an end the moment the project was completed.
- Establishment of strategic partnerships is fundamental for the sustainability of capacity building at organization, community and national level.
- For effective and sustainable training and education and in the broader sense capacity development, needs to be adapted to the local market demand.
- Encouragement of partnerships and collaborations among the different stakeholders may assist in allocation of resources and linking to training opportunities.
- Building of local capacity for training is crucial to ensure the sustainability of capacity building. Training a set of individuals for example the peer educators, local leaders and parents among others for a specific project ensured that the project activities were executed successfully, given that the trained capacities worked with the project throughout its implementation.
- Ownership and responsibility.
- Partnerships and networking with various stakeholders.

### Up-scaling

- Make Capacity building demand driven, responding to the interests and needs expressed by the project staff, communities, peer educators and local leaders.
- Investment in training materials and hiring expertise for regular skills building and training.
- Conduct continuous training needs assessment to identify gaps and make recommendations for training of different stakeholders.
- Organize exchange learning visits to different partner groups, organizations and institutions.
- Encouragement of partnerships and collaborations among the different stakeholders may assist in allocation of resources and linking to training opportunities.
- Organizational assessment, evaluation of overall effectiveness for and strategic planning.
- Board and Staff Development related to defined objectives for improvement in overall management and governance.
- Development of a fully -costed capacity building plan in consultation with the different stakeholders.
- Positioning of the organization within the external environment and making it adapt to changes in the external environment.

### Conclusion

Capacity Building in regard to acquisition of competences and capabilities improves organizations’ systems and operations, strengthens its ability to serve the ACSWs and other clients.
Chapter Four

SUCCESS STORIES AND CASE STUDIES

Success Story 1

Girl who experienced grief sexual exploitation in a coerced early marriage after loss of her care taker- celebrates success in life.

HANIFAH (not real name) 24 years a resident of Busega dropped out of school in senior three, due to lack of school fees. The grandmother due to old age could not manage to raise the school fees. She lost her mother while in primary one and grew up under the care of her grandmother in Kiboga District. Hanifah and her sibling from the same mother did not receive any support from her father and does not relate well with the father. After dropping out of school, Hanifah remained home doing house chores and since they could not afford to buy basic needs, at the age of 15 years, Hanifah started engaging in commercial sex so that she could buy herself basic needs.

At age 16 years, Hanifah came with the maternal auntie to Kampala who promised to get her a job. She stayed in Nansana with the Auntie with the hope that the Auntie will soon find her a job. Hanifah Narrates, “One day my auntie told me that there is a man who owns a shop and needs a shop attendant. This man picked me up from my auntie’s home in Nansana and took me to his home in Nalukolongo but did not give me a job. He instead told me that I was going to be his wife. I had no option because I did not want to go back to the village where we did not have any money. At the age of 17 years I got pregnant, my spouse did not provide me with basic needs and did not care about me and the baby I was carrying and only demanded for sex every time he came back home. I had to survive somehow and so I resorted to commercial sex work to be able to provide for myself and the child I was expecting. I had three sexual partners who I met at different occasions and they would each give me UGX10,000 to UGX20,000 per sexual encounter. I used this money to buy airtime for my phone, basic needs and shoes. “Hanifah Later learnt that the Auntie had received money from the man who had forced her to be his wife as payment for a wife.

Hanifah was identified and referred to the UYDEL drop-in centre in Nateete by a former UYDEL beneficiary. At the centre she was assessed by a social worker and recruited into the hairdressing classes. She received counseling, and information on correct and consistent condom use and the dangers of engaging in commercial sex.

After completing her hairdressing course, Hanifah went and started working in a friend’s salon. She saved up some money and started her own salon in Mengo and employed a fellow classmate. She opened up a saving account with micro finance bank and saved up to UGX79,000 per month. She bought a fridge and started to sell soda and passion fruit drinks and drinking water. She also bought a telephone.
and offered people telephone services at a cost and this contributed to the growth of her business. Hanifah says that the business skills training she received while at the UYDEL centre was one of the most profitable trainings she received and this helped her achieve all the successes in her business.

She is now separated from the father of her child but she is happy because she is able to provide for her child’s needs. She is grateful to UYDEL for the start-up kit she received and a start-up capital of UGX 100,000 which helped her grow her business idea and is happy that she is now self-reliant and does not have to rely on commercial sex to get basic needs.

Case Study 1

Girl fall victim of Defilement due to deceptive promises- UYDEL rebuilds her traumatized life.

AGNES (not real name) 15 years old was residing with her father and mother both farmers at Amonta in Kole which is found in the northern part of Uganda. Akite dropped out of school in primary seven because the parents were not able to raise enough funds for her school fees in Secondary school. It was then that the brother asked her parents for permission to let him bring Akite to live with him in Bukoto, Kampala District and promised that he would take her back to school. However, on arrival in Bukoto, the brother did not take Akite back to school but instead asked her to take care of his home while he went out to work.

“One day when my brother went to work and his wife had gone to the salon, one of my brothers’ friends came by the house to visit, when I opened the door, he started to ask for sex and when I refused he forced his way into the house (one roomed house) and threw me on the bed and started to undress me. I screamed and fought but he was to energetic, he squeeze my neck and I could no longer make any noise as he raped me”, Agnes in tears narrates the awful ordeal that changed her life and scarred her for life. The brother reported the friend to the police and he was arrested but surprisingly the friend was released after two weeks.
At the time of assessment at the UYDEL drop-in centre in Kamwokya, Akite told the social worker that she had not tested for HIV and AIDS and that she had fears that the rape incident had caused the irregularities in her menstrual cycle. Akite received psychosocial counseling, SRH counseling, was supported to know her HIV status and is being assisted to acquire skills in Hairdressing course and will complete her training in July 2013. She has plans to start her own hairdressing salon with the help of her brother who has promised to buy her a hand dryer and give her some capital to buy the other items for her salon.

**Case Study 2**

**Self-Stigma took a high toll in a child victim of sexual abuse, resentment and extreme poverty.**

**DANIELLA** (not real name) 15 years, a resident of Kabowa, Nateete, Rubaga Division, Kampala District dropped out of school in Primary Seven in 2011 because her mother could not afford the school fees as she earns very little money collecting empty plastic bottles. Her father died in 2007 due to a strange disease that was not known to the doctors that were taking care of his treatment.

After dropping out of school, she went to stay with her paternal aunt in Busega who mistreated her. “If I did not complete my house chores in time, my auntie would make carry heavy stones on my head for 10-20 minutes and deny me lunch yet I was the one who had prepared the lunch,” say Daniella.

![Image](image_url)

On one fateful day, Daniella, was sexually abused by the auntie’s son. Daniella narrates, “He locked me in the bedroom and had unprotected sex with me. And when I told my auntie, she was angry with me and chased me away from her home blaming me for what had happened. I went back to live with my mother in Kabowa in a garage which was given to her by a friend of my late Father.”

Together Daniella and her mother collect empty plastic bottles and sell a kilogram at UGX 1500 each. The business has its own challenges as sometimes people mistake them to be thieves, insult them and the men (especially the boda boda cyclists) sexually assault them, call them names and others want them to go into their houses for the bottles so that they can sexually abuse and rape them. They walk long distances to work and yet they don’t have enough to eat and drink.

Daniella has a boyfriend (boda-boda cyclist) who gives her money for her basic needs and sometimes takes her to party places, discos and bars. She takes alcohol especially when she goes to visit the boyfriend and her specialty is Sweet gin, Beckam gin and V&A. She sometimes uses condoms for protection but is not consistent because in most cases they are not available.

Daniella was referred to the UYDEL drop-in centre in Nateete by a local leader and on assessment she was enrolled into the hairdressing class and this was an avenue that was used to talk to her about HIV/AIDS prevention, correct and consistent condom use and risky factors that could expose her to HIV and AIDS, STIs, unplanned pregnancy and alcohol and drug abuse. She is currently completing training and will be graduating in July 2013.
Success Story 2

A Girl whose dream was later restored by UYDEL - recalls how she preserved endless sexual violence in favor of a Job and shelter.

SHARON (not real name) aged 19 years is currently staying in Kibuye in a one roomed rented house with 2 of her friends. She dropped out of school in senior three due to delinquency, peer influence and lack of school fees from her parents. She later moved to Kampala by one of her friends in 2009. She was 15 years of age by then. At her friend’s place, she worked as a house girl. After 6 months without pay, she was taken by some other man to work as a dry cleaner at Kibuye. Sharon was provided with residence by this boss who had his own interests. The boss many times forced her into sex without her consent. She could not report the boss because she feared the boss chasing her out of his home and also from the job. Sharon feared becoming both jobless and homeless. She accepted later to continue in a relationship with her boss. She got pregnant with the boss’s child but she aborted due to fear of the boss’s wife. At one time, the wife’s boss learnt about the relationship and Sharon felt so bad but she had nothing to do. Sharon however had other partners besides her boss who could give her money in exchange for sex.

To relieve stress and all the fears she had, Sharon decided to start taking alcohol and drugs. She could also take family planning pills without proper information because the boss would just force her into sex at any time he wanted and especially with the wife’s absence. “I later got tired of the boss because he was abusing other girls as well in the homestead. I decided to rent a small room with my two friends,” said Sharon. The boss however stopped paying her because he wanted her to go back to his place. Sharon declined the boss’s proposal and she continued to stay with her friends. She continued in commercial sex to earn money for survival and contribute to rent. Sharon started Commercial Sex Work at the age of 17 years, having 3 partners a day and could earn between 5000 – 100,000 Uganda Shillings a day.

Sharon was identified by a social worker and was recruited under the Health Matters Project at UYDEL Nateete drop-in-center. She had ever suffered STI’s and had signs of STIs at the time of identification. Sharon is now STI free as a result of free treatment received under the project. She was counseled on the
dangers of engaging in commercial sex work and also acquired knowledge of other reproductive health issues. She was trained in life skills and business skills.

Sharon currently works at a Mobile Money point at Mid-City in Kikuubo. She is paid monthly, earns 200,000 UShs. Per day she makes between 20,000 – 60,000 UShs. “My self-esteem was boosted while at UYDEL. I am now confident talking to people. Besides, I have never made any losses so far, I am using the business skills acquired at UYDEL to make sure that I keep record of whatever I do,” said Sharon. Sharon is progressing on well and has hope in the future to come. She saves UGX 1,000 per day.

**Success story 3**

TEOPISTA (not real name) aged 18 years is a resident of Nateete Kigaga zone, Rubaga division, Kampala district. She is currently staying with her sister who is a housewife. Teopista dropped out of school in 2009 due to lack of school fees. She stopped in primary seven. She is a maternal orphan, the fifth born out of 12 siblings. Her father is a peasant and stays in Masaka district. “Before Coming to Kampala, I worked as a housemaid in Nyendo Masaka for one and a half years. I was paid only 20,000 Uganda shillings a month which was too little to meet my basic needs. I also faced physical abuse where the boss used to slap me whenever she found her baby crying. I was introduced to commercial sex by a friend in order to supplement on the income I was getting as a housemaid. My customers were mainly boda-boda cyclists who used to take me in different lodges and hideouts in Masaka during day time for commercial sex work because during this time of day, my boss was away for work. In a day, I would serve 1 – 2 partners from different stages. I would earn between UGX 3000 – 7000 shilling a day if it was a good day. Some customers would pay in form of gifts and sometimes buy me beer” Says Teopista.

However, Teopista says, “I faced so many challenges from this Commercial Sex Business such as contracting STI’s like syphilis, little pay by customers and some customers usually failed to pay completely. There was a time when I had accumulated 50,000 Uganda shillings and then I discovered that I had syphilis. I used all the money for treatment and it was not even enough.”

When the boss got to know that Teopista was involved in commercial sex work, she chased her away, that’s when she decided to come to Kampala to stay with her sister in Nateete Kigaga zone. However, still at her sister’s place, she decided to continue with the commercial sex work. She started taking alcohol (local brew, beers) at the age of 11 years. They stay 5 people in a two-roomed rented house. They usually have two meals a day and the provider of the meals is the husband of the sister.

Teopista was identified and referred to the UYDEL drop –in-center in Nateete by a former beneficiary. She wanted to acquire vocational skills training in hair dressing and expected to look for a job after graduation. She was recruited under the project to start benefiting from the project’s services. Among the services received include; Vocational skills training in hair dressing, business skills training, life skills training, Treatment for Syphilis, HIV counseling and testing, individual and group counseling on menstruation, dangers of commercial sex work, HIV care and prevention, Personal hygiene, alcohol and drug prevention among other reproductive health information.
Teopista is currently employed at “Holy Enterprises Beauty Salon” as an employee. They are three people in the saloon (Teopista, her boss, plus one other employee). According to the report by the boss, she is progressing on well. She now knows everything that she came not knowing. She works from Monday to Sunday and payment depends on the availability of customers. On each customer she plait or works on, the boss has to remove 2000 UShs for rent and 1000 UShs for electricity and the balance is hers. When they work on the customer two people, they have to share the balance after deducting money for rent and electricity. The charges for each hair style include; Twist – 10,000UShs, Retouch – 20,000UShs, Retouch and Treatment – 25,000UShs, Corn rows (puff) – 15,000UShs, Corn rows (straight) – 10,000UShs Treatment – 7,000UShs (T-tree) and 5000 UShs (Movit). Per month, Teopista is able to save 120,000 Uganda shillings every month and has completely withdrawn from commercial sex work.

**Success story 4**

**NIGHT** (not real name) 20 years resides in Nateete slum found in the outskirts of Kampala City. She is the eldest in their home and dropped out of school at age 16 due to lack of school fees. Life became hard in the village that she found means of coming to Kampala to stay with her 10 cousins who lived in the same house, so she could look for a job in the city. One of her cousin who was a commercial sex worker introduced her to the trade.

“My first day into commercial sex, I was afraid but because of the situation I was going through I had to get used to it and as time went by I was able to raise some money that I would send my mother so she could take care of my siblings back home in the village. But I used to pass through a lot of unimaginable things. Being a Commercial Sex Worker is not a good experience”, Night laments.

For two years she did commercial sex work. On a typical day she would get $2 to $4 per person in exchange for sex. She faced violence from peers who would gang her and steal her money; men would pay little and sometimes nothing after having sex with her. She also suffered syphilis and candida. Night was referred to UYDEL by a local leader but she at first resisted the idea because she knew she was HIV positive, “spoil” and worthless. After knowing that she had friends and cousins who were also doing commercial sex, the social workers contacted them but they declined. Night was counseled and involved in the peer education club at the UYDEL Nateete youth center. She learned hairdressing, was treated of the STIs and also acquired life skills and business skills. She used her story to influence other girls to seek treatment for STIs and provided information on SRH through behavioral change sessions organized by the peer educators at the center. She was among the first girls that graduated in 2010. She was followed up to understand her life after UYDEL. With great pleasure, she shared the following with the follow up team (social workers).

“The hair dressing skills I acquired at UYDEL are helping me a great deal. I get customers to plait almost every day who give me money that helps me in my day to day living and also supporting my family. These customers find me at home and others, we make appointments and I can find them at their places of work or homes. I now have a small market business where I sell vegetables to further support my income.
generation. I was able to establish this market through the money I saved that I got from plaiting various customers. I charge 15,000 shillings per head for corn rows, 10,000 shillings for braids, weaves, and twist. I completely withdrew from commercial sex work. I am renting my own house now and I am happy for this”.

This is a clear indication that Night’s life has changed from a situation of vulnerability to opportunity.

Success story 5

Boy who sexually suffered at the fate of peer pressure, gained resilience from UYDEL and still views the future with optimism.

TIMOTHY (not real name) aged 18 years is a resident of Kitebi. He is a double orphan living with his friend in Mpigi. “I lost my parents while I was in primary two and thus stopped schooling. We were staying in Mpigi. I was taken to stay with my uncles in Kayunga but they subjected me to extreme torture, exploitative labour (carrying stones) and stealing in the late hours at night. I reported to people in the community but nobody could help me out of the danger. Later, I was brought back to Mpigi to stay with my grandparents. Here, I started working as a shamba boy so as to be able to earn money because my grandparents never used to work and therefore could not give me any money.” Timothy was trafficked to Kampala by a friend who promised to look for him a job. His friend used to work in one of the lodges in Makindye connecting girls in that lodge to the customers. He acted as a link to customers for these girls who stayed in the lodge. Timothy said he had no idea where the girls were got from to come to stay in the lodge. Under the influence of his friend, Timothy said he also started engaging in risky sexual behaviors especially with sugar mummies and different girls whom he saw had money so as to get money from them and meet his basic needs. He was 16 years by then. Per day, he would earn roughly 20,000 Uganda shillings with 3 customers.

Timothy was identified by a peer educator who advised him to visit UYDEL to seek for help. At first, he resisted the idea due to fear of stigmatization but later he accepted. Timothy was recruited to start benefiting from the project services because he was vulnerable to HIV/AIDS and unplanned children. He expected to acquire vocational skills training in hair dressing skills and on completion planned to look for a job such that he can be able to sustain himself. While at Nateete drop-in-center, Timothy received counseling on: Abstinence, Correct and consistent Condom use, dangers of CSW and having healthy relationships. There was positive feedback from Timothy especially from the counseling received on having healthy relationships. He reported quitting his friend who had exposed him to all the afore mentioned risks and therefore joined this other friend he is currently staying with whom he said advises and guides him whenever he is going astray. Timothy acquired vocational skills training in hair dressing and successfully completed the course. He is currently a very competent hairdresser, self-employed as well as occasionally employed by other saloons which call him for plaiting customers who want dreads especially. He majorly plait dreads and charges $70,000 UShs per head. For other styles, he charges; Twist – $20,000 UShs, weave – $10,000 UShs and Braids $15,000 – $20,000 UShs. Per month, he is able to earn $270,000 UShs. The challenge he faces is usually from female customers - their improper dressing
and conduct. “Some ladies want you to plait them from their bed rooms and when they are indecently dressed! This really annoys me so much but I just look on,” said Timothy. Another challenge is that some customers do not pay full amounts and they delay to pay the remaining balances.

Timothy is a singer as well, an upcoming artist. He sings from Wallet pub, club Monalisa, MM pub, Ngoma cultural center. The money he gets usually is from the audience, those who have been touched by what he has performed. Usually, she collects between 10,000 – 30,000 UShs from the audience. He also performs on functions such as birthdays, graduation, introduction ceremonies. So far, he has performed on three functions and payments for such functions range between 50,000 – 70,000 UShs. The challenge he faces in music is that some people do not know him and he also faces competition from other renowned artists who sometimes steal songs of upcoming artists.

Success story 6

HAJARA (not real name) aged 23 years is a resident of Nateete church zone, Rubaga division, Kampala district. She is currently staying with her paternal aunt who is a housewife. Hajara says, “I grew up under the care of my grandparents in Masaka. I was told by my grandparents that my mother died while giving birth to me. With support from the Buganda Kingdom, I was able to receive an education up to senior four. My father refused to pay for my school fees to advance on further. I had to stay at home to take care of my grandparents. In 2006, I decided to leave Masaka for Kampala to look for my paternal aunt. This came after I had been exposed to extreme torture by my grandparents. I started working as a domestic worker at my paternal aunt’s place in Nateete but without pay which affected me terribly.”

As a result of extreme pain and feelings of disappointment, Hajara decided to cohabit with her boyfriend. At the age of 19 years, she gave birth to her first child who died in the early stages of its birth. “I quit cohabiting in 2010 after finding out that my boyfriend was in different relationships with other girls and women and some of them were rumored to be HIV positive,” says Hajara. She was 3 months pregnant then with another child. As the saying goes, blood is thicker than water, She decided to go back to stay with her paternal aunt. She lived a life of emotional pain, trauma, with feelings of rejection, worthlessness and hopelessness. She resorted to taking alcohol (waragi) as a solution to forgetting the problems she was faced with. Hajara was directed by a community member to the UYDEL drop-in-center in Nateete because she wanted to receive counseling and guidance to boost her self-esteem and also acquire skills in hair dressing as she thought this would help her earn some money to cater for some of her needs. She was recruited and received the following services from the project; Counseling on: - Proper Nutrition (balanced diet for herself and her child), Proper hygiene (personal and environmental), Adherence to PMTCT treatment, Behavioural change, Effects of taking alcohol, Importance of HIV testing, and Parenting. She was trained in vocational skills in hair dressing, business skills and life skills. She graduated with a certificate in vocational skills training in hair dressing in August 2012 and was given startup capital by the organization (a drier).

She was fortunate to get a job just after graduation in one of the saloons in Nateete. She used to save some money earned and in January 2013, she decided to join with one of her friend to start their own saloon. Rent per month for the saloon is 80,000 Uganda shillings and each contributes 40,000 Uganda Shillings to the rent. Although customers are minimal during weekly days, she gets more customers over the weekend (i.e., Saturday and Sunday). She can work on 8 customers a day over the weekend. She charges 15,000 UShs for corn rows (straight), 13,000 UShs for corn rows (puff), between 15,000 – 20,000 UShs for twist and braids, 10,000 – 15,000 UShs for weaves, 15,000 UShs for retouch (without own product) and 7,000 UShs for retouch (with own product), 3,000 UShs for Shampoo and set and 5,000 UShs for treatment. She has a saving box where she puts 500 UShs per day. The challenge she faces is that she does not have enough products stocked inside the saloon; she usually relies on the customers’ money. In future, she plans to have her own saloon without joining with anyone.
Case study 3

Trafficked girl got struck at a crossroad of life

DIANA (not real name) 18 year old female, Nateete joined the programme in August 2010. She was trafficked from a rural central district called Kayunga to work as a housemaid. During her stay the employer’s husband sexually abused her and she ran away to join a group of girlfriends who were involved in karaoke (strip dancing). She learned to take alcohol to get high in order to get confident on stage. One day she drank herself to stupor and fell ill. At this time she looked for her paternal aunt with whom she currently lives. Even after finding her aunt, she continued doing the strip dancing and supplementing it with commercial sex work. One time, one of the girlfriends was murdered and she got scared that she started being careful about her movements. At about the same time UYDEL conducted a drama show and a community local leaders meeting where they were sensitized on SRH for young people and urged to work with the project team to give support to such girls in their communities. One of the local leaders referred her. She participated in the peer educators club at the center, learned more about SRH through counseling, behavioral change sessions, dialogues and life skills trainings. She acquired hairdressing and business skills that she would use to earn income once out of the project. She also opted for abstinence and stopped doing commercial sex and strip dancing. Through peer education, she shared her story that inspired many girls to adopt safer sex practices and to get accurate information and treatment for STDs. She graduated from the project in February 2012. She is currently employed at one of the established salons near the city and earns $3 per head as opposed to commercial sex that originally paid her $1. Her future plan is to establish her own salon after saving money for capital. Diana continues to attend peer education sessions at the Centre, mobilizes other girls involved in commercial sex to participate in the project and also encourages them to take the intervention seriously for the betterment of their lives.

Success story 7

Parental Neglect exposed child to CSW

TEZIRA (not real name) aged 16 years is a resident of Nateete. She is currently staying with her maternal aunt who is a market vendor. She dropped out of school in senior two because her mother could no longer raise her school fees. The father abandoned the family and married another woman.

Tezira narrates, “I stayed with my step mother for some time but she mistreated me severely, denying me food and at one time, I suffered jiggers because she never cared for me. I was taken by my father to my grandmother’s place in Mpiigi to help out in her grocery but I could not stay there any longer. I was then taken on by her maternal aunt who lived in Kampala. I started engaging in Commercial Sex Work at the age of 15 years while at my aunt’s place. But this I did without my aunt’s knowledge. The reason for engaging into commercial sex work was to relieve stress from past disappointments of my father and stress from my aunt whom she said is too tough and does not provide for all my needs.”
Tezira says, she always had one partner per day who is a regular sexual partner and was paid by cash (usually earned between UGX 10,000 – UGX 80,000). She was identified by a social worker and was recruited under the project. She sought for an HIV test because she had never tested before and therefore was not sure of her status. She was thirsty for knowledge on family planning and how to protect her life. She also wanted to acquire vocational skills training in hair dressing and expected to look for a job after graduation. Tezira was able to acquire the following services from UYDEL; Vocational skills training in hairdressing, acquired the following hair dressing skills - twist, retouch, corn rows, tinting, styling, treatment, dreads, shampoo and set, weave, conditioner, geling and braiding. She was tested for HIV and was found negative, counseled on negative living, consistent and correct condom use, having healthy relationships, HIV care, treatment and prevention, the dangers of engaging into commercial sex work such as having unwanted pregnancies and alcohol and drug prevention.

Tezira currently works at Road side Maa ma Yusuf beauty Salon. According to the boss, Tezira is not a bad person although she needs to learn different hair styles such as corn rows plus other new styles. She is willing to learn. She is not yet considered a full employee because she is still being tested in terms of capability. “To be considered a full employee depends on how well you are working,” said Tezira’s boss. The only problem the boss has with Tezira is time keeping. Tezira is good at braids, weaves and twist and on each customer she works on; she is given part of the amount paid by the customer. The charges include; weaves 10,000 – 15,000 UShs, braids and twist – 20,000 UShs. Although she has not started making visible savings, Tezira was very positive that the future is bright. She said she completely withdrew from commercial sex because of the dangers associated with the business as told while at Nateete Youth Center.

Success story 8

Girl miss-out on education due to gender based violence but was economic empowered by UYDEL which marked the end of her fate

ZAINABU (not real name) aged 19 years is a resident of Nateete. She is currently staying with her uncle who is a mechanic. She dropped out of school in Senior three when the father refused to pay her school. This is because the father had separated with her mother and had chased both of them (Zainabu and her mother) from the house.

Zainabu’s mother lost her job as a market vendor and she is now in the village (Butambala) working as a peasant farmer. Zainabu’s uncle picked her from Butambala to come to Kampala and work for him as a house girl. She has been working as a housemaid for 3 years since 2008 without a monthly pay but the uncle buys for her food, provides shelter and sometimes give her 10,000 UShs whenever she wants to visit her mother in the village. “I am living a life of disappointment and I regret the day I dropped out of school. I cry day and night because my hope of becoming a nurse was shattered by my father. As a result, I feel worthless and depressed,” lamented Zainabu. At her uncle’s place, Zainabu said she is being
subjected to torture and abuse, denial of food and sometimes she sleeps hungry. This led her to develop ulcers. Due to the above conditions, Zainabu said she decided to engage in survival sex. By then, she was 16 years old “I have four sexual partners from whom I get money to meet my needs. This was not my option but I could not just look on and continue suffering. I will quit these men in case I get something to do to give me money to meet my needs.” Zainabu was identified by a UYDEL former beneficiary.

She was recruited under the project because she stood the risk of contracting HIV/AIDS and having unwanted pregnancies. She was tested for HIV and found negative. She was counseled on the dangers of having multiple sexual partners and on the importance of having healthy relationships. She was trained in vocational skills training in hair dressing so as to have a secure source of income than commercial sex work. She successfully completed the training and graduated with a certificate. She is currently working from home. She looks for customers herself and those who have her contact always phone in to make an appointment with her to work on them. She charges 20,000 UShs for twist, between 8,000 – 15,000 UShs for weaves, retouch – 10,000 UShs (without your own product) and 6000 - 7000 UShs with your own product - she uses the sun or borrows a drier for purposes of drying the customer’s hair. In a good week, she can work on 8 customer’s altogether but when customers are scare; she can work on only 2 per week. Per month, she is able to earn 120,000 UShs. When she deducts all the basic necessities from that money, she is able to save 40,000 UShs per month. The Challenges she faces – some customers come with dirty hair, others do not come with full amounts (give partial payments), flooding in the area which hinders her to get some customers on those specific days. Zainabu is a peer educator and she still refers young people to the UYDEL Nateete drop –in- center. She also distributes condoms in the community.
Annex

Annex 1

Operational definitions and descriptions of terms

Adolescents:
The world Health Organization (WHO, 1999) defines adolescents as persons in the 10-19 years age group while youths are defined as those between 15-24 years. The World Health Organization combines these two overlapping groups into one entity of “Younger people” covering the age range of 10-24 years. In this study, teen age (13-19 age group) was considered.

Adolescence:
is a period of biological and psychosocial turmoil. Adolescents have to make decisions pertaining to their teenage life and their future life. The biological change concern for appearance, sexuality, and search for identity, sex roles and the whole question of their future status are quite overwhelming. They have no prior experience of such pronounced change, which makes the whole situation difficult to understand.

Health:
Health is the complete physical, mental, and social well being and not merely the absence of disease or infirmity. This underpins the need for a holistic approach, concerned with a broad range of health problems and social conditions affecting young people and with issues related to attitudes and behaviors as well as illness and injury.

Supportive environments:
Include rules and policies that promote sexual and reproductive health such as policies that facilitate preventive and corrective health behaviors and rule or regulations that govern adolescent sexual reproductive health related behaviors. Adolescent

Friendly reproductive Health Services:
This is a setting that is welcoming, pleasing and comfortable to adolescents and even relaxing and enjoyable. AFRH services are services that are user friendly such that they are private, confidential; affordable accessible, and staffed with sensitive service providers.
Annex 2

Treaties, conventions and agreements relevant to reproductive health and rights

- 1948 Universal Declaration of Human Rights: A key document that has inspired the whole human rights discourse and many constitutions and national laws, and a source of international customary law.
- 1968 Tehran Conference on Human Rights proclaims and declares the right of individuals and couples to information, access and choice to determine the number and spacing of their children.
- 1969 Convention on the Elimination of all Forms of Racial Discrimination
- 1969 United Nations General Assembly Declaration on Social Progress and Development, resolution 2542 (XXIV), Article 4: “Parents have the exclusive right to determine freely and responsibly the number and spacing of their children.” The Assembly also resolved that the implementation of this right requires, “the provision to families of the knowledge and means necessary to enable them to exercise their right…”
- 1976 International Covenant on Civil and Political Rights, which is used by civil rights groups in their fight against government abuses of political power.
- Article 12 of the Covenant recognized the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- 1979 The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is the only international human rights document that specifically references family planning as key for ensuring the health and well-being of families. CEDAW provides the basis for realizing equality between women and men by ensuring women’s equal access to, and equal opportunities in, political and public life—including the right to vote and to stand for election—as well as education, health and employment.
- 1986 Declaration on the Right to Development calls for development that aims at the well-being of the entire population, free and meaningful participation and the fair distribution of the resulting benefits.
- 1989 Convention on the Rights of the Child sets standards for the defense of a child against neglect and abuse in countries throughout the globe. In order to protect the best interests of the child, it aims to:
  - Protect children from harmful acts and practices, including commercial and sexual exploitation and physical and mental abuse, and maintains that parents will be helped in their responsibilities of the positive upbringing of a child where assistance is needed.
  - Ensure the right of children to have access to certain services, such as health care and information on sexuality and reproduction.
  - Guarantee the participation of the child in matters concerning his or her life as s/he gets older. This includes exercising the right of freedom of speech and opinion.


- 1994 At the International Conference on Population and Development (ICPD) in Cairo, 179 governments agreed that population and development are inextricably linked, and that empowering
women and meeting people’s needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development. The conference adopted a 20-year Programme of Action, which focused on individuals’ needs and rights, rather than on achieving demographic targets. Advancing gender equality, eliminating violence against women and ensuring women’s ability to control their own fertility were acknowledged as cornerstones of population and development policies. Concrete goals of the ICPD centered on providing universal access to education, particularly for girls; reducing infant, child and maternal deaths; and ensuring universal access by 2015 to reproductive health care, including family planning, assisted childbirth and prevention of sexually transmitted infections including HIV.

 Velocity of change

- 1995 Beijing Declaration and Platform for Action, United Nations Fourth World Conference on Women
Reiterates broad definition of right to family planning laid out in ICPD Programme of Action.
- 1999 Key Actions for the Further Implementation of the ICPD Programme of Action
- A gender perspective should be adopted in all processes of policy formulation and implementation and in the delivery of services, especially in sexual and reproductive health, including family planning. Emphasized giving priority to sexual and reproductive health in the context of broader health reform, with special attention to rights and excluded groups.
- 2000 The Millennium Declaration was drafted by 189 nations which promised to free people from extreme poverty by 2015. The connections with reproductive health were initially understated.
- 2001 The Millennium Development Goals (MDGs). The goals are a road map with measurable targets and clear deadlines; the targets relevant to reproductive health include:
  - Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio (MDG-5).
  - Achieve, by 2015, universal access to reproductive health (MDG 5-B).
  - 2004 The 57th World Health Assembly adopted the World Health Organization’s first strategy on reproductive health, recognized the Programme of Action and urged countries to implement the new strategy as part of national efforts to achieve the MDGs.
  - Make reproductive and sexual health and integral part of planning, budgeting as well as monitoring and reporting on progress towards the MDGs.
  - Strengthen health systems to provide universal access to reproductive and sexual health care, with special attention to the poor and other marginalized groups, including adolescents and men.
- 2005 World Summit 2005, follow-up to the 2000 Millennium World Summit. World leaders committed to universal access to reproductive health by 2015, to promote gender equality and end discrimination against women.
- 2006 Convention on the Rights of Persons with Disabilities
- 2010 MDG/10 Review Summit. World leaders renewed their commitment to universal access to reproductive health by 2015 and promote gender equality and end discrimination against women.
- 2011 The Committee on the Elimination of Discrimination against Women issued a decision establishing that all States have a human rights obligation to guarantee women of all racial and economic backgrounds timely and non-discriminatory access to appropriate maternal health services.

Adapted from the State of the world Population Report 2012
Annex 3

Uganda Government Policies and Legislations in regard to Sexual Reproductive Health and child Protection

- Uganda Ministry of Health – Reproductive Health Department (October 2004); National Adolescent Health Policy for Uganda.
- Uganda Ministry of Health (May 2001); The National Policy Guidelines and Service Standards for Reproductive Health.
- Uganda Ministry of Health (December 2004); A strategy to improve Reproductive Health in Uganda, 2005-2010.
- Uganda Ministry of Health (2005) National family planning advocacy strategy
- Adolescent sexual and reproductive health (A Job Aide) September 2011. (MOH-RH Department).
- National Training curriculum for health workers on Adolescent health and development (Trainee Handbook) October 2011 (MOH-RH Department).
- National Health Policy II (NHP 2010/11-2019/20) and the Health Sector Strategic Plan (HSSP), which is currently in its third phase (2010/11- 2014/15). HSSP III - recognizes SRH as one of the four priority areas alongside Child Health, Health Education and the Control and Prevention of Communicable Diseases (HIV/AIDS, Malaria and Tuberculosis) (DSW 2011).
- The Uganda National Minimum Health Care Package (UNMHCP)
- Prevention of Trafficking in Persons Act (PTIP) 2009, - aims to provide for the prohibition of trafficking in persons, Creations of offences, prosecution and punishment of offenders, Prevention of the vice trafficking in persons, protection of Victims of trafficking bin persons, and other related matters.
- The Uganda National Plan of action on child sexual abuse and exploitation – 2010-2015
- National Strategic Programme Plan of Interventions For Orphans and Other vulnerable Children 2011/12–2015/16, MOGLSD: The NSPPI-2 is intended to guide the provision of sustainable quality services that minimize vulnerability of children and provide them with the right to live healthy and meaningful lives that can propel them into becoming responsible citizens.
Annex 4

Uganda Youth Development Link (UYDEL)

*Health Matters’ Project Lessons Learned tool*

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Focus Area: ........................................ Project or Organization Role: ..................................................

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**Lessons learned purpose and objectives**

Throughout each project life cycle, lessons are learned and opportunities for improvement are discovered. As part of a continuous improvement process, documenting lessons learned helps the project team discover the root causes of problems that occurred and avoid those problems in later project stages or future projects. Data for this report was gathered by using Project Lessons Learned Record sheets and is summarized in the table.

The objective of this report is gathering all relevant information for better planning of later project stages and future projects, improving implementation of new projects, and preventing or minimizing risks for future projects.

**Lessons learned questions**

✦ What worked well - or didn’t work well - either for this project or for the project team?

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✦ What needs to be done over or differently?

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✦ What project circumstances were not anticipated?

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Interventions for ACSWs - 2013; A UYDEL Publication 45
What surprises did the team have to deal with?

Were the project goals attained? If not, what changes need to be made to meet goals in the future?

_Uganda Youth Development Link_

**Health Matters’ Project Highlights**

**Top 3 Significant Project Successes**

<table>
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<tr>
<th>Project Success</th>
<th>Factors That Supported Success</th>
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<tbody>
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</tbody>
</table>

**Other Notable Project Successes**

<table>
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<tr>
<th>Project Success</th>
<th>Factors That Supported Success</th>
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</table>
## Project Shortcomings and Solutions

<table>
<thead>
<tr>
<th>Project Shortcoming</th>
<th>Recommended Solutions</th>
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Prepared by: ................................................................. Sign: .................................................................

Dates:.................................................................................................
Annex 5

Uganda Youth Development Link (UYDEL)

Health Matters’ Project (June 2012 to May 2013)

Good Practices Template

Definition:

Good practices can also be defined as the most efficient (least amount of effort) and effective (best results) way of accomplishing a task, based on repeatable procedures that have proven themselves over time for large numbers of people.

In the table below are some of the Good Practices identified in the Health Matters Project from June 2010 to May 2013:

- Psychosocial care and support
- Behavioral Change and Communication-(using models like the Street Smart and Motivational Interviewing among others)
- Vocational skills training
- Life skills Education
- Peer Education
- Finance and Accounting
- Data and Research
- Capacity Building (trainings in ASRH, Business skills, entrepreneurship skills, strategic planning, monitoring and evaluation, proposal writing, peer education and others...)
- Partnerships and Networking
- Community outreach, mobilization and referral for SRH services
- Provision of Youth- friendly ASRH services
- Community Engagement and participation
- Drama and Community theatre
- Follow up and Mentoring
- Reintegration and reunification
- Family integration and dialogue
- Condom promotion
- Counseling and guidance
- Monitoring and joint support supervision
- Others Specify
Please choose one of the good practices in the list above and write about it extensively using the template below as a guide.

<table>
<thead>
<tr>
<th>Element</th>
<th>Guiding Questions</th>
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</thead>
<tbody>
<tr>
<td><strong>Title:</strong></td>
<td>What is the name that best describes the good practice?</td>
</tr>
<tr>
<td><strong>Dates:</strong></td>
<td>When was the good practice published?</td>
</tr>
<tr>
<td><strong>Author:</strong></td>
<td>Who wrote the good practice document?</td>
</tr>
<tr>
<td><strong>Location/geographical coverage:</strong></td>
<td>What is the geographical origin of the good practice? This includes, when possible, country, region, province, district, and village</td>
</tr>
<tr>
<td><strong>Summary:</strong></td>
<td>What is the context and challenge being addressed? Please provide a short one or two sentence description of the good practice, What is the period during which the practice has been carried out? Please refer to how gender stands in both the challenge being addressed and the good practice itself</td>
</tr>
<tr>
<td><strong>Stakeholders and Partners:</strong></td>
<td>Who are the beneficiaries or the target group of the good practice? Who are the users of the good practice? Who are the institutions, partners, implementing agencies, and donors involved in the good practice, and what is the nature of their involvement? Please explain the different roles men and women play as they benefit from the good practice</td>
</tr>
<tr>
<td><strong>Method used:</strong></td>
<td>What methodology has been used or experimented with in order to lead to the good practice? What has been the process, and in what way has it been participatory? How often has the practice been carried out in order to derive the lessons learnt and identify the key success factors? Include gender aspects addressed in the description of the methodological approach</td>
</tr>
<tr>
<td><strong>Validation:</strong></td>
<td>Has the good practice been validated with all the stakeholders and final beneficiaries/users? What were the validation processes?</td>
</tr>
<tr>
<td><strong>Impact:</strong></td>
<td>What has been the positive impact on the beneficiaries’-both men and women -livelihoods? Please explain how the impact may differ between men and women. Have the beneficiaries’ livelihoods been positively affected environmentally, financially, and economically, and if yes how?</td>
</tr>
<tr>
<td><strong>Innovation and Success Factors:</strong></td>
<td>In what way has the good practice contributed to an innovation in the livelihoods of men and women? What are the conditions that need to be in place for the good practice to be successfully replicated?</td>
</tr>
<tr>
<td><strong>Constraints:</strong></td>
<td>What are the challenges emerging or that can emerge for men and women in applying the good practice? How can they be addressed?</td>
</tr>
</tbody>
</table>
**Constraints:**
What are the challenges emerging or that can emerge for men and women in applying the good practice? How can they be addressed?

**Lessons Learned:**
What are the key messages and learning to take away from the good practice experience, as much as for men as for women?

**Sustainability:**
What are the elements that need to be put into place in order to ensure the good practices is established in the long term?

**Up-scaling:**
What are the opportunities for and feasibility of up-scaling the good practice? What would be the challenges to be aware of, and conditions to put in place, to up-scale the good practice for both men and women? How can we to ensure the good practice is successfully transferred to both men and women in other contexts?

**Conclusion:**
Conclude about the impact and usefulness of the good practice. When possible, use

**Contact details:**
Who are the people responsible for the project one can contact, if they need more information about the good practice?

**URL of the practice:**
Where can one find the good practice on the Internet?

**Related Website(s):**
What are the Web sites of the projects to which the good practice is related? What are the projects in the context of which the good practice has been identified and replicated?

**Related resources that have been developed:**
What training manuals, guidelines, fact sheets, posters, pictures, video and audio documents, Web sites and else have been created and developed as a result of identifying the good practice?

**References**

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