

ANGLICAN CHURCH OF UGANDA

A TRAINING HANDBOOK FOR RELIGIOUS LEADERS AND CHURCH INSTITUTIONS

CHRISTIAN-BASED APPROACH TO:

**Maternal and Child Health
Sexual Reproductive Health**

HIV and AIDS

Gender

Gender Based Violence

Family Planning

Table of Contents

Acknowledgement	vii
Forward	viii
List of Acronyms	ix
MATERNAL AND CHILD HEALTH	1
1.0 INTRODUCTION	1
1.1 Why focus on Maternal and Child Health?	1
1.2 Maternal Morbidity and Mortality	2
1.3 Steps towards Safe motherhood	3
1.3.1 The Six Pillars of Safe motherhood	4
1.3.2 The Foundations of Safe motherhood:	5
1.4 Strategies for Integrating Maternal Health into Christian Health Education Programs	7
1.4.1 Strategy 1: Increasing Attendance of Antenatal Attendance (ANC).....	7
1.4.2: Strategy 2: Improving Access to Emergency Obstetrical and New Born Care (EMoNC)	10
1.4.3 Strategy 3: Increasing accesses to Family Planning (FP)	13
1.4.4 Strategy 4: Providing Adolescent Sexual Reproductive Health Services (ASRH)	14
1.4.5: Cross cutting Strategy Involving communities as major areas of intervention for reduction of maternal mortality	16
1.5 Male involvement and participation in reproductive health issues and services	17
SEXUAL REPRODUCTIVE HEALTH AND RIGHTS	23
2.0 INTRODUCTION	23
2.1 The full scope of SRH.....	23
2.2 Components of Sexual Reproductive Health	23
2.3 Sexual Reproductive Health and Rights (SRHR)	24
2.4 Sexual Reproductive Health and HIV	25
2.5 Integrating Reproductive Health Services for HIV-Positive Adolescents	25
2.6 Guiding Principles for Integrating SRH into Church Health Programmes.....	26
2.7 Community Involvement in Reproductive Health Services	26
2.8 Partnerships	26
2.9 Inclusion of Health Promotion activities	26
2.10 Advocacy for Sexual Reproductive Health Rights (SRHR)	26
2.11 Networking and Collaboration with Line Ministries	27
2.12 What can be done?.....	27
2.13 Role of the Stakeholders in realizing Reproductive Health Rights	27

HIV and AIDS	29
3.0 INTRODUCTION	29
3.1 Background of HIV	29
3.2 What do HIV and AIDS do in the Body?	30
3.3 Behaviours that Expose People to High Risk of Getting HIV	30
3.4 The Body Fluids in which HIV Survives	30
3.5 Three Modes of HIV Transmission	30
3.6 Relationship between HIV infection and STI's?	31
3.7 Ways of Preventing HIV Transmission	31
3.8 Using Condoms Correctly	32
3.9 Benefits of Testing for HIV	33
3.9.1 Possible HIV test Results	34
3.10 HIV Couple Discordance.....	34
3.11 Disclosure.....	34
3.12 HIV and Gender Perspectives	35
3.13 HIV Vertical Transmission.....	36
3.13.1 Elimination of Mother-to-Child Transmission of HIV (EMTCT).....	36
3.14 The Role of the Church in Preventing HIV and AIDS.....	40
GENDER	42
4.0 The Concept of Gender:	42
4.1 Difference between Sex and Gender	42
4.2 Status of Gender Inequality in Uganda	42
4.3 Gender and Sexual Reproductive Health or Maternal Health	45
4.4 Gender and Culture	46
4.5 Gender and Religion	47
4.6 Women in Development (WID) and Gender and Development (GAD)	48
4.6.1 Women in Development (WID) Approaches	49
4.6.2 Gender and Development (GAD) Approaches.....	50
4.7 Gender Roles between Men and Women	51
GENDER-BASED VIOLENCE	53
AN OVERVIEW OF GENDER-BASED VIOLENCE.....	53
5.0 What is Gender-based Violence?	53
5.1 Root Causes of GBV	53
5.2 Causes or Contributing Risk Factors of Gender-based Violence	55
5.3 When and Where does Gender-based Violence Occur?.....	56
5.4 Types of Gender-Based Violence	57

5.5	Consequences of Gender-Based Violence	57
5.5.1	Consequences of Domestic Violence for Individuals, Families and Communities:.....	58
5.6	The Impact on Gender-based Violence on Women’s Health	59
5.6.1	Physical and Psychological Health Problems.....	59
5.6.2	The Impact on Women’s Family and Dependants.....	60
5.6.3	The Impact of Violence on the Perpetrators	60
5.6.4	The Impact of Violence on Society:	60
5.7	Services to the Victim/Survivor	61
5.8	Human Rights in the Context of GBV	63
FAMILY PLANNING.....		72
6.1	Need for Family Planning	72
6.2	Status of Family Planning in Uganda	72
6.3	Family Planning Methods	72
6.3.1	Natural Methods.....	73
6.3.2	Artificial Methods.....	74
6.3.3	Barrier Methods	79
APPENDIXES		88
KEY DEFINITIONS AND REFERENCES.....		91
Chapter One:	Key Definitions.....	91
Chapter One:	References	92
Chapter Two:	Sexual reproductive health Operational Definitions.....	92
Chapter Two:	References	93
Chapter Three:	Key Definitions.....	93
Chapter Three:	References	94
Chapter Four:	Key Definitions.....	94
Chapter Four:	References	95
Chapter Five:	Operational Definitions.....	95
Chapter Five:	References	96
Chapter Six:	Operational Definitions.....	96
Chapter Six:	References	96

LIST OF FIGURES

Table 1: WHO’s Millennium Development Goals (MDGs):..... 1

Table 2: Reproductive Health Indicators in Uganda..... 1

Table 3: Stakeholders and their Expected Collaborative Efforts 20

Table 4: Child Related Health indicators in Uganda..... 21

Table 5: Difference between Sex and Gender 42

Table 6: The difference between WID and GAD 49

Table 7: Activity profiles for Gender Analysis..... 50

Table 8: Common Gender Roles Stereotypes..... 51

Table 9: Summary of the Causes or Risk Factors of Gender-based Violence 55

Table 10: Health Consequences (Non-Fatal health consequences of GBV)..... 58

Table 12: Synopsis of Involvement of Men and Women in Church of Uganda and Decision Making and Leadership Activities 70

LIST OF FIGURES

The pie-chart below indicates the causes of maternal mortality:..... 3

Figure 1: Causes of Maternal Mortality..... 3

Figure 2: Figure Depicting the Six Pillars of Safe motherhood 4

Figure 3: Pillars of Primary Health Care..... 6

Figure 4: Examination of a pregnant woman by a health worker 8

Figure 6: Hardship faced by Ugandan women when travelling to health units 12

Figure 7: The Three Delays Model 13

Figure 8: Male Involvement in Reproductive Health Issues and Services 18

Figure 9: Indicates the Four pronged Approaches to EMTCT Strategy 37

Figure 10: Figure Depicting the Lifecycle of Gender Discrimination and Health 43

Figure 11: Chart indicating Contraceptive Prevalence Rate (CPR) by Region (%)..... 71

Acknowledgement

Church of Uganda is grateful to United Nations Population Fund for supporting the development and publication of this handbook. We would like to especially thank Dr. Ochan Wilfred and Ms Acema Peace who provided valuable support during the development of this handbook. In special way would also want to thank Uganda Christian University Team of Dr. Fabian Nabugoomu, Dean Faculty of Health Sciences UCU, Dr. Edward K. Kenyesigye, Senior Lecturer and Head Department of Health Sciences, Dr. Rev. Alex Kagume, Rev. Amos Turyahabwe, and Ms Harriet Nakanyike for their contribution in the development, design and Christian perspective in reproductive health.

Special thanks also go to the health department team especially Ag. Provincial health coordinator Mr. Joseph Adweka and Dr. Twesigye Patrick for their tearless effort in having the book pre tested edited and printed.

We are also very grateful to the leadership of Church Of Uganda Provincial Secretariat provided by Rev. Canon George Bagamuhunda provincial secretary, Mr. Richard Obura provincial Treasurer, Mr. Vasco Kura Provincial Education coordinator.

In addition we are very grateful to the dioceses that are implementing the UNFPA program for their great contribution in the pretesting of the handbook.

We also benefited greatly from the ideas and contributions of many individuals from different institutions. Some of them participated in the four-day workshop in April 2010 to define the final content of the handbook.

Then the line ministries, Ministry of Health, Ministry of Education and Ministry of Gender, Labour and Social development for their efforts in reviewing the draft handbook.

Forward

The church of the province of Uganda is committed to helping government of Uganda achieve the millennium development goals. In this respect millennium development goals 3,4,5 and 6 on gender equality and empowerment, reduction of child morbidity and mortality, improvement of maternal health, and combating HIV/AIDS, Malaria and other diseases respectively. This is to be done through supporting all programs that promote communication on health matters using a Christian based approach targeting religious leaders at all levels of Church of Uganda institutions.

This hand book offers a unique opportunity to equip religious leaders with update knowledge on sexual reproductive health, family planning, maternal child health, HIV/AIDS, Gender equality and Gender based violence with relevant scriptural references. Use of this hand book will help guide us religious leaders in development of short messages on reproductive health for integration in church sermons, marriage counseling sessions and other Christian gatherings where one has to communicate. This will enable us communicate a uniform message on reproductive health based on scientific facts while upholding our Christian values. As Church of Uganda the hand book will go a long way in helping us achieve our mission that is to fulfill Christ's mission through holistic teaching, evangelism, discipleship and healing for a healthy and Godly nations as well as have social economic transformation of our congregation.

I use this opportunity to appeal to all men and women of Christ to seek and share information on reproductive health so that we can eradicate all preventable causes of maternal death, child death, and gender based violence and HIV/AIDS as we live complete fulfilling lives.

I extend our sincere gratitude to our development partners in this case United Nations Population Fund (UNFPA) for the support extend to us that has enabled us develop this hand. I also thank Uganda Christian University, line ministries of Health, Education and Gender for the technical support offered in development of this hand book.

Let us continue to work together to serve God's people. God bless you all



The most Rev. Stanley Ntagali
Archbishop of Church of Uganda

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	AnteNatal Care
ART	Anti-Retro Viral Therapy
ASRH	Adolescent Sexual Reproductive Health
AFHS	Adolescent Friendly Health Services
BEMoC	Basic Emergency Obstetrical Care
CBO	Community-Based Organization
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CEMoC	Comprehensive Emergence Obstetrical Care
CGS	Cross Generational Sex
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DRC	Democratic Republic of Congo
EOC	Emergency Obstetrical Care
FGC	Female Genital Cutting
FP	Family Planning
GBV	Gender-Based Violence
Hb	Haemoglobin
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HSSP	Health Sector Strategic Plan
IEC	Information Education and Communication
IFC	Individuals, Families and Communities
IUCD	Intrauterine Contraceptive Device
IPT	Intermittent Presumptive Treatment
MCH	Maternal Child Health
MoA	Ministry of Agriculture
MoFPED	Ministry of Finance Planning and Economic Development
MoLG	Ministry of Local Government
MoLGSD	Ministry of Labour Gender Social Development
MoD	Ministry of Defence
MoW	Ministry of Works

MPS	Making Pregnancy Safer
MTCT	Mother To Child Transmission of HIV
MVA	Manual Vacuum Aspiration
NGO	Non Governmental Organization
PAC	Postal Abortion Care
PHC	Primary Health Care
PLWA	People living with AIDS
PNC	Postnatal Care
PSI	Population Services International
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health Rights
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Diseases
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TT	Tetanus Toxoid
UCU	Uganda Christian University
UJCU	Uganda Joint Christian Council
UNFPA	United Nations Population Fund
VAW	Violence against women
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
WHO	World Health Organization

1

MATERNAL AND CHILD HEALTH

1.0 INTRODUCTION

Improving maternal health and reducing maternal mortality have been key concerns of several international summits and conferences since the late 1980s, including the Millennium Summit in 2000. At the United Nations (UN) Millennium Summit in September 2000, world leaders initiated the Millennium Development Goals (MDGs) and set the year 2015 as the completion date for the project and the table below indicate these MDGs.

Goal 1:	Eradicate extreme poverty and hunger
Goal 2:	Achieve Universal Primary Education
Goal 3:	Gender equality and empowerment of women
Goal 4:	Reduce child morbidity and mortality 75% by 2015
Goal 5:	Improve maternal health by 75% by 2015
Goal 6:	Combat HIV/AIDS, malaria, and other diseases
Goal 7:	Ensure environmental sustainability
Goal 8:	Develop global development partnerships

From the above table, **goals 4, 5, and 6** are the health-related Millennium Development Goals.

Maternal Indicators	
Total fertility rate (TFR)	6.9 children/ woman
Maternal Mortality Ratio	435 /100,000 Live births
HIV Sero-prevalence	6.2%
Total Population	32 million
Population Growth Rate	3.4%
Access to Health Services	69%
Deliveries in Health Facilities	36.6%

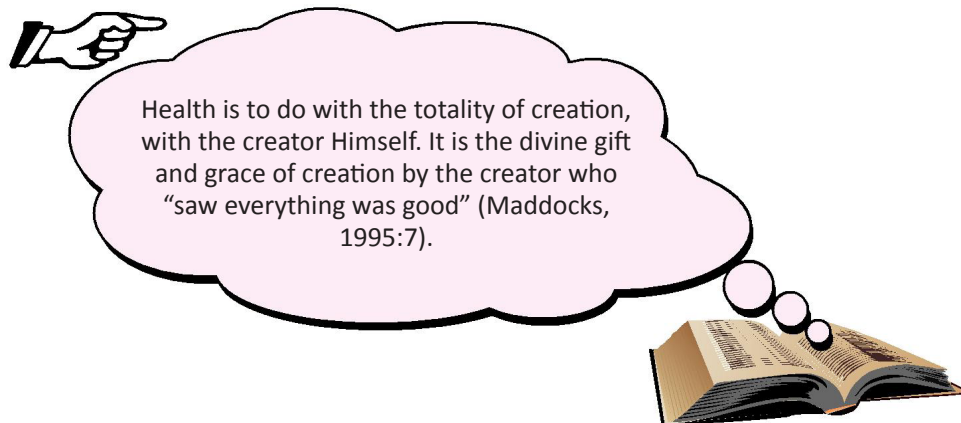
Note: Maternal mortality ratio is the indicator used to track the status of MDG five.

1.1 Why focus on Maternal and Child Health?

- In developing countries, pregnancy and childbirth are the leading causes of death, disease and disability among women of reproductive age group [18 - 45years].
- Maternal health issues account for at least 18% of the burden of disease in women of the reproductive age group – more than any other single health problem.
- Maternal health interventions are among the most cost-effective investments in health.

- Mothers care for children more, and if a mother is ill or dies, her children do not get care they deserve. Research has shown that children who do not have their mothers are ten times more likely to die as compared to those who have their mothers.

From Christian point of view,



1.2 Maternal Morbidity and Mortality

The causes of maternal ill health and death broadly falls under three categories namely: Direct, indirect and other causes.

1. Direct [pregnancy-related] Causes:

Fifteen (15%) of all pregnancies have complications which include: bleeding (24%), infections (15%), and unsafe abortion (13%), hypertension [convulsions] (12%), and prolonged labour (8%) (REDUCE Data, 2004).

2. Indirect [Non-pregnancy-related] Causes:

Indirect or non-pregnancy related causes include: HIV/AIDS, Tuberculosis, Pneumonia, Malaria, and other medical diseases [Refer to figure 1 that shows the proportionate causes of maternal Mortality]. Evidence suggests that HIV infection in pregnant women increases the risks of complication causing maternal death.

3. Other Causes and Predisposing Factors:

- A woman can die regardless of whether she is pregnant or not, other predisposing factors may include: accidents, burns, injuries, suicide, death during wars to mention but a few.
- High poverty levels, gender inequalities, low education levels, poor male involvement, poor health seeking behaviour and negative cultures.
- Disabilities due to pregnancy and childbirth: chronic anaemia, fistulae, chronic pelvic pain, emotional depression, and maternal exhaustion.

The pie-chart below indicates the causes of maternal mortality:

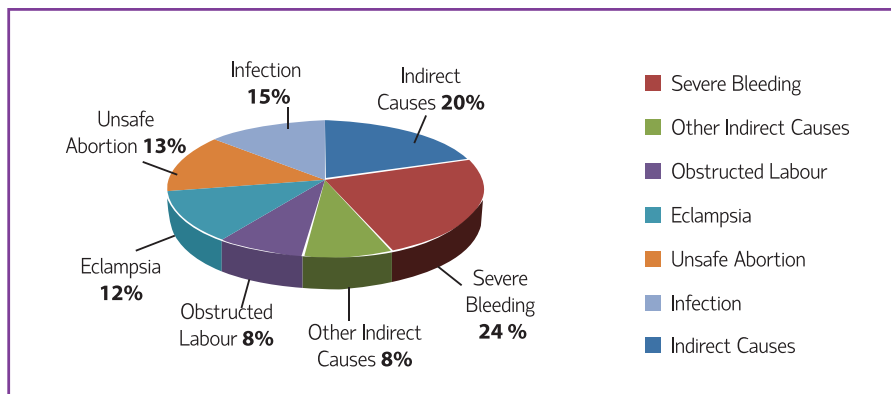


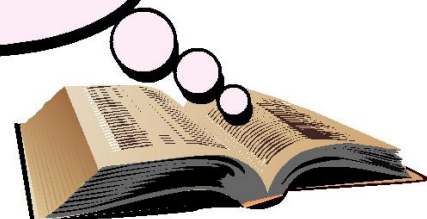
Figure 1: Causes of Maternal Mortality

From Christian point of view,

Suffering is not God’s will because;



From the beginning God created man healthy and intact. But due to wrong choices of sin – (disobedience) man started suffering and the consequences such as pain, labour pain, hard work and eventually death followed thereafter. **(Genesis 3: 16-19.)** The good news is that Jesus came so that human kind can experience life in all its fullness and including good health **John: 10.10**

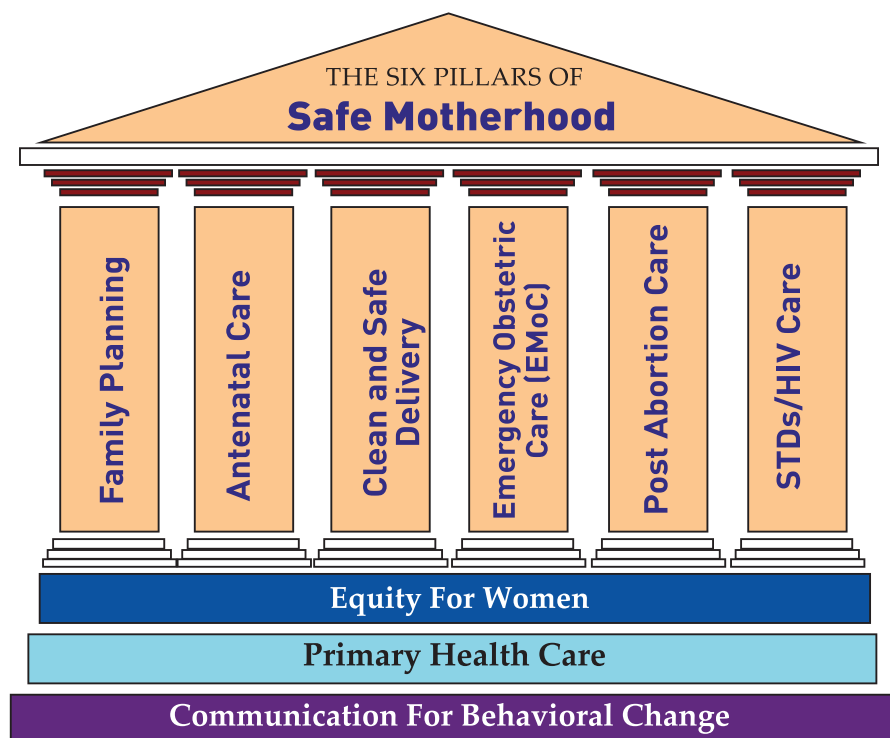


1.3 Steps towards Safe motherhood

Safe motherhood is a programme for ensuring that all girls and women receive the care they need to be safe and healthy throughout pregnancy and childbirth. This can be made possible by providing timely, appropriate and comprehensive quality obstetric care during preconception, pregnancy, childbirth and puerperium special emphasis to emergency obstetric care.

1.3.1 The Six Pillars of Safe motherhood

Figure 2: Figure Depicting the Six Pillars of Safe motherhood



Source: WHO, *Making Pregnancy Safer (MPS)*, 2002

Pillar 1: Family planning

Family planning allows individuals and couples to anticipate and attain their desired number of children, the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.

Pillar 2: Antenatal care

Early and regular Antenatal care- prevents maternal/infant morbidity and mortality by encouraging early detection of high risk mothers, complications of pregnancy, early treatment and referral of difficult cases, prevention and treatment of STDs and HIV and other conditions.

Pillar 3: Clean and safe delivery

Clean safe delivery involves updating knowledge of the health workers, equipping of all health units, maintenance of equipments and applications of life saving skills such as manual removal of placenta. This promotes maternal/infant health by preventing the five major causes of maternal mortality as discussed in section 1.2.

Pillar 4: Emergency Obstetrical care

Emergency obstetrical care promotes identifying and managing danger signs, counselling the mother on maternal nutrition during lactation as well as providing family planning services. Other services include: promoting good traditional social support and conducting maternal mortality audits.

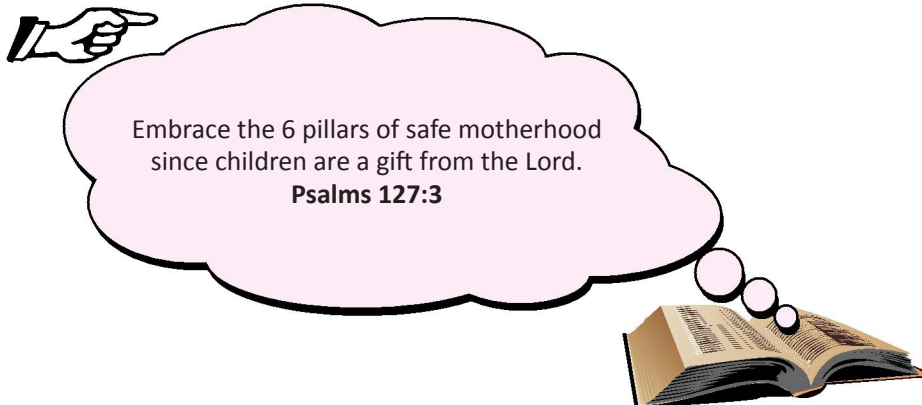
Pillar 5: Post-abortion Care (PAC)

Train and equip personnel to offer Manual Vacuum Aspiration (MVA), counselling and providing family planning services as well as starting prompt treatment for post abortion infections (Sepsis).

Pillar 6: STD/HIV Control

This can be done by offering voluntary counselling and testing (VCT), screening pregnant women for syphilis, managing cases and their complications, and continuous implementation of prevention strategies.

From Christian point of view,



1.3.2 The Foundations of Safe motherhood:

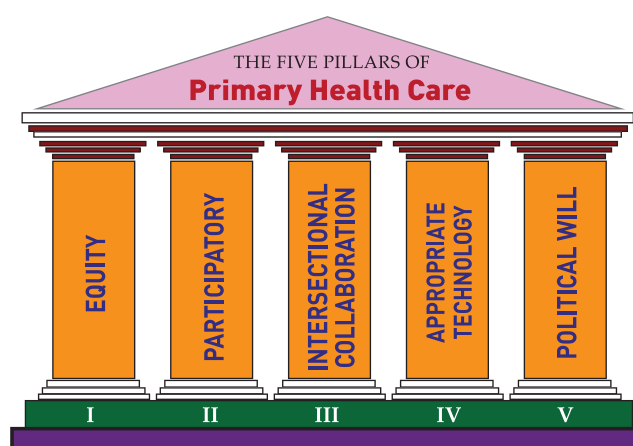
(i) Primary Health Care

Primary health Care (PHC) is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

The 5 Pillars of Primary Health Care (PHC)

1. Equity made universally accessible to individuals and families.
2. Participatory – through their full participation
3. Inter-sectoral collaboration by involving all the line ministries (refer to table 3)
4. Appropriate technology
5. Political will

Figure 3: Pillars of Primary Health Care



Components of Primary Health Care (PHC)

1. Health Promotion and Education
2. Promotion of food supply and proper nutrition
3. Safe water supply and basic sanitation
4. Maternal and Child Health including Family Planning
5. Immunization against major diseases
6. Prevention and control of local diseases
7. Appropriate treatment of common diseases
8. Provision of essential drugs.

(ii) Equity for Women

Mothers are at times have limited access to information or resources to preserve their lives and that of their children. They lack “bargaining power” as in when to have children and how many children they should have. Equity for women emphasizes empowering women to have equal opportunities as men.

(iii) Behaviour Change Communication

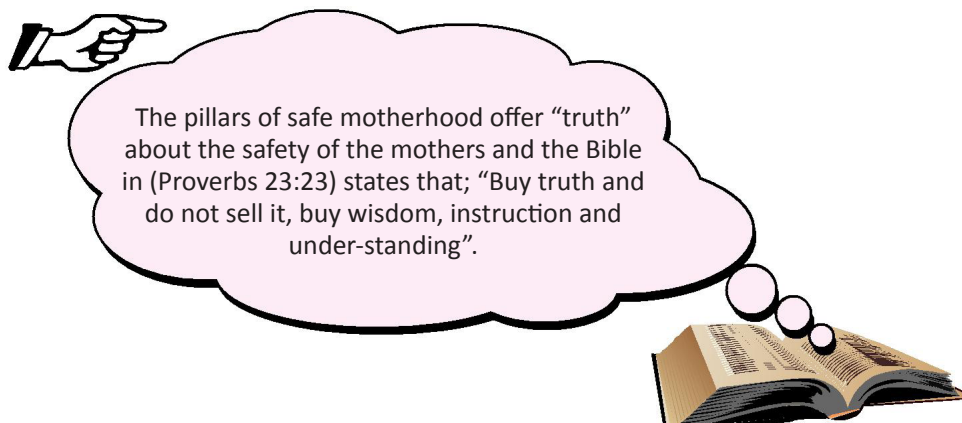
Behaviour change is a set or sets of interventions geared at influencing positive change and transformation in an individual, group or society.

Behaviour change Communication (BCC) approaches such as information, education and communication (IEC), social marketing, and behavior change communication (BCC) represent systematic attempts to influence positively the health practices of large populations. Their main goal is to bring about improvements in health-related practices.

Integrating Primary Health Care into Maternal Health Services Requires:

- Organized efforts by the government and the private health sector through Public-Private Partnerships (PPPH) for maternal health services.
- Integration of the prevention, curative, and rehabilitative components of primary health care.
- Conducting outreaches by collaborating with the Village Health Teams (VHTs) that reach out to the households.

From Christian point of view,



1.4 Strategies for Integrating Maternal Health into Christian Health Education Programs

The Government of Uganda is committed to the improvement of maternal mortality through implementation of the Health Sector Strategic Plan (HSSP I, II and III) which is the roadmap, pegged to the key strategic areas for the reduction of maternal mortality.

The key interventions contained in the Making Pregnancy Safer (MPS), needed for achieving the targeted goal of 50% reduction in maternal deaths are discussed under 4 key strategies below:

1. Increasing Antenatal Attendance (ANC)
2. Increasing Access to Emergency Obstetric and Newborn Care (EmONC)
3. Increasing Access to Family Planning (FP)
4. Providing Adolescent Sexual Reproductive Health (ASRH) services

1.4.1 Strategy 1: Increasing Attendance of Antenatal Attendance (ANC)

Ante-natal care is defined as a planned programme of medical management of pregnant women directed towards making pregnancy and labour a safe and satisfying experience with an outcome of a healthy baby and mother.

Current Practice of Antenatal Care

The current practice is that 94.9% of the mothers attend antenatal care at least once however only 47.6% attend 4 or more visits as recommended by WHO standards. In order to attain the desired standards, all women should have four or more visits of at least twenty minutes each visit, where women can access:

- Multivitamins
- Iron/folic acid supplements
- Two tetanus injections
- Various laboratory investigations test

This has resources implications since it involves increasing the existing resources including: health facilities, equipment, health facility staff and staff remuneration.

Status of Antenatal Care:

- Only 47% of women attend the recommended four times during antenatal (UDHS, 2011).
- Only 23% of women get post partum care during the first two days following child birth.



Figure 4: Examination of a pregnant woman by a health worker

Importance of Attending Antenatal Care:

- To ensure that women should go safely through pregnancy, child birth and have healthy infants to prevent maternal, peri-natal and infant deaths.
- To promote good health in pregnancy in order to have a healthy mother and baby through detection, treatment and prevention of disease.
- To identify and treat problems during pregnancy such as anaemia and infections.
- It is during antenatal care visit that screening for complications and advice on a range of issues including place of delivery and referral of mothers with complications occur.
- It is through ANC that HIV+ is screened and PMTCT is carried out to have HIV free infants.

Effective Interventions included in focused antenatal care:

- Iron/Folic acid supplementation as well as de-worming
- Intermittent Presumptive Treatment (IPT2) of Malaria
- Routine Counselling and Testing (RCT) and Anti-retro Viral (ARV) therapy
- Counselling on dual method of protection
- Hemoglobin estimation
- Syphilis detection and in case the woman has syphilis treatment is administered to prevent congenital abnormalities.

The Radical Model of ANC:

This model emphasizes four (4) visits for those at lowest risk;

1. The first as early as possible, preferably before the 12th week
2. The second at or near the 26th week
3. The third near 32nd week
4. The fourth during weeks 36 to 38

Out of 47% of the pregnant women that attend antenatal, only 32% deliver from a health facility.

The Medical Model of ANC encompasses;

- Registering pregnant women
- Detailed questioning about their health and family health through a checklist.
- Physical examination to gather biophysical characteristics such as gait, height, weight and abdomen where the baby may be felt.
- Laboratory investigations.
- Prevention of diseases by administering Tetanus Toxoid (TT) immunisation, medications (Fansidar/IPT) for malaria, iron/folic and vitamins to prevent anaemia, Highly Active Antiretroviral Therapy (HAART) for all HIV positive mothers to prevent them from passing HIV to the unborn baby.
- Treat diseases like syphilis.
- Promote healthy habits: good nutrition and encourage the pregnant woman to rest.
- Modification of behaviour change: avoid smoking, avoid alcohol, and practice safe sex.
- Learn about danger signs or how to recognise disease or problems that develop during pregnancy.
- Prepare for the birth of the coming baby.

The following conditions can be detected and prevented through antenatal care attendance:

- (a) Bleeding (Haemorrhage) may arise any time during pregnancy, labour and puerperium. It may be due to spontaneous early abortion or placenta previa. In case of spontaneous abortion urgent medical attention is required in form of PAC. For placenta previa, medical care and management is offered so as to reduce maternal mortality.
- (b) Reduced blood levels (Anaemia) intensifies the effects of bleeding, thus iron prophylaxis should be given especially in the areas of high anaemia prevalence.
 - Antenatal care reduces the proportion of women with low Haemoglobin (Hb) level and the need for blood transfusions post partum.
- (c) Infection after Delivery (Puerperal Sepsis) is mainly due to unclean home deliveries, higher rates of genital tract infections and poor hygiene after the rupture of membranes.
 - Antenatal care provides health education on how to deal with spontaneous preterm rupture of membranes.
- (d) Very high blood Pressure during pregnancy (Preeclampsia) is diagnosed by a raised blood pressure measurement and detection of protein in the urine. The mother's weight should be regularly recorded and high risk mothers should be followed-up more closely or referred to higher levels of care [especially young primigravida, those with eclampsia or Preeclampsia in previous pregnancies].
 - Antenatal care leads to improved survival especially when the pregnant woman has underlying hypertensive disorder because they are detected and managed.
- (e) The baby getting stuck (Obstructed labour): During the first pregnancy, maternal height is used to select those with low stature for hospital delivery.
- (f) Deaths due to unsafe abortion During antenatal care; the health provider educates the mother about family planning and dangers of unsafe abortion.

Note: Antenatal care alone does not reduce maternal mortality. However, maternal mortality can be reduced by combining resources within the health care delivery system, such factors include training more skilled attendants and having an enabling environment.

Challenges:

- Insufficient awareness on danger signs and safe motherhood in general
- Low status of women decision making
- Poor Education level
- Poor health seeking behaviour
- High fertility rate
- Poor infrastructure and poor transport system in rural areas

1.4.2: Strategy 2: Improving Access to Emergency Obstetrical and New Born Care (EMoNC)

Emergency Obstetrical Care is urgent medical care given to a woman for complications related to pregnancy, labour, delivery and puerperium.

Basic EmOC includes:

Parental (intra-venously administered medicine) antibiotics; parental oxytocic drugs; parental sedatives for eclampsia; manual removal of the placenta; manual removal of retained products; assisted vaginal delivery.

Comprehensive EmOC: includes:

This includes all the intervention under **Basic EmOC PLUS**; Surgery (caesarean section), anaesthesia, and blood transfusion.

A needs assessment of Emergency Obstetric Care revealed that basic EmOC was available in only 4% of Health Centre III and Comprehensive Emergency Obstetrical Care (CEmOC) was available in only 6% of the Health Centre-IV and 65% of the hospitals and yet 15% of all pregnancies have complications like bleeding, hypertension, convulsions and obstructed labour can only be treated when EmOC services are available.

Effective Interventions:

Emergency Obstetrical Care for the mother:

1. Appropriate monitoring of labour progress
2. Timely caesarean sections
3. Safe blood transfusion
4. Prompt management of Eclampsia
5. Prompt management of Sepsis and Post abortion care

Emergency Obstetric Care for the Newborn:

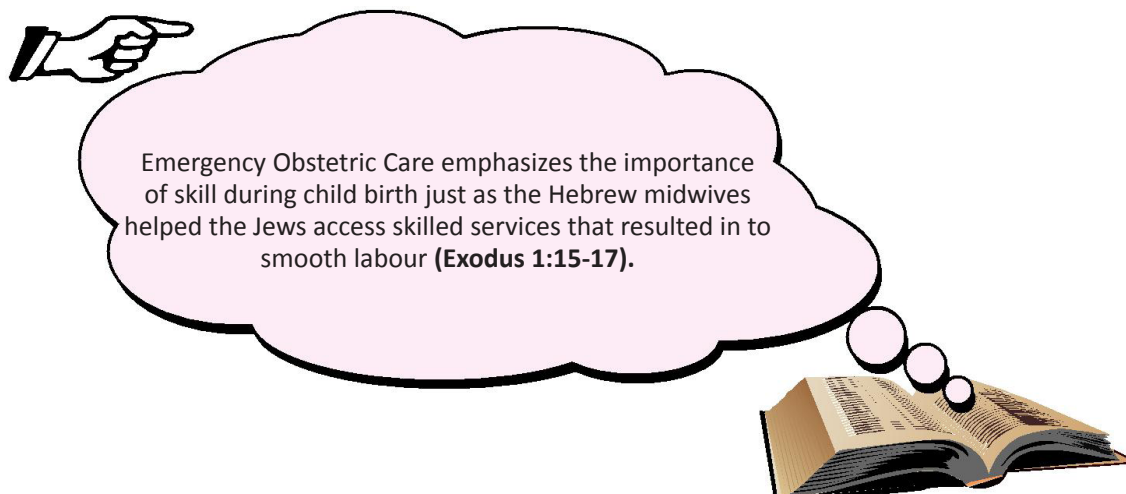
1. Essential newborn care and resuscitation by providing appropriate resuscitation measures
2. When required ensure clear air entry (for proper breathing)
3. Providing warmth to the newborn

4. Ensuring clean cord and eyes to avoid infections.
5. Initiating exclusive breast feeding

Requirements of Good Emergency Obstetric Care:

1. Information on signs of labor, what to expect and what to do
2. Monitoring labour and documenting
3. Referral if it becomes necessary
4. Provision of clean supplies [Maama Kit]
5. Networking with National Medical Stores (NMS) to provide drugs required for safe delivery
6. Communication with the family members especially the spouse
7. HIV testing and counselling for MTCT of HIV
8. Infant feeding options

From Christian point of view,



Constraints in Implementing Emergency Obstetric Care

The Three-Delays-Model:

According to Dr. Sentumbwe, WHO, most women die either during pregnancy, childbirth or with in the first six weeks after delivery and this is largely due to three major delays;

(1) Delay at household level:

This is closely linked with inability to appreciate the danger signs of pregnancy and delivery and this is usually due to inadequate knowledge and poor health seeking behaviour. In addition, some cultural/ traditional practices restrict women from seeking health care the woman is so much dependent on the decisions made by the man. The woman cannot leave her home without permission from her husband or others.

(2) Delay in accessing health facilities:

This delay is related to inability of pregnant woman (especially those with complications of labour) to access available facilities when the need arises. This can be due to inappropriate location of the health facilities, poor roads and communication network, lack of means of transportation and inadequate community support. Even where health facilities are available, the woman or family may not have sufficient resources

to seek appropriate health care as more than 38% of the population lives below the absolute poverty line. [Poverty at the household level also limits decision making to seek health care]

- Deaths occur due to poverty, delays at home or community and lack of transport.
- Public transport is inappropriate or not feasible for the woman with complications or in labour.
- Families are too poor to afford private transport or pay for fuel for a government ambulance.



Figure 6: Hardship faced by Ugandan women when travelling to health units

(3) Delay in accessing care at the health facility:

(Phase three. receiving adequate and appropriate treatment)

- This is the most critical and worst delay for the survival of the pregnant woman and her new-born. It refers to the time between the woman's arrival at the health facility and the time she receives definitive management.
- At the facility level, preparedness to respond to obstetric emergencies is key to the survival of women and the new-born.
- Many health facilities lack skilled attendants, equipment, drugs and supplies to provide the much needed appropriate care.
- Commodities like blood are largely inadequate in health facilities, hence haemorrhage accounts for 26% of all causes of maternal deaths.
- Maternal deaths surveys in hospitals showed that most maternal deaths occur due to lack of:
 - Blood
 - Intravenous fluids (IV) fluids
 - Ergometrine
 - Antibiotics
 - Magnesium sulphate
 - Inadequate staffing

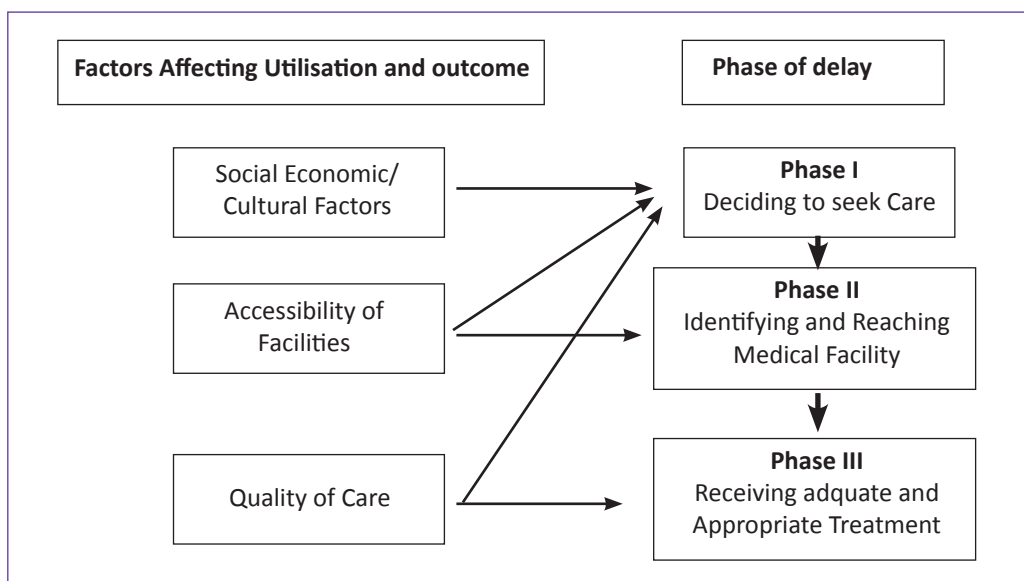


Figure 7: The Three Delays Model

The three delays model helps programme implementers and communities to understand the determinants of maternal mortality. Unless the three delays are addressed, maternal mortality will still remain a big challenge in developing countries.

1.4.3 Strategy 3: Increasing accesses to Family Planning (FP)

Currently, 26% of the pregnancies occur too early, 22% too late, 28% too soon and the remaining 24% too many yet the wanted fertility rate is just 4.8 among women, and 5.6 among men.

Family planning is a national priority program to reduce maternal and child morbidity and mortality rates, to reduce poverty at household level, and to promote economic development at all levels.

Effective Interventions:

Strengthening Family Planning services and increase uptake (utilization) by;

- Strengthening family planning information and service provision for women, men and couples who space or limit their child bearing thus preventing unwanted and/or untimely pregnancies that increase the risk of maternal death.
- Providing information and services that will enable individuals and couples to decide freely and responsibly when, how often and how many children to have.
- Providing adequate commodities for appropriate method mix at all levels.
- Training of health workers in family planning service delivery skills.
- Educating communities on benefits of family planning.

This can be achieved through;

- Increasing the number service delivery points
- Encouraging adolescents to delay first pregnancy
- Keeping girls in school
- Encouraging couples to space births
- Updating service providers' skills

- Contraceptive technology
- Counselling for family planning

Family planning has a greater impact on maternal mortality in high-fertility populations and it reduces maternal mortality in three ways:

- (i) By reducing the proportion of births to high-risk women,
- (ii) By eliminating unwanted pregnancies that may end in unsafe abortions, and
- (iii) Reducing the total number of births.

By enabling women to plan, space, and prevent pregnancies, family planning could prevent thousands of maternal deaths. Spacing births three to five years apart not only improves child survival, but also can save mothers' lives.

Increasing family access to and availability of quality client-centred family planning information and services, where a wide range of effective contraceptive methods is offered and responsive counselling provided, reduces the number of unplanned pregnancies that often lead to unsafe abortion procedures.

Strategic Results/Outputs:

Meeting the unmet need for family planning (35%) services would reduce pregnancies as well as maternal deaths.

Challenges:

- Access to family planning is challenged by failure to target single women, men, adolescents and promoting new methods such as emergency contraception.
- Myths and misconceptions by intended users of family planning
- Poor response to adolescent family planning services
- Stock outs of family planning commodities at health facility level

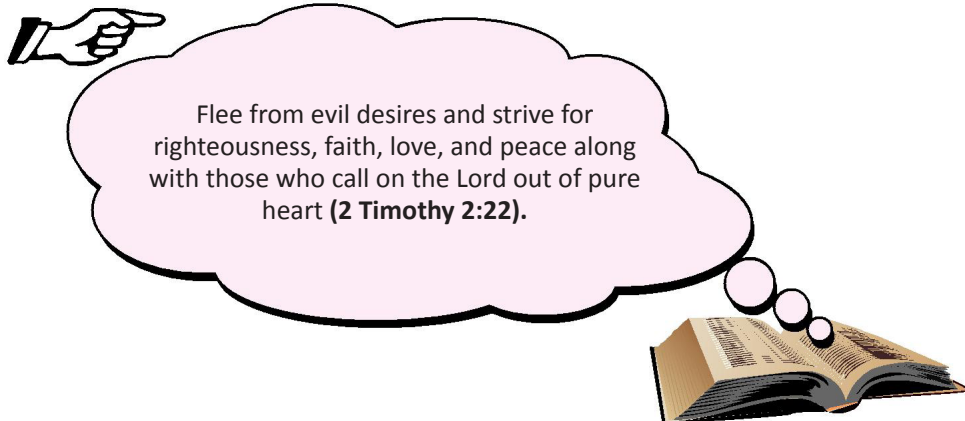
1.4.4 Strategy 4: Providing Adolescent Sexual Reproductive Health Services (ASRH)

According to **WHO**, adolescents are individuals between the age of 10 and 19 years of age.

Why focus on Adolescent Sexual Reproductive Health (ASRH)

- To address Adolescent Sexual and Reproductive Health (ASRH) issues that affect adolescents.
- To increase the proportion of adolescents who accurately assess their risk of STIs, HIV/AIDS and pregnancy and take appropriate action.
- To have empowered adolescents who accurately assess their risks and take precautions.
- Adolescents are important for the future development of institutions and society as a whole. However they are affected by a range of problems that threaten their well-being and survival.

From Christian point of view,



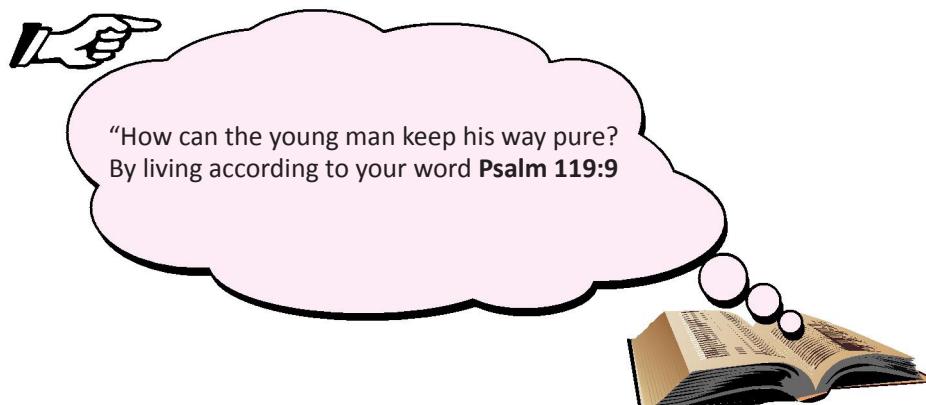
Health problems that affect adolescents:

- Early and unprotected sex
- Unwanted pregnancy
- Substance abuse
- Unsafe abortion
- Sexually transmitted infections (STIs) including HIV/AIDS

Effective Interventions include:

- Information on sexuality and reproductive health
- Adolescent Friendly Health Services (AFHS)
- Youth centers for promoting good character formation
- Life skills acquisition and income generation activities
- Promotion of girl child education and eliminating harmful customary and traditional practices, including early and forced marriages
- Ensuring access to reproductive health services; to essential antenatal care, including immunizing mothers with Tetanus Toxoid (TT)
- Providing skilled assistance at delivery.

From Christian point of view,



Challenges

- Limited access to valid and accurate ASRH information, anxieties due to puberty a period when growth processes reflected in the physical and psychological changes, low-risk perception regarding HIV/AIDS.
- Inadequate values to support adoption of preventive behaviours and inadequate life planning skills.

Lack of integration of ASRH into the existing co-curricular activities in schools for example drama, debating clubs and sports.

- Social cultural practices that impact negatively on ASRH for example early marriage and Female Genital Cutting (FGC).
- Unaffordable cost of ASRH services in private health facilities for young people.
- Inadequate support and commitment of the decision makers and local leaders to ASRH matters.
- Inadequate capacity/resources to implement integrated friendly ASRH services.

1.4.5: Cross cutting Strategy Involving communities as major areas of intervention for reduction of maternal mortality

Empower communities to utilise services for maternal and new born care and to ensure a continuum of care between the household and the health care facility (WHO Working with Families Individuals, and Communities, IFC, 2000).

Goal: To contribute to the empowerment of women, families and communities to improve and increase control over maternal and new-born health, as well as to increase access and utilization of quality health services, particularly those provided by skilled attendants.

Effective Interventions:

The above goal will be achieved through strengthening of the referral linkages by;

- (i) Educating women and communities on danger signs, birth and emergency preparedness
- (ii) Community action for health by encouraging community responsibility for the transfer of pregnant women in emergencies
- (iii) Reinforcing inter-facility referral flow
- (iv) Providing functional transport and equipment
- (v) Institutional strengthening and local advocacy, implemented largely in the settings of household, community and health services (IFC, WHO, 2000).

The intervention of working with Individuals, Families and Communities (IFC) is organised into the following four (4) key priority areas:

1. Developing **CAPACITIES** to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies;
2. Increasing **AWARENESS** of the rights, needs and potential problems related to maternal and newborn health;
3. Strengthening **LINKAGES** for social support between women, men, families and communities and with the health care delivery system;
4. Improving **QUALITY** of care and of health services and of their interactions with women, men, families and communities.

A healthy community for pregnant women, mothers and newborns is an informed, participatory and supportive community, playing an active role for supporting access to skilled care, such as developing financing and transport schemes, as well as supporting other maternal and newborn health needs, for example, reduced workload of pregnant women, supporting breast-feeding and others.

The role of men and other influential decision-makers is to be critical when designing healthy community programmes for maternal and newborn health.

Community involvement in analyzing information on maternal and newborn health creates awareness, and at the same time stimulates social support and participation in problem-solving related to maternal and newborn health. This involvement contributes to the establishment of mechanisms for transparency and accountability of health services to the community (IFC, WHO, 2002).

Challenges in the implementation of the IFC strategy:

The greatest challenge is resource mobilisation, including a number of “hidden resources” (local organizations, traditional structures, groups) to integrate or link them into the district health system. The key principle is to start with what exists and build on it. Partnerships and formal collaboration and coordination between stakeholders are required to develop coherent implementation processes at the district, intermediary and national levels (Sentumbwe, IFC, WHO, 2002).

Conditions Needed:

In order to achieve the desirable outcomes reflected in the above strategies, the following conditions are necessary:

1. Strong political commitment at all levels to maternal and newborn health and survival by political leaders, decision makers and developmental partners at national and local levels [Commitment]
2. A clear focused national maternal health and survival strategy [Strategy]
3. A realistic, appropriate, and sufficient investment in the maternal health and survival strategy [Investment]
4. An implementation framework with clearly defined supervision, monitoring, and evaluation mechanisms [Implementation]
5. Strengthening the referral systems to respond to critical needs of pregnant women and newborns.
6. Community involvement and participation
7. Resource mobilization and partnership
8. Realistic and appropriate investment in Adolescent Sexual Reproductive Health
5. Sustained family planning services with emphasis on informed choice and adequate commodities and logistics

1.5 Male involvement and participation in reproductive health issues and services

- To achieve the desired reduction in maternal and newborn deaths, more information on male involvement and participation is key for the survival of the pregnant woman and the newborn.
- Men must know about and be encouraged to provide adequately (adequate birth preparedness) for the needs of their wives during pregnancy and delivery as well as that of their new-borns.

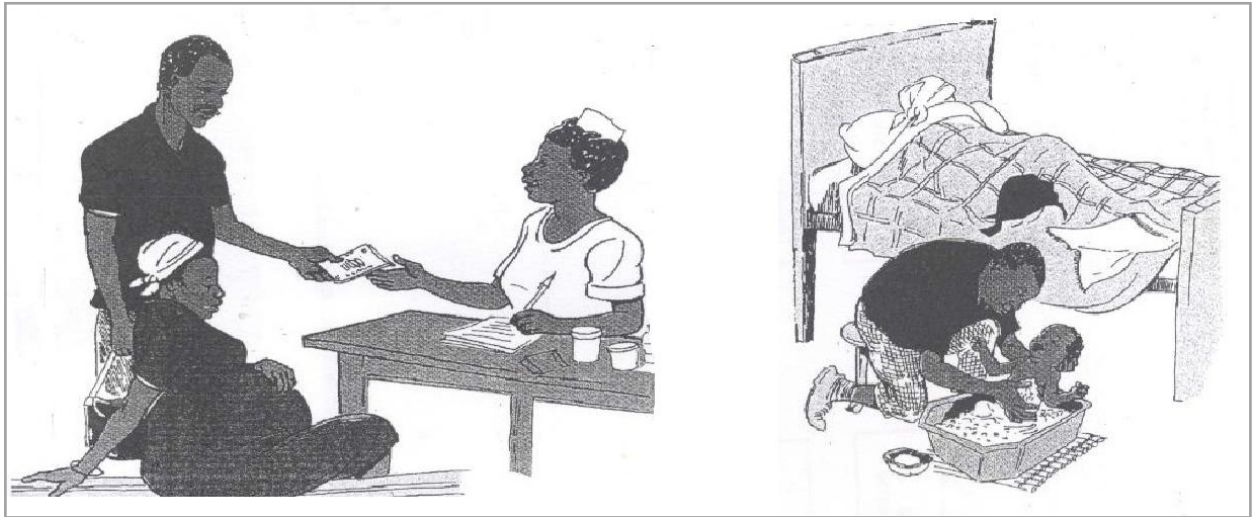


Figure 8: Male Involvement in Reproductive Health Issues and Services

The Role of the Husband in Male Involvement

This is divided into the following three categories:

i.) During Pregnancy

- There is need for the husband to understand and appreciate the
- discomfort, anxieties, and tiredness that pregnancy may cause in his partner.
- Take over the physical tiring tasks like lifting heavy loads, gardening, washing and other domestic chores.
- Take care of other children
- Accompany wife when going to health unit for antenatal care.
- Provide good nutrition during pregnancy
- Provide all the necessary support the wife may need

ii.) During Child birth

- Avail the necessary like financial and emotional support.
- Be available during labour and even massage her in between contractions.

iii.) After delivery

- Be able to adopt the new visitor (baby) in the family
- Help wife in position the baby when going to breast feed

Why Low Male Involvement in Maternal Health

There are a number reasons why men are not involved in maternal health, these constraints include:

- Cultural beliefs
- Financial limitations

- Inaccessibility of Reproductive health services for example family planning, obstetric care etc
- Lack of health education and information
- Polygamy
- Gender stereotypes
- Peer pressure
- Lack of love and trust

Determinants of Male Involvement in Safe motherhood

- Gender roles
- Socio-cultural
- Economics and wealth creation
- Education
- Politics [women are not empowered]
- Physical environment [homesteads]

From Christian point of view,



The story of Joseph participating with Mary when giving birth and dedicating Jesus in **Luke 2:1-7** and **21-24** respectively is a good gesture for husbands' involvement in antenatal and postnatal experiences as in the level of male involvement for Manoah and his wife, Zackariah and Elizabeth as well as Joseph's participation in searching for Jesus when he had stayed in Jerusalem is also a lesson to husbands to be involved in the affairs of children's upbringing (**Luke 2:41-51**). **Judges 13:6-24**



Key issues for consideration on maternal and neonatal health

1. Increasing national commitment and financial support
2. Strengthening co-ordination amongst partners
3. Addressing health systems issues like infrastructure, human resource for health and logistics and supplies
4. Improving access to quality skilled care
5. Ensuring community participation and health seeking behaviour

The Need for a Collaborative Effort of all Stakeholders

Effective implementation of sexual reproductive health interventions requires joint collaborative efforts where the Ministry of Health works with all sectors to ensure coordinated implementation because the health of women depends on other inputs which are in other line ministries.

Government response to improving Reproductive Health

A community mobilisation law has been drafted by The Ministry of Gender, Health, the Population Secretariat and other stakeholders. This law will hold leaders accountable for mobilisation of communities for health and other development activities. (ANC, Skilled Delivery Care and FP).

Table 3: Stakeholders and their Expected Collaborative Efforts		
	Sector	Roles and Responsibilities
1	Ministry of Health (MoH)	To ensure that the mothers and their new born survive by providing the necessary policies and guidelines to implementers of health programmes.
2	Ministry of Finance Planning and Economic Development (MoFPED)	To mobilize of resources and rational allocation of resources according to different priorities
3	Ministry of Gender Labour and Social Development (MoGLSD)	To ensure gender mainstreaming, advocacy, and prevention of Gender Based Violence (GBV); Community mobilization and developing policies for social protection of vulnerable groups
4	Ministry of Local Government (MoLG)	To ensure good governance and accountability, to recruit and deploy appropriate trained staff (health workers), supervision and monitoring of health service delivery in the districts
5	Ministry of Education and sports/ Universities/ Tertiary Institutions.	To ensure pre-service, in-service training of health workers and education of the citizens especially the girl child.
6	Ministry of Agriculture (MoA)	To ensure food security production of food (both plant and animal sources of food) essential for growth and development and prevention of anaemia.
7	Ministry of Works (MoW)	To ensure road safety
8	Ministry of Defence (MoD)	To ensure all the line ministries operate in an enabling environment and are protected from external aggression.
9	Ministry of Internal Affairs	To ensure security of life and property.
10	Ministry of Justice	To ensure law and order
11	The Church of Uganda	- Service delivery through hospital, health centre and schools. - Spiritual blessing of the marriages and the newborn child. - Community mobilisation and sensitisation.
12	Civil Society Organisations (CSOs)	To partner with the public sector and to ensure availability of funds.
13	Communities	Community participation and mobilisation

Source: REDUCE, 2004

B. CHILD HEALTH

Children make up half of the population and usually more than half of the patients needing care. Since many of the children's diseases are preventable, most countries have special clinics to help children stay healthy. Such children's clinics have many different names, such as under-five clinics, child well fare clinic of health and are run by many kinds of health workers. The usual services provided for children at these clinics are immunization, nutrition, evaluation and as well as referral for more difficult cases.

Table 4: Child Related Health indicators in Uganda

Indicator	Deaths
Infant Mortality Rate	54/1000 Live births
Under 5 mortality rate	90/1000 Live births
Child Mortality Rate (CMR)	147/1000
Child stunting at 2 years of age	45%
Proportion of 1 year-old children immunised against measles	75.8%

Activities carried out at Young Child Clinic (YCC)

1. Recording

There must be a recording station where the initial recording of attendance of children is done at this station and different records are ascertained from children mothers and recorded in to the young child cards as well as the clinic register.

2. Weighing

Next comes the weighing station at this point, the children and pregnant mothers are weighed and they are recorded on their cards in the right place.

3. Health Education on Nutrition

This is best given at each of the different stations, by every person working in the clinic usually different sessions on health trends especially nutrition hygiene and care for children are educated to mothers.

4. Examination and advice

The examination and advice station is the next is the center of the clinic, manned by a qualified medical worker. In small clinics, only one station is necessary for both mothers and their children.

5. Immunization and dispensing

Most vaccines need to be kept in the refrigerator if they are to be kept active and if a refrigerator breaks down; vaccines should be transferred to the nearest health facility with a refrigerator.

The immunization and dispensing stations can be combined in small clinics and manned by an assistant and volunteers. However, in large clinics, they should be run separately to save the mothers from waiting too long.

Are Mothers and Children Safe?

“Women are an important force driving the development of human society, and children represent the hope and future of the world; the welfare of women and children is an indicator of modern civilization and social progress, and their health bears directly on the future of mankind.” (Chen Zhu, Minister of Health, the Peoples Republic of China).

From Christian point of view,



“Children are a gift from the Lord; they are a real blessing” (Psalms 127:3) so as Christians we are obliged to, plan for, love and offer the best care available to children. Christ himself In Mark 10:13-17 welcomed the children and blessed them and also taught that if anyone was to enter the kingdom of God he/she had to live his/her life like that of children because of their innocence (**Mat.18:1-5,Luke 18: 15-17**).

Protection of Children: In Mark 9: 42 Jesus said “And if any one causes one of these little ones who believe in me to sin”, it would be better for him to be thrown into the sea with a large millstone tied around his neck. So we are commanded by Christ to protect children.



Role of the church;

We share a common task as Church in caring for the children and nurturing their moral and spiritual lives. It is clearly an important and complex task that requires a cooperative effort among; parents, relatives, friends, religious communities, schools, the state and the international organisations (McCnnel 2007: 65).

2

SEXUAL REPRODUCTIVE HEALTH AND RIGHTS

2.0 INTRODUCTION

Sexual reproductive health (SRH) is an important part of the human life cycle. Culture and society frame people's ideas about sexual health and reproduction. Many health planners see SRH as a women's health issue, mostly related to pregnancy and childbirth. This is a rather narrow view. Both men and women need access to information and appropriate health services throughout their lives. Such information and services should be gender sensitive and allow for:

All individuals to make informed choices about sexuality, reproduction, having a safe satisfying sexual life, that is free from STIs/HIV/AIDS, violence and coercion.

Women to go safely through pregnancy and child birth

Couples to have the best chance of having a healthy infant;

Women to avoid unwanted pregnancy, and to address the consequences of unsafe abortion, which include the management of complications of abortion

2.1 The full scope of SRH

To a large extent, SRH services are already planned and managed as part of the district health plan. In doing so, the districts set priorities in what can be done by carefully considering the available financial and human resources. As part of integrated planning for health, implementers of health programmes within the church-founded institutions may find that they can do more to improve coverage and quality of SRH services, especially with decentralized planning and budgeting responsibilities.

2.2 Components of Sexual Reproductive Health

1. Adolescent sexual reproductive health (ASRH)
2. Family Planning (FP)/birth preparedness services.
3. Maternal and child health (MCH)
 - Antenatal care (ANC)
 - Skilled attendance at delivery
 - Management of obstetrical and newborn emergencies
 - Postnatal care (PNC)
 - Nutrition
 - Management of abortion complications and provision of PAC
 - Early diagnosis and treatment for breast cancer and male/female reproductive tract cancers
 - Promotion education and support for exclusive breast-feeding
 - Prevention and appropriate treatment of sub-infertility and infertility
4. Prevention and treatment of Sexually Transmitted Diseases including HIV and AIDS
5. Gender issues (Genesis 2:24)
6. Prevention and management of Gender-Based Violence (GBV). (Proverbs 18:22)

Source: Programme of Action, International Conference on Population and Development ICPD, 1994.

2.3 Sexual Reproductive Health and Rights (SRHR)

In 1948, the General Assembly of the United Nations (UN) adopted and proclaimed the Universal Declaration of Human Rights (UDHR), the first step towards establishing an International human rights law and global system of human rights protection within the UN framework.

This system embraces all human beings in their abstraction and generality.

The construction and recognition of human rights has since then evolved and expanded into areas of vital importance for the preservation of human dignity.

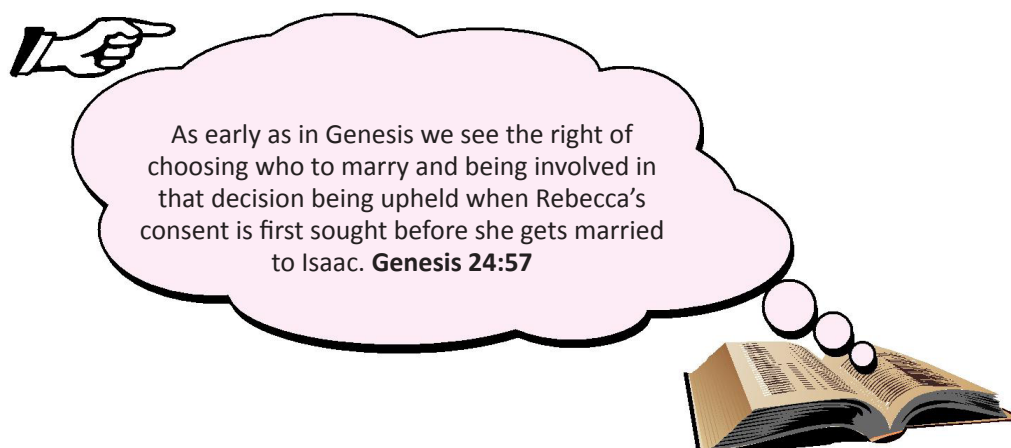
It is this process that led to the emergence of human rights for women and, later Sexual and Reproductive Health Rights (SRHR). Below is a summary outline of the SRH rights of young people;

1. The right to adequate and valid SRH information
2. The right to friendly SRH services
3. The right to choose whether to marry, when to marry, where to marry, and who to marry within the provisions of Ugandan law regarding the age of consent. **(Genesis 24: 57)**
4. The right to be protected and to protect one's self from; unwanted pregnancy, STIs/HIV, sexual abuse and violence.
5. The right to be involved in decision making particularly decisions concerning ones sexual reproductive health.

For rights to be fully enjoyed one must play his part of exercising the accompanied responsibilities that are outlined below;

1. Inquire about available reproductive health services
2. Share correct reproductive health history
3. Share correct information
4. Make an informed choice
5. Consult your service provider in case of doubt or complaint
6. Follow instructions
7. Use services correctly

From Christian point of view,



The importance of SRHR in terms of meeting Millennium Development Goals (MDGs) has increasingly been recognized by the international community. Reproductive rights are essential to the enjoyment of other fundamental rights. Also the Beijing Platform for Action details the sexual reproductive health rights and also the Cairo Programme's definition reaffirms the reproductive health rights by advocating for the following Reproductive health rights:

1. Right to access reproductive health information and services
2. The right to religion, spirituality and freedom of thought
3. Healthy sexual development (biological and social)
4. Equitable and responsible relationships and sexual fulfilment
5. Freedom from illness, disease, disability, violence and other harmful practices related to sexuality.

2.4 Sexual Reproductive Health and HIV

Over all it is envisaged that the integration of SRH and HIV-related policies and programming can lead to important public health, social- economic, and individual benefits that will yield the following beneficial results:

- Improved access and uptake of key HIV and SRH services.
- Better access of people living with HIV to SRH services tailored to their needs
- Reduction in HIV- related stigma and discrimination
- Improved coverage of underserved/vulnerable/key populations.
- Decreased duplication of efforts and better utilization of scarce resources.
- Better understanding and protection of individuals' rights by adapting the existing legal and policy frameworks.
- Enhanced programme effectiveness and efficiency hence improved quality of care
- Increased access to HIV and SRH services by PLWA under the same roof or in the same facility increasing the opportunities for a continuity of care without being externally referred. Improved access to and uptake of key HIV and SRH services that are tailored to the needs of PLWA.
- Expansion in the range of clinical services provided beyond HIV treatment and care to include management and treatment of sexually transmitted infections, congenital syphilis, family planning, cervical cancer screening and treatment, infertility treatment, prevention of mother-to-child transmission and other related services.
- Reduction on the frequency and costs of health related appointments – as it reduces the need to take additional time out of work to attend appointments and transport costs.
- Reduction on HIV related stigma and discrimination as HIV will be 'normalized' as a core service within a facility.

2.5 Integrating Reproductive Health Services for HIV-Positive Adolescents

Young people born with HIV/AIDS (PLWA) are maturing into adults, and the available maternal and HIV health services are not adolescent-friendly this situation becomes even more complex for adolescents living with HIV.

Current policies and programs fail to include HIV-positive adolescents because of the stigma associated with the disease and the failure to acknowledge the rights of intimacy among this cohort. However, leaving this cohort out of reproductive health programs has serious health consequences, including high unintended pregnancy and maternal mortality rates, and increased rates of infants born with HIV.

2.6 Guiding Principles for Integrating SRH into Church Health Programmes

Integration as a strategy for improving reproductive health services can be done through;

1. Community involvement
2. Partnership with civil society organisations
3. Inclusion of health promotion activities
4. Advocacy for sexual and reproductive health and rights
5. Collaboration and joint coordination across services, sectors, and line ministries

2.7 Community Involvement in Reproductive Health Services

Community involvement in analyzing information on maternal health, HIV/AIDS, SRH, GBV, gender mainstreaming and family planning creates awareness, and at the same time stimulates social support and participation in problem-solving. This involvement contributes to the establishment of mechanisms for transparency and accountability and improvement of health services that are extended to the community. In addition to improved access to health services and improved satisfaction with services, community involvement in quality also strengthens relations between the health service and the community. Determinants of increased use such as belief in the efficacy of care, in the capacity of the care available to solve health issues, and perceived sensitivity to socio-cultural realities are also addressed through these approaches.

Communities are made up of many groups with varying interests and problems. There are differences between the sexes, age groups, the rich and the poor, and between people of different ethnic or religious backgrounds. Community participation in health means that all these different groups are involved at all the stages of the church health programmes. The first level where SRH information and services are provided is the family/community level. Nearly all activities at this level are related to health promotion including information, education and communication (IEC). Health workers usually hold health education sessions at community level. However, knowledge gained through education does not automatically lead to behaviour change. For behaviour change to occur people must feel ownership over the decisions and activities, and believe that the change will have a positive impact on their lives.

2.8 Partnerships

Partnerships within the district health system

Partnerships for health within the district health system should be formulated in order to facilitate coordination between public and private health services, and between the Ministry of Health, NGOs and community organizations. These are essential to ensure coordination and convergence of efforts, ensure quality and avoid duplication of activities. Also, formal coordination between public and private actors would be useful to develop coherent health planning at the local, intermediary and national levels.

2.9 Inclusion of Health Promotion activities

Health promotion activities encompassing the principles and strategies that seek to foster conditions that allow populations to be healthy and to make healthy choices.

2.10 Advocacy for Sexual Reproductive Health Rights (SRHR)

- Church institutions should advocate for addressing the underlying factors of improved maternal and new-born health, in particular poverty alleviation, gender-equity, and the education of girls and women to produce the desired long-term improvements.

- Individuals, families and communities should work closely with these advocacy efforts at the district health system level, to raise awareness, improve the quality of services, build alliances with other sectors, and influence decisions for finding solutions and allocating resources for maternal and newborn health.

2.11 Networking and Collaboration with Line Ministries

Prevention of unwanted pregnancy and reproductive tract infections (RTIs), malaria, HIV/AIDS and the prevention and management of unsafe abortion represent other related sexual and reproductive needs to be addressed where appropriate at the IFC level. In particular, adolescent reproductive and sexual health should be considered through a strong collaboration with relevant partners. Both poor and good health are cumulative and reflect an individual's development experiences over time.

2.12 What can be done?

The human rights-based approach is concerned not just with outcomes but also with the process by which outcomes are achieved. It requires that all stakeholders be included. It recognizes that people are actors in their own development, rather than passive recipients of commodities and services. Informing, educating and empowering stakeholders is key. Participation is central, as both a means and an end, not only to ensure ownership, but also to guarantee continuity.

Culturally sensitive approaches, gender mainstreaming, advocacy and partnership are strategies that UNFPA employs to promote human rights in all of its work. However, the various programmatic areas may also require more targeted approaches and perspectives, through:

- Improving reproductive health care
- Making motherhood safer
- Promoting gender equality
- Preventing HIV/AIDS
- Addressing Gender-based violence
- Supporting Adolescents and Youths
- Building coalitions and networks for safe motherhood, who to involve, how to Network and entering/drafting Memorandum of Understanding.

2.13 Role of the Stakeholders in realizing Reproductive Health Rights

Role of the Church

Church-founded institutions play a vital role in formulation and realization of sexual reproductive health rights so they should not act as watch dogs, but contribute to empowerment of citizens and support roles of various stakeholders.

These institutions should recognize that SRH is a concern to everyone, and that both men's and women's health are important for healthy reproduction, healthy children and consequently a healthy society. Therefore, both men and women need access to information and appropriate health services throughout their lives. Such information and services should be gender sensitive and allow for:

- All individuals to make informed choices about sexuality and reproduction, and to have a safe and satisfying sexual life, free from STIs/HIV/AIDS, violence and coercion
- Women to go safely through pregnancy and childbirth
- Couples to have the best chance of having a healthy infants
- Women to avoid unwanted pregnancies, and to address the consequences of unsafe abortion, which include the management of complications of abortion.

From Christian point of view,



The Church as a servant of People: Just as God called Israel to serve Him and His people, God called the Christian Church for service. If we therefore serve others we must make sure that we advocate for their rights. The Church leaders are called upon to be servants but not bosses (**2 Cor.4:5, Mark. 10:45; John 15:5**). The Church must work as light and salt to the world and then go out to make disciples as mandated in the great commission (**Mat.5:13-16;28-19**).



3

HIV and AIDS

3.0 INTRODUCTION

Purpose: The purpose of this session is to prepare Church institutions to support their community members in preventing HIV transmission by equipping them with an understanding of the biological and social factors that affect HIV transmission.

To facilitate better understanding of the role of the Church in addressing the HIV pandemic, with particular attention to the gender determinants of HIV transmission, family values and implications of HIV/AIDS on society, build the capacity of stakeholders as well as the role of Government in holistic Church ministry.

3.1 Background of HIV

AIDS is caused by a virus called HIV

HIV — short for Human Deficiency Virus is the virus that causes AIDS.

Human — means it is only found in people.

Immuno-deficiency — means it weakens the body.

Virus — means tiny germs.

AIDS short for Acquired Immune Deficiency Syndrome, is a combination of illnesses that come about as a result of reduced immunity.

Acquired — means it is caught from someone.

Immune — means it relates to the body's defence mechanism.

Deficiency — means it is weakened and fails to do what it is supposed to do.

Syndrome — means a variety of different symptoms and illnesses.

AIDS is a sickness which weakens a person's body so they no longer have the strength to fight the disease.

- AIDS is an incurable disease which is passed on by sexual intercourse.
- In Uganda, about 85% of People Living With HIV/AIDS became infected through sex. However, AIDS can also be passed on by infected blood and by infected mothers to their unborn child.
- Safer sex means being sure that neither partner is infected, remaining faithful to each other, and using a condom in case of any doubt.
- People suffering from other Sexually Transmitted Diseases like genital ulcers and gonorrhoea should seek urgent treatment. The presence of other STDs makes it much easier to transmit and become infected with HIV.
- Any injection or cut with an un-sterilized needle, syringe, razor blade or other skin piercing instrument is dangerous.
- Women infected with HIV should think carefully about having a baby and seek medical advice.

Source: *Facts for Life, Uganda Ministry of Health and UNICEF*

3.2 What do HIV and AIDS do in the Body?

Currently there is no known cure for HIV or AIDS, only treatment to delay HIV from turning into AIDS. The only way to know whether one has HIV or not is by taking the HIV test. Condom use is the most effective method to prevent HIV infection apart from sexual abstinence.

HIV: infects cells in the immune system, the body's natural defence system that helps to fight diseases. When HIV enters the body, it weakens the immune system by multiplying and destroying the cells that fight diseases. As a result of this, people with HIV get sick easily.

AIDS: A person is described as having AIDS when the HIV related immune weakness (or deficiency) is so severe that various life – threatening opportunistic infections occur. These infections are called opportunistic infections because they take the opportunity provided by the weakened immune system. Examples of Opportunistic infections include: TB and Malaria.

3.3 Behaviours that Expose People to High Risk of Getting HIV

- ▶ Multiple sexual partnerships (long and short term)
- ▶ Substance abuse mostly - Alcohol (abuse)
- ▶ Domestic/sexual violence against women
- ▶ Cross- generational sex (sugar daddies and mummies)

3.4 The Body Fluids in which HIV Survives

Although there may be traces of HIV in body fluids such as saliva, urine and sweat, the quantities are too low for successful transmission to take place. Fluids known to have large quantities of the virus are:

- ▶ Blood
- ▶ Semen
- ▶ Vaginal Fluids
- ▶ Breast milk

Note: Other body fluids such as urine, sweat, and tears do not contain enough of the virus for transmission. Mosquitoes cannot carry HIV because it cannot survive in their bodies.

3.5 Three Modes of HIV Transmission

The three major modes of HIV transmission are:

1. Unprotected sexual intercourse with an infected person

This is the main way through which most people get HIV/AIDS in Uganda. HIV is in the semen or vaginal fluids of a person who is HIV positive. The virus is passed on from an infected person to the other person during unprotected or unsafe sex (sex without a condom). Unprotected sexual encounters with multiple partners and unfaithful long-term partnerships are where most infections are taking place.

2. An exchange of HIV infected blood

Sharing needles with someone who is infected with HIV or does not know their status can put you at risk of transmission. HIV can also be passed on through blood transfusions. In Uganda blood is tested for HIV before it is used for transfusions so the risk of getting infected through blood transfusion is very low.

3. From an HIV infected mother to her child during pregnancy, at labour and through breast feeding.

There is always a risk that a mother who is HIV positive can pass the virus to her baby. This can happen during pregnancy, delivery or through breast-feeding.

3.6 Relationship between HIV infection and STI's?

STIs have a close relationship and association with HIV in that a person with an STI can easily get HIV because STIs usually cause sores in private parts, which make it easy for HIV transmission. The care and prevention of STIs is an important and effective strategy for control of HIV/AIDS. There are many reasons why STIs and HIV are closely linked:

- ▶ STIs cause inflammation; this means that the white blood cells (infection fighting cells) will go to the inflamed area. HIV can find these cells much more easily in the presence of an STI.
- ▶ STIs cause damage to the skin; this increases the likelihood of HIV successfully entering the body during sexual intercourse.
- ▶ Having HIV may also make it difficult to treat an underlying STI.
- ▶ HIV and other STIs are both embarrassing for people, stigmatized by others and as signs of infidelity, can cause divorce and/or domestic violence.
- ▶ Most STIs can be treated. However, HIV has no cure. The care and prevention of STIs is an important and effective strategy for control of HIV/AIDS.

3.7 Ways of Preventing HIV Transmission

Protection from Sexual Transmission

Know your Sero-status (whether you are infected or not) and that of your sexual partner before you engage in sexual intercourse. Testing as a couple helps them to make decisions together. It is possible that one of you may be infected with HIV while the other is not (discordant). It is good to share your HIV test results with trusted members of your family or friends who can help you plan for your future.

The ABC Strategy for Preventing HIV

- **A – Abstain**

If you are HIV positive, abstain from sex or use a condom to avoid re-infection (getting another type of HIV) or infecting others.

From Christian point of view,



1 Corinthians 6:18-20

Flee from sexual immorality. All other sins a man commits are outside his body, but he who sins sexually sins against his own body.



- **B – Be faithful to your sexual partner**

Many sexual partners put you at risk since some of them may be infected with HIV or have other partners. The more partners you have, the higher the risk of you getting infected.

From Christian point of view,



Hebrews 13:4

Marriage should be honoured by all, and the marriage bed kept pure, for God will judge the adultery and all the sexually immoral.



▪ C – Use condoms correctly and consistently in marriage

If you do not know your status or one of you is HIV positive. Even if you have been in a long-term relationship, use condoms until you know your HIV status. Condoms also prevent unwanted pregnancy and STIs if used correctly and consistently.

Note: Cut down on risky habits like alcohol and drug use as alcohol and other drugs can lower the control over your behaviours and, can lead to unprotected sex with someone whose HIV status you do not know.

3.8 Using Condoms Correctly

- ▶ Condoms substantially reduce the risk of unwanted pregnancy, HIV and STI infection when used correctly and consistently.
- ▶ You can perform better with a condom only because it can help to hold the erection longer.
- ▶ Condoms do not usually burst unless they have been stored or used incorrectly. One reason for bursting is if one of the partners is too dry, or sex is getting too rough.
- ▶ Use a water-based lubricant or saliva and make sure the female partner is well lubricated. Do not use oil-based jelly since it corrodes the rubber.

Knowing when and how to use a condom for married couples consistently:

- Plan ahead. A trip to a pharmacy (drugstore) to buy condoms does not always fit the mood.
- Stay sober enough. Alcohol and drugs impair good judgement.
- Remember, the fewer partners you have the less risk you take.
- Be responsible. If you have an STI, like HIV or Herpes, advise your sexual partner to use condoms.
- If pregnant, always use a condom to protect your baby from complications caused by STIs and HIV.
- Safer sex conversations can start with *“Because I care about us, we need to talk....”* Or *“Let’s be clear now, so we can enjoy sex later.”*
- Check the expiry date of condoms. Throw out old condoms and buy fresh ones. Never re-use a condom.
- Remember, it’s better to be safe than sorry. You can start today.

The following Steps Indicate Proper Condom Use

1. Inspect the condom
2. Do not use if there are tears or past expiry date
3. Open the Condom
4. Lay the condom on the palm of your hand and squeeze the condom in the package to one edge.

5. Tear the condom free edge of the package and take out the condom. Ensure that your nails do not cause a tear in the condom.
6. Inspect the condom to determine how it will unroll when placed on the penis.
7. Squeeze the tip of the condom to squeeze out the air.
8. Place the condom on the head/tip of the erect penis.
9. While holding onto the tip, unroll the condom down the shaft of the penis all the way to the base of the condom.
10. Use the condom
11. Withdraw the condom after sex
12. Hold on to the condom at the base of the penis and withdraw from the vagina while the penis is still erect/hard.
13. Remove the condom from the penis while the penis is still hard.
14. Hold the condom at the base of the penis as well as the tip and slide it off the penis, ensuring that the semen collected at the tip does not spill/ leak.
15. Safely dispose the condom after use
16. Tie a knot on the condom to prevent the spilling or leaking of semen.
17. Dispose the condom in a safe place where it cannot be handled by another person.
18. Wash your hands to ensure that there is no potentially infected vaginal secretion on the hands.

3.9 Benefits of Testing for HIV

The only way to find out about your HIV status is to have an HIV test. If you are HIV negative, you can protect yourself. If you are positive, you can protect your partner and your unborn children. You can also receive treatment as soon as possible. Knowing your HIV status also gives you time to make plans for your dependants. Living in light (**Ephesians 5: 8-10**)

HIV Testing Process

The HIV antibody test checks the blood for antibodies that cause HIV/AIDS (the body produces antibodies to fight off disease agents) the test does not detect the presence of the virus itself.

When results of HIV test are positive (sero-positive), it means that HIV anti-bodies have been detected in a person's blood. The person has HIV and will develop AIDS at a certain point in time.

A negative test result (sero-negative) indicates either no antibodies or an undetectable level of antibodies to the virus. This means that person may not have HIV. A person might be having HIV but still in the HIV "window period." There is need to do a repeat test to confirm HIV status after 3 months. Repeat test should also be done if the person has a high risk exposure such as unprotected sex.

If a person wants to know their HIV status, they can talk about this with an HIV counsellor. The counsellor will talk with them about worries they might have with getting an HIV test, and what might happen if they find out that they have HIV. This is called pre-test counselling.

The HIV blood tests used today are 99% accurate. A small blood sample will be taken and tested (using rapid test). The results will be available within an hour. The counsellor will call the person back for another meeting (post counselling) to tell them about the result and talk about it. If the person had HIV, the counsellor will discuss with them about what to do and make sure that they have the support they need to live positively (positive living).

People who learn that they have HIV feel many different emotions. Is it natural to have strong feelings. No matter how much one is prepared, it is a shock to learn they have HIV.

The test result is private, and the counsellor will not share it with anyone without the person's permission.

3.9.1 Possible HIV test Results

When you test for HIV the following are the possible results:

HIV negative – You do not have HIV.

HIV positive – Antibodies to the HIV virus were detected in your blood and you do have HIV.

- Window Period - Antibodies can be found in a test earliest at 12 weeks after you have been involved in risky sexual behaviors.
- If your partner is infected with HIV and you tested negative, make sure to protect yourself with a condom and do another test after 3 months.

It is important for couples to test together so that they learn about each other's HIV status. However, there are cases where one partner can be HIV negative while the other is HIV positive (discordant couple).

3.10 HIV Couple Discordance

HIV Discordance;

- Is when one partner of a couple is infected with HIV (HIV Positive) when the other is not (yet) infected (HIV negative).
- Is very common in Uganda. There are more discordant couples than couples that are both HIV positive.
- Is not a sure sign that someone has been unfaithful (infection may have happened before they got together)
- Can last for a long time but the un-infected partner is not immune but always at risk through unprotected sex.

Key Fact:

- In Uganda, there are more discordant couples than there are couples where both people are HIV positive.
- The negative partner in a discordant couple is at high risk of contracting HIV but transmission CAN be prevented.
- If you are discordant, discuss ways of protecting the uninfected partner.

3.11 Disclosure

Disclosure means sharing of your HIV status with your partner or any other trusted members of your family or friends. This is important because:

- ▶ It can prevent further spread of HIV because it will encourage your partner to get tested as well and/or start protecting themselves from infections.
- ▶ It can relieve the stress of keeping your status a secret and will allow your family and friends to support you.
- ▶ The HIV test can sometimes make people anxious. Counsellors are trained to help those who test understand the procedure and be able to cope with the results.

The role of the counsellor is to:

- Meet with you to discuss risky behaviours related to HIV.
- Share information on how to decrease risk of HIV infection.
- Talk to you about the HIV testing procedures and possible HIV test results.
- Review information on how to reduce your risk of HIV infection.
- Give you your test results.
- Whatever you discuss with the health provider (counsellor) is kept confidential. The counsellor cannot share your HIV test results or what you talk about with anyone else.

This is what you can do every day to keep healthy and save some money:

- Get tested if you are sexually active or do not know your or your partners' HIV status.
- Get tested when you are or want to get pregnant: A woman with HIV can pass it on to her baby while pregnant, during birth or when breast-feeding.
- Once you have tested positive, know that there are drugs available to slow down the disease. These drugs cannot cure AIDS.
- Treat others the way you want to be treated: Let them know what your HIV status is so they have a choice. And if they tell you about their HIV status, take a deep breath and be supportive.
- Learn about “*assisted disclosure*” where AIDS service organizations help you tell your loved ones about your HIV status.

3.12 HIV and Gender Perspectives

What makes women vulnerable to HIV infection?

- *Gender Inequality* is the major reason for women's increased vulnerability to HIV infection. In most societies, women are not accepted as men's equals; they suffer discrimination, deprivation and exclusion simply because of their gender. Thus, women are less able than man to exercise control over their bodies and their lives yet they have little influence over their partners, sexual behaviour.
- *Lack of education*: The link between inequality and vulnerability to HIV starts at an early age of girls. They have very limited schooling compared to boys, despite the fact that education is the key defence against HIV infection. Educated women are more likely to know about HIV prevention, to delay sexual activity and, when sexually active, to protect themselves against infection, and women who have higher levels of education are more likely to gain self-esteem and life skills that help them to develop economic and intellectual development.

HIV Interaction with Reproduction and Sexual Health

- **Newly infected person**: only very high viral load and so highly infectious (1-12 months from time of infection). No effect on capacity to reproduce or sexuality.
- **1-5 years after infection**: healthy person, no effect on reproduction or sex life but can transmit infection.
- **5-10 years after HIV infection**: The person develops reduced immunity and becomes susceptible to opportunistic infections like TB and malaria as well as progression into AIDS.
- Women-reduced fertility/infertility.

- **During pregnancy:** The pregnant woman is at risk of abortion while the baby is at risk of dying in the womb (intra-uterine death), or being born preterm (prematurity) or a high risk of neonatal death (death soon after delivery).

3.13 HIV Vertical Transmission

This is transmission of HIV from the mother to the unborn baby because of their biological relationship: the baby is in the womb/uterus (and closely interacts with the mother); HIV is transmitted during pregnancy, delivery and breast-feeding.

3.13.1 Elimination of Mother-to-Child Transmission of HIV (EMTCT)

- EMTCT is a comprehensive approach that includes among other services; HIV counselling and testing, antenatal care, provision of Anti-RetroVirals (ARVs), delivery in a health centre, infant feeding and family planning counselling.
- In Uganda, about 20,000 children are infected with HIV each year in the womb, during birth or breast-feeding. The EMTCT services can help to increase the chances of a baby born free of HIV.
- There are less chances of getting an HIV positive baby when the pregnant woman accesses PMTCT services. Only 2 out of every 100 women will pass HIV to their baby during pregnancy if they receive EMTCT services as compared to 25 out 100 not using PMTCT services.
- Pregnant mothers need to test for HIV together with their partners so they can learn about each other's HIV status and plan together.

The text box below indicates what a pregnant woman can do every day to protect her baby from HIV to keep healthy and save money:

- If you get tested for HIV, you can make a plan for keeping your baby healthy.
- Tell your partner your HIV status to prevent further infections.
- Remember to use condoms every time you have sex during your pregnancy to prevent infecting your baby.
- Make sure you access EMTCT services and follow the treatment as recommended by the health provider.
- Get help to decide on your infant feeding options
- Start putting money aside every day for the needs of the baby.
- ▶ In 1991: 29% of pregnant women were HIV positive and in 2006 approximately 8% of women were HIV positive.
- ▶ If no interventions or precautions of any kind are put in place, 1:4 babies are exposed to HIV infection. [that is 25% of babies born to HIV infected women are infected with HIV]. However, if interventions are carried out, they reduce this figure to between 1 and 10%.

When Does HIV Transmission from Mother to Child Occur?

- ▶ Intrauterine approximately 10% due to viral factors, placental damage and lowered maternal immunity.
- ▶ Intra-partum approximately 60%: through maternal blood and vaginal secretions contamination of the baby getting into contact with fetal skin abrasions.
- ▶ Postnatal approximately 30% through breast feeding.

Four Pronged Strategies for Elimination Mother-To-Child Transmission of HIV

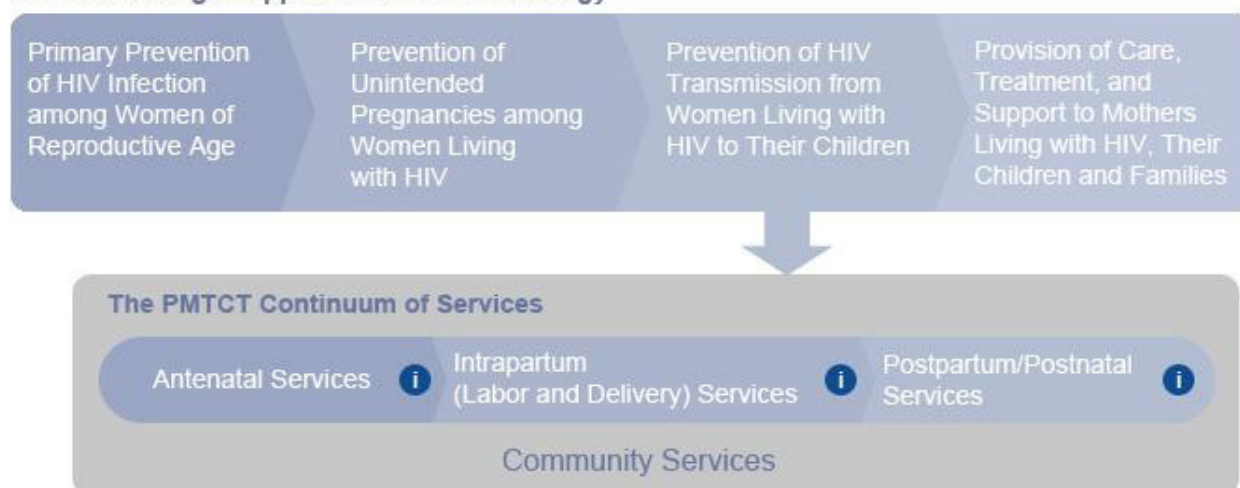
According to the national behavioural survey (2004/5), HIV infection is still high among youth (15-29) and married couples. This means that, women of childbearing age are susceptible to the infection thus passing it to their un-born babies. About 40% of HIV infection exists among the new born babies. A lot of work is done at the health facility but uptake has remained low.

The government of Uganda has established EMTCT services at the regional referral hospitals, district hospitals, private health facilities, and Health Centres (H/Cs) IV and III. At H/C IV and hospitals, a comprehensive EMTCT package including provision of HAART. At H/C II, a basic HIV testing, support to the mothers and their partners in making appropriate infant feeding choices. With all these efforts, EMTCT uptake has remained low.

In 2000, a national programme was put in place to prevent MTCT of HIV based on the four-pronged WHO strategies. Each of the four “prongs” represents a stage at which program services work as depicted in the diagram below:

Figure 9: Indicates the Four pronged Approaches to EMTCT Strategy

The Four-Pronged Approach to PMTCT Strategy



Source: USAID Aid Star Project.

Other Prevention measures include:

- Antiretroviral drugs (HAART-3 drug combination) this combination treats the mother as well.
- Modified practices during care for example post exposure prophylaxis (PEP).

Components of EMTCT

- Identify HIV infected women
- Counselling (about HIV, disclosure, supportive, positive living, antiretroviral drugs, breast-feeding)
- Antiretroviral drugs (mother and new-born)
- Care of the new-born: drug prophylaxis, drying, cord care, delay bathing)
- Safe feeding practices for the baby

Diagnosis of HIV Infected Babies

- Babies born to HIV infected women are referred to as “exposed” babies
- Diagnosis of HIV in a new-born baby is difficult: at birth, the baby has antibodies from the mother and ordinary tests are not useful. Ordinary tests can only be used for babies 12-18 months old (using Elisa and Rapid tests).
- DNA tests can diagnose HIV in new-born at birth and 6 weeks this is more advanced and can be done in health facilities only.

Breast Feeding and HIV/AIDS

- Exclusive breast feeding is the best food for the baby since it boosts the immune system, facilitates psychological development and reduces the risk of HIV transmission.
- No breast feeding at all; risks poor child growth and death.
- Mixed breast feeding leads to high risk of transmission

Factors to Consider in the Integration Process of HIV and AIDS into Reproductive Health Programs

- Gender issues empowerment
- HIV positive women: treat in their own right for their health
- HIV positive individuals have rights to have children!
- Partners with different HIV status should be provided with information, counselling and support
- Information and education about HIV, vertical transmission, gender roles
- Advocacy for male involvement in maternal health issues
- Peer group education and support: encourage HIV testing individually or as couples, behaviour change
- Employers: give men services at work places, give time off to accompany wives to MCH services, paternity leave

Programmatic Challenges

- Scaling-up EMTCT coverage to cover all pregnant women; currently, the programme reaches less than 50% of all pregnant women.
- Operating in a limited-resource setting: Nearly 75% of EMTCT services are currently supported by partners, government resources are still very low (national and district levels)
- Increasing uptake of HIV infected women into EMTCT programmes
- Scaling up integration of HIV into reproductive health (RH) services
- Increasing access of pregnant women to HAART
- Improving infrastructure and increasing resources: health workers, equipment, drugs and consumables.

Safe Male Circumcision

Safe male circumcision (SMC), a surgical procedure carried out on young men and infant boys in many parts of the world including much of Africa, now is proven to reduce the risk of HIV transmission in men by approximately 60 percent. Safe male circumcision is particularly significant for places hardest hit by

the HIV pandemic, such as countries in the sub-Saharan Africa, where HIV is high and one third or less of men are typically circumcised. Now there is an enormous opportunity to add the procedure to the list of proven HIV prevention strategies, such as reductions in the number of sexual partners, in particular the number of concurrent partners, and consistent and correct condom use. Scaling-up services that offer male circumcision will have the most pronounced prevention effect in HIV prevalent countries.

Where SMC should be performed?

Safe male circumcision should be performed in a clean place, using clean tools and trained health workers. A clean environment allows the wound to heal easily because it does not come in contact with dirty objects.

Is it true that SMC reduces the risk of HIV infection for men?

Yes. Recent research conducted in Uganda, Kenya and South Africa shows that men who have been circumcised are less likely to get HIV through sex. However, SMC only reduces a man's risk of getting HIV. It does not provide complete protection against HIV. Also, circumcised boys and men who are HIV positive can still transmit HIV to their sexual partners. So, it's important to use other safer sex methods, such as abstaining from sex, sticking to one partner, or using condoms to prevent HIV.

How does SMC reduce a man's risk of HIV infection?

There are several ways in which SMC reduces the risk of HIV.

- There is a soft layer inside the skin that covers the tip of the penis. This layer is usually wet and keeps viruses alive and active. Removing the whole skin reduces the ability of HIV to enter a man's body.
- SMC reduces the risk of sores caused by some sexually transmitted infections (STIs) which tend to form inside the skin of the penis. These sores make it easy for HIV to enter the body. Removing the foreskin reduces a man's risk of getting the sores and HIV.
- The soft inside part of the skin of the penis may break during sex and make it easy for HIV to enter the body. After SMC, the skin that remains at the tip of the penis becomes harder and difficult to break. This makes it hard for HIV to enter the body.

What are the Benefits of SMC?

SMC decreases the risk of diseases that affect the outlet of the penis through which urine passes, and prevents the possibility of cancer of the penis.

Sexual partners of circumcised man also face the risk of some cancers e.g. cancer of the cervix and of sexually transmitted infections (e.g. Chlamydia, Syphilis, chancroids, and genital herpes).

Women prefer a circumcised man for sex because they believe a circumcised penis looks better, is likely to be cleaner, and possibly gives greater sexual satisfaction.

Does SMC also reduce the Risk of HIV infection for women?

There is no evidence that MMC reduces the risk of HIV infection for women.

What are the Risks of SMC?

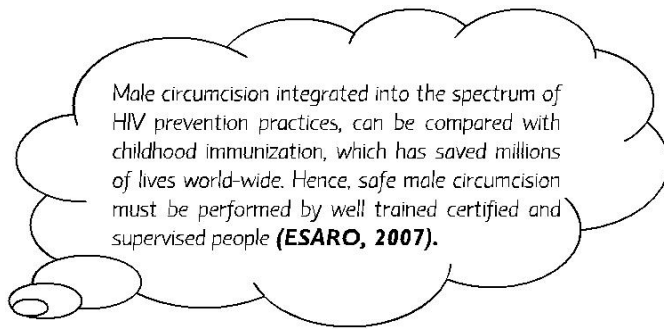
If SMC is done properly and in a clean environment, complications are rare and very minor. However, circumcision can be dangerous if the procedure is performed by untrained persons, under unclean conditions. In such a situation, circumcision can damage the penis or cause serious illness.

When can One be Circumcised?

A man can be circumcised as an infant, an adolescent, or an adult. The decision to be circumcised, and at what age, is a personal choice.

When can one resume sex after getting SMC?

It is advised that men abstain from sex for at least 6 weeks after being circumcised. This is necessary to ensure that the wound has healed completely. When not properly healed, the wound provides a ready entry point for HIV. It is therefore advisable to return to the health centre for a check-up before having sex.



Facts about HIV

- * AIDS is an incurable disease which is passed on by sexual intercourse.
- * In Uganda about 85% of People Living With HIV and AIDS (PLWA) became infected through sex. AIDS can also be passed on by infected blood and by infected mothers to their unborn child.
- * Safer sex means being sure that neither partner is infected, remaining faithful to each other, and using a condom in case of any doubt.
- * People suffering from Sexually Transmitted Diseases like genital ulcers and gonorrhoea should seek urgent treatment. The presence of other STDs makes it much easier to transmit and become infected with HIV.
- * Any injection or cut with an un-sterilized needle, syringe, razorblade or other skin piercing instrument is dangerous.
- * Women infected with HIV should think carefully about having a baby and seek medical advice.
- * People living with AIDS need love, care, understanding and support.

Source: *Facts for Life, Uganda Ministry of Health and UNICEF*

3.14 The Role of the Church in Preventing HIV and AIDS

“Is AIDS the judgment of God against the unfaithful ones in marriage and loose living in sin in the world today?”

- * AS a Church we appreciate the fact that we are living in a fallen world of sin since **Genesis 3**. The consequences that came to the world then are still a reality today AIDS inclusive.
- * The Church is not silent. Among others it is involved in creating awareness that HIV and AIDS has come and it is a reality without cure yet. For instance the Anglican Church of Uganda set

some Sundays as HIV/AIDS Sunday to pray, create more awareness but also get involved in counselling and establishing counselling centres where PLWA and other related challenges can be listened to.

- * From the theological point of view, the above question can be answered both as “Yes” and “No”. No because Jesus warned us not to interpret calamities as God’s specific judgement upon evil people. (Luke 13: 1-5).
- * No because some AIDS victims include many women, especially faithful married who have been infected by their unfaithful husbands (and **vice versa**), with a substantial minority of innocent haemophiliacs and children. But “Yes” in the sense that Paul meant when he wrote, “Do not deceive your-selves, no one makes a fool of God”.
- * On the other hand, “*a person will reap exactly what he sows*” (**Gal.6:7 GNB**). The fact that **we** reap what we sow, or that evil actions bring evil consequences, seems to have been written by God into the ordering of his moral world. Christians cannot regard it as an accident, for example, that promiscuity exposes people to venereal diseases that heavy smoking can lead to lung cancer. Moreover, this cause and effect relationship is viewed in scripture as one of the ways in which God’s wrath that is his just judgement on evil is revealed (**Rom. 1:18-32, John 3:18-21, 5:24-29**).
- * AIDS may rightly be seen then as, “*part of God’s judgement on society*”. It is a calling the bluff of the permissive society that there is any such thing as sexual liberation in promiscuity” (Stott 1990: 353-354).
- * As a Church, we have a pastoral role to extend to PLWA and their relatives and friends in one way or another. As community salvation we are called to extend the caring and loving hand not a judgemental one learning from Jesus as given in the gospel of John 8:10-110 “Where are the accusers? Didn’t any one condemn you? ...Neither do I. Go and sin no more”.
- * The Church needs to reach out to the suffering and play the Christ’s role like in (**Mathew 25:35-40**) and encouraging the people to come out and declare their status and reduce stigma.
- * The other aspect that the Church must do in integrating her teaching in situations of HIV and AIDS is education. This is important because equipping the community with facts and the truth about the causes, symptoms and preventive measures of HIV and AIDS helps in combating ignorance, prejudice, fear and promiscuous behaviour.
- * Our society should be equipped with Christian worldview regarding issues like sex and responsible living so as to avoid complacency and conformity. For instance sex is divine and it has its position in and only in marriage (**Rom.12:2, Gen. 2; 24**).
- * The Church should emphasize faith, hope and love which helps in accepting God’s standards and accepting people as those created in the image of God that need love and be loved including the singles.

In conclusion, the Church is a healing community that must go out to the suffering and even those who are well so that they can be helped to remain well and take care of others. “**Be each other’s keeper**”.

4

GENDER

4.0 The Concept of Gender:

What is Gender?

- Gender is a neutral term, either good or bad, right or wrong.

The word gender has become associated with women's issues and women's programs, feminists, and for some people gender has become a negative word connotes exclusion or hatred of men.

- The term "*gender*" is widely used in humanitarian aid programmes unfortunately; many humanitarian workers do not understand its meaning.
- Gender is an English word; the meaning has changed overtime. Twenty years ago, "*gender*" had the same definition as "*sex*." The word does not translate easily into other languages. For each language, we must find a way to describe the concept of gender in ways that can be understood, but not simply use the English word "*gender*."

4.1 Difference between Sex and Gender

Table 5: Difference between Sex and Gender

	Sex	Gender
Definitions	<ul style="list-style-type: none">• Refers to the physical/biological differences between males and female	<ul style="list-style-type: none">• Definitions can change• It refers to the social difference between male and female.
Determined	<ul style="list-style-type: none">• Sex is determined by biology	<ul style="list-style-type: none">• Determined by social factors — history, culture, societal norms, religion and
Involves	<ul style="list-style-type: none">• Does not change without surgical intervention	<ul style="list-style-type: none">• Gender in any given society involves the socialization for boys and girls, men and women that determines roles, responsibilities, opportunities, privileges, limitations and expectations

4.2 Status of Gender Inequality in Uganda

In Uganda, women find themselves in subordinate positions to men and are socially, culturally, politically, religiously and economically reliant on men. Women are largely excluded from making decisions, have limited access to and control over resources; are restricted in their mobility, and are often under threat of violence from male relatives. Sons are perceived to have economic, social, or religious utility; daughters are often felt to be an economic liability because of the dowry system.

From Christian point of view,



Genesis 2:18

The Lord God said, "It is not good for the man to be alone. I will make a helper suitable for him".

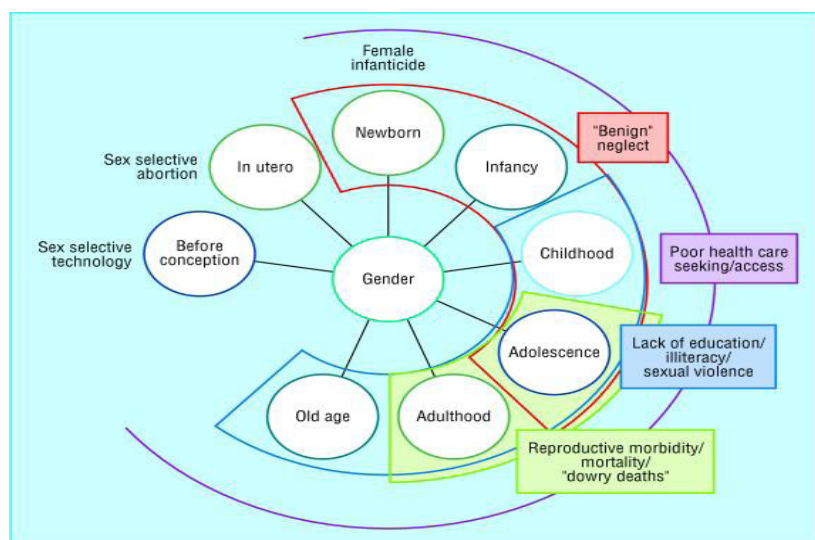


Individual and societal beliefs about and attitudes towards appropriate gender specific roles, and the choices of individuals and households on the basis of these factors, mean that women are disadvantaged with regard to health and health care. There are some instances in which gender differences hurt men’s health—for example, men are more likely to be involved in road crashes or occupational accidents as they are more likely to be outside the home or in a workplace than women. However, most of the evidence shows that gender inequalities have led to a systematic neglect of women’s health.

The Life cycle of Gender Discrimination and Health

Gender discrimination at each stage of the female life cycle contributes to this imbalance. Sex selective abortions, neglect of girl children, reproductive mortality, and poor access to health care for girls and women have all been cited as reasons for this difference.

Figure 10: Figure Depicting the Lifecycle of Gender Discrimination and Health



Source:

From Christian point of view,



Genesis 2:24
For this reason, a man will leave his father and mother and be united to his wife, and they become one flesh.



- **Neglect of girls**

Neglect of girls leads to gender-based health disparities among the population aged less than 5 years. It may take the form of poor nutrition, lack of preventive care (specifically immunization), and delays in seeking health care for disease.

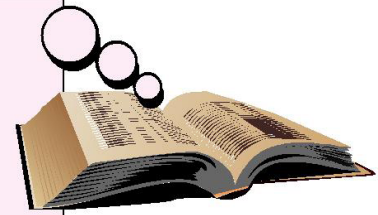
- **Health of adolescents**

From Christian point of view,



Proverbs 22:6,

“Train a child in the way he should go, and when he is old he will not turn from it”



Adolescence is a time when vulnerabilities to injury, including motor vehicle crashes and suicide, as well as substance abuse, are on the rise. Early marriage and pregnancy, anaemia, sexual violence, as well as poor educational opportunities all contribute to ill-health among female adolescents. Adolescents, especially young women, are disproportionately affected by HIV infection. This combined with the distressing practice of “dowry,” means that young Ugandan women are at a particular risk from violence. Despite this, little attention has been paid to these conditions in the context of gender inequity.

- **The Risks of Reproduction**

These are reproduction health hazards that are borne by women alone. Mothers that are too young, receive minimal antenatal care, and are malnourished or anaemic during pregnancy. [Refer to causes of maternal death in Chapter One].

Women cite economic circumstances or opposition to delivery in hospital as the most common reasons for delivery at home. Decisions about seeking care in such emergencies are made largely by the husband or the elder members of his family.

- **Gender Differences and Health care for Women**

Women are less likely to seek appropriate and early maternal health care services. Yet pregnancy-related illnesses are the leading causes of death and disability among women of the reproductive age group (15-45).

Diseases that generally have an equal prevalence in men and women are found to have affected women disproportionately. As more women survive into old age, the role of gender differences among older adults becomes more important.

Women experience greater ill health and a loss of income as they age. They are more vulnerable because they are likely to be illiterate, unemployed, widowed, and dependent on others. The combination of perceived ill health and lack of support mechanisms contributes to a poor quality of life.

- **Gender biased Food allocation**

Gender biased food allocation and heavy workloads cause anaemia, malnutrition and increased susceptibility to infectious diseases in girls and women.

Most gender-based health differences can be dealt with by tackling the underlying factors: decreasing fecundity and consequently a preference for sons, spread of the practice of dowry across most groups in the region, and the marginalization of women in agriculture.

All of these factors are tied to the perceived lack of economic utility of women. Similarly, the scarcity of resources causes society to undervalue women, who, as a rule, are not making a visible economic contribution.

Attempts to address gender disparities must take into account these underlying issues. However, education and improved economic circumstances alone are likely to be insufficient to change practices that have become culturally, socially, and in some cases legally, enshrined.

Programmes and policies aimed at reducing differences at the level of education and employment between men and women must enshrine gender equity as a core value. In this respect religious, political and cultural leaders have a great role to play to minimize gender differences in education and employment levels in Uganda. This will eventually lead to a healthy life expectancy equivalent to those of industrialized countries.

The violation of fundamental human rights, and especially reproductive rights of women, plays an important part in perpetuating gender inequity. It is therefore imperative that a rights based approach be taken across all developmental activities within the religious institutions.

4.3 Gender and Sexual Reproductive Health or Maternal Health

Sexual Reproductive health covers the following components: (a) Safe motherhood [discussed under Chapter one of this handbook], (b) Family planning [discussed under Chapter two of this handbook], (c) Reproductive tract infections and HIV/AIDS (d) Gynecological cancers and infertility (e) Gender based violence or GBV [discussed in Chapter five of this handbook], (f) Adolescent sexual reproductive health, and (g) Male reproductive health.

- **Access to Quality Health Services**

Access to quality health services is crucial to upholding sexual and reproductive health rights. Women and men need access to health care services including those related to family planning where necessary, free pre-and post-natal services, including information, counseling, and nutrition for women.

For example:



The Abuja Declaration called on governments to use tax exemptions and other strategic incentives to reduce the prices of drugs and other health inputs. It also called for governments to allocate 15% of their national budgets to health.

Similarly, the Maputo Declaration encouraged for the strengthening of health systems.

- **Reproductive tract infections and HIV/AIDS-Related Infectious Diseases**

Sexual and health rights relating to HIV prevention, treatment, care, and support are an important consideration in relation to maternal health. International and national instruments have stressed the need for health systems to uphold rights of people living with HIV (PLWHA) (e.g. CEDAW).

- **Information Education and Communication (IEC)**

Declarations have highlighted the role of IEC for example the Abuja Declaration emphasized the development of special IEC for youth programs and called for the documentation and sharing of successful experiences across countries.

- **Gynaecological Cancers**

Most gynaecological cancers affect specific genders:

Women of reproductive age (15-45) are more at risk of the following cancers: breast cancer, ovarian cancer, cervical cancer, uterine cancer, endometrial cancer, vaginal cancer and cancer of the vulva. In case of female cancers, treatment is usually by surgical excision e.g removal of ovary or uterus! Such a woman cannot conceive and give birth after this. Other treatment programs such

as chemotherapy and radiation are painful and have long term life effects. Most of these cancers cause death.

- Men are at a risk of cancers such as: prostate cancer. These cancers greatly affect the reproductive ability of both sexes' genders.

- **Pregnancy Related Problems**

The relationship between gender and reproductive health is seen in pregnancy related issues; this only affects women. The chief causes of maternal deaths & illness are pregnancy-related (See *Direct-pregnancy-related causes of maternal morbidity and mortality in Chapter one of this handbook*).



Reproductive stress is caused by too many, too frequent and poorly spaced births leading to poor maternal and infant health.

Child marriage as a form of violence

- Early pregnancy and childbirth have severe consequences for adolescent mothers including complication at birth, obstetrical fistula (leakage of urine/feaces) and death, often linked to unsafe abortions
- All these facts put girls at a disadvantage compared to boys. Boys have the opportunity to complete their education and therefore have a prosperous future while girls majorly depend on their husbands.

From Christian point of view,



For the man who does not love his wife but divorces her,covers his garment with violence... **(Malachi 2:16)**



- Gender equity has a significant influence on women's health; yet few culturally specific indicators of gender relations exist which are applicable to health.
- Gender inequity potentially influences women's sexual and reproductive health as regards to health information seeking, gynecological care access, contraceptive use responsibility, and child bearing.



It is important for religious institutions to address gender relations as a major determinant for health interventions in order to promote gender-based equity in sexual and reproductive health.

4.4 Gender and Culture

There is a great influence of culture and tradition on restricting women's enjoyment of their fundamental rights, including sexual and reproductive health rights.

For example:



The Sabinu women in Uganda and the Kalengi in Kenya are facing the custom of Female Genital Mutilation (FGM) yet the Beijing Declaration called for the rights of all women to control all aspects of their health as a basis for women's empowerment.

- FGM is the removal of all or part of the young women's genitalia for non-medical reasons; it is most prevalent in part of West, East and Northeast Africa. Though also practiced in Asia, the Middle East and the immigrant populations of North America and Europe.
- FGM is practiced for social-cultural and the economic reasons, family honor, the insurance of virginity until marriage, and social integration are often used as justifications for the procedure.

Cultural pressure may force girls to marry and bear children at a very young age with serious reproductive health consequences. As a result of early child bearing, young girls may end up having obstructed labour, ruptured uterus, leaking of urine or faeces (fistula) for the rest of her life.

4.5 Gender and Religion

Some gender and religious issues as either "internal" or "external".

- *Internal religious issues* are studied from the perspective of a given religion, and might include religious beliefs and practices about the roles and rights of men and women in government, education and worship, beliefs about sex or gender of religious figures and beliefs about the origin and meaning of human gender.
- *External religious issues* are defined as examination of a given religion from an outsider's perspective, including possible clashes between religious leaders and the influence of differences, between religious perspectives on social issues.
- Religion and gender are closely linked as each usually have an influence on the other. Religion defines roles and restrictions for different genders.

From Christian point of view,



Wives, "submit to your own husbands, as to the Lord. Husbands love your wives, as Christ loved the Church and gave himself up for her...
(Ephesians 5:21-25).



- Religion dictates dressing codes in some societies, e.g. Muslim ladies are expected to cover entire body. This may affect *vitamin D* absorption; hence bone problems at a later age.
- ▶ Religion may influence use of certain contraceptives
 - Gender influences the low level of male responsibility in the use of contraception.
 - Some men also prevent women from using family planning methods of a woman's choice and from limiting the family size.
 - Educate people on the dangers of producing too early, too late, too many and too often.
 - Encourage people to increase uptake of modern family planning methods to ensure health families.

► Religious Practices

- There are societies in which women are not allowed to seek health care, even for life threatening emergence conditions if the decision to seek for health care is not made by a male relative.
- There are also traditional practices where there is a preference to receive care only from female attendants and yet in Uganda, the majority of health care workers are men.

► Gender Roles in Marriage

Nearly all religions recognize marriage and many religions also promote views on appropriate gender roles within marriage.

From Christian point of view,



In Genesis 3:20, Adam names his wife (“life”) because she was “the mother of all living.”



Marriage with Different Faith

Couples in different faith marriages often face resistance and hostility, both from family members and religious leaders. Occasionally both Muslims and Christians feel pressure to convert to another’s faith in order to avoid rejection from family members.



This may contribute to depression and suicide or violence against the woman from in-laws.

• **Gender and Christianity**



Some religious leaders consider women as morally inferior to men and consider women as a source of sexual temptations for men.

4.6 Women in Development (WID) and Gender and Development (GAD)

Women in development (WID) is a concept, which denotes an approach that advocates for women targeted interventions within the mainstream of development so as to improve their condition.

Gender and development (GAD) is an approach that affirms and supports women’s equal role in development. GAD does not mean a de-emphasis on women; rather its goal is women’s empowerment and equality of women and men. This approach shifts the focus from women as a group to the socially determined relations between men and women.

Table 6: The difference between WID and GAD		
	WID	GAD
Definition	<ul style="list-style-type: none"> WID is an approach that advocates for women targeted interventions within the main stream of development so as to improve their condition 	<ul style="list-style-type: none"> GAD is an approach that was developed after the failure of WID projects to effect qualitative and long-lasting changes in women's social status.
Gender Relations	<ul style="list-style-type: none"> Integrates women in economic development through legal and administrative support 	<ul style="list-style-type: none"> Questions gender relations between women and men and the gender roles ascribed to them.
Gender Division	Examines the sexual division of labor and the differential impact of gender in development.	Sees the gender division of labor as the root of inequality, since it undervalues the work done by women in the household.
Women emancipation	Focuses on advocacy strategies for more equal participation of women in education, employment and other spheres of society.	<ul style="list-style-type: none"> Focuses on social, economic, political and cultural forces that determine how men and women participate in, or benefit from project resources differently. Recognizes women as agents of development, not merely as passive recipients of development assistance.
Women as Change agents (woman of Noble character Proverbs 31:10-16)	<ul style="list-style-type: none"> Does not challenge gender relations and assumes that these will change as women become economic partners in development. 	<ul style="list-style-type: none"> Promotes interventions and affirmative action programs that integrate women into ongoing development efforts.

From Christian point of view,



Women as Change agents example of Deborah Judges 4:4, Ruth in the book of Ruth; the example of Phoebe; Romans 16:1-3



4.6.1 Women in Development (WID) Approaches

Moser (1989) identified five dominant WID approaches that include:

1. The **welfare approach** that aims at women as mothers and wives who were viewed as passive recipients of services.
2. The **equity approach** that aims at promoting equal participation of women and men.
3. The **anti-poverty approach** that focuses on basic needs of the poor society as recipients of benefits in the field of housing, sanitation and employment.

4. The **efficiency approach** is an elaboration of the equity approach.
5. The **empowerment approach** is the least common that promotes women as feminists.

Although the different approaches have appeared in a chronological order, they have not replaced each other and each approach is still found today.

Another approach used is the bottom-up approach that includes:

1. Campaigns mobilizing women to vocalize their needs and demand for legal, social and economic rights.
2. Training, helping and encouraging women to take initiative and involve themselves in shaping or influencing government policies and development planning.
3. Establishing women’s access to and control over basic resources such as labour, land, tools and capital.

4.6.2 Gender and Development (GAD) Approaches

Gender Analysis and Planning

Gender analysis is a systematic way of looking at the different impacts of development, policies, programs and legislation on women and men that entails, collecting sex-disaggregated data and gender-sensitive information about the population concerned. Gender analysis can also include the examination of the multiple ways in which women and men, as social actors, engage in strategies to transform existing roles, relationships, and processes in their own interest and in the interest of others.

The identification of gender division of labour is crucial because it defines men’s and women’s socio-economic opportunities, constraints and incentives. The main question to ask is:

- Who does what?
- Where do men and women work?
- When do men and women work and for how long?

The following table depicts an example of activity profiles for gender analysis that religious leaders can use to construct their own gender activity profiles as relevant to their respective church communities.

Table 7: Activity profiles for Gender Analysis		
	Gender: Women/Girls OR Men/Boys	Time
Social-economic Activity		
Paid Labour Activity	M: exclusively male	
Unpaid labour e.g. Collection of firewood, ploughing, weeding, harvesting, cooking and childcare	F/m: Predominantly female	<ul style="list-style-type: none"> • Daily • Weekly • Seasonal • Dry season
Reproductive Activity		
Un paid labour for the church community • Singing in the church choir	M/F: Equally male and female	<ul style="list-style-type: none"> • Daily • Weekly • Seasonal • Dry season • 3 hours daily • 35 hours weekly
Leisure time, education, training	M/f: Predominantly male	

Source: Adapted from Gender Issues in the World of Work: Gender Training Package ILO, Geneva, 1995.

Key: *F: Exclusively female M: exclusively male F/m: Predominantly female M/F: Equally male and female M/f: Predominantly male*

Interpretation:

- In order to advance economically through paid labour and to fulfill traditional family responsibilities, women must work longer hours than men and comparably little time for leisure force, reduces the gender pay gap, and equal opportunity for education.
- Women are still primarily responsible for household chores and caring for family members.
- Major household expenditures remain largely under men’s control and authority. Men are often regarded as the family bread winner; and women are expected to be obedient, submissive, and self-scarifying in order to maintain family harmony.

4.7 Gender Roles between Men and Women

A gender role is a set of social and behavioral norms that are generally considered appropriate for either a man or a woman in a social or interpersonal relationship. Gender roles differ according to cultural-historical context, and while most cultures express two genders, some express more. Gender expression refers to the external manifestation of one’s gender identity, through “masculine,” “feminine,” or gender neutral behavior characterized by the hairstyles, clothing or body characteristics.

For example:

1. Women cannot receive needed health care because norms in her community her from travelling alone to a clinic.
2. A teenage boy dies in an accident because of trying to live up to his peer’s expectations that young men should be “bold” risk-takers.
3. A married woman contracts HIV because societal standards encourage her husband’s promiscuity while simultaneously preventing her from insisting on condom use.

Table 8: Common Gender Roles Stereotypes	
Male	Female
• Aggressions	• Submissive
• Ambition	• Modest
• Cold	• Warm
• Decisive	• Indecisive
• Independent	• Dependent
• Rational	• Flighty
• Strong	• Weak
• Unemotional	• Emotional
• Unexpressive	• Expressive
• Worldly-wise	• Home Centered

Conclusion

Gender norms and values negatively affect men’s and women’s health.

The pervasive gender inequalities despite these noble efforts indicate the need for effective economic empowerment of women as a prerequisite for their effective emancipation.

Policy makers, program managers, health professionals, and human rights workers need to be aware of and responsive to the detrimental health effects that gender plays throughout the life cycle. Therefore religious leaders need to be responsive to the detrimental health effects that gender plays throughout the life cycle.

Key Points to Remember:

- Gender discrimination at each stage of the female life cycle contributes to health disparity, sex selective abortions, neglect of girl children, reproductive mortality, and poor access to health care for girls and women.
- The violation of fundamental human rights, and especially reproductive rights of women, plays an important part in perpetuating gender inequity.
- In order to enhance women’s equity and autonomy in attaining sexual and reproductive health, it is necessary for religious leaders to promote gender equity as a major health determinant.

5

GENDER-BASED VIOLENCE

AN OVERVIEW OF GENDER-BASED VIOLENCE

5.0 What is Gender-based Violence?

Gender-based Violence or **(GBV)** is used to distinguish common violence from violence that targets individuals or groups of individuals on the basis of their gender. According to CEDAW, Gender-based Violence is violence directed at a person on the basis of gender or sex. It includes acts that inflict physical, mental or sexual harm or coercion and other deprivations of liberty.

Gender-based violence is any act or practice that results in physical, sexual, psychological or economic harm or suffering because of a person's gender or socially defined role. It is the manifestation of control and power, mostly by men over women, resulting from unequal power relations between the male and female sexes. Majority of the victims or survivors of gender-based violence are women and girls.

Gender-based Violence is a violation of human rights. This kind of violence perpetuates the stereotyping of gender roles that denies human dignity of the individual and human development.

Some people prefer the use of GBV instead of Sexual-gender-based violence (SGBV) because adding "*sexual*" in the phrase implies that somehow GBV itself does not include sexual violence (which is not accurate).

Some people prefer VAW because it clearly emphasizes the needs and vulnerabilities of females, making clear exactly what/who we are talking about. Other people feel strongly about viewing all of these issues in the context of gender, so they prefer GBV.

Even within the United Nations system, there are different terms used to describe GBV. The variances among the UN agencies illustrate the complexity and depth of the issues involved in GBV:

- UNFPA uses GBV
- WHO uses VAW
- UNHCR uses SGBV

5.1 Root Causes of GBV

The root causes of gender-based violence are gender discrimination and gender inequality as discussed below:

1. Gender Discrimination

The root causes of gender-based violence lie in a society's attitudes towards and practices of gender discrimination, which place women in a subordinate position in relation to men.

2. Gender Inequality

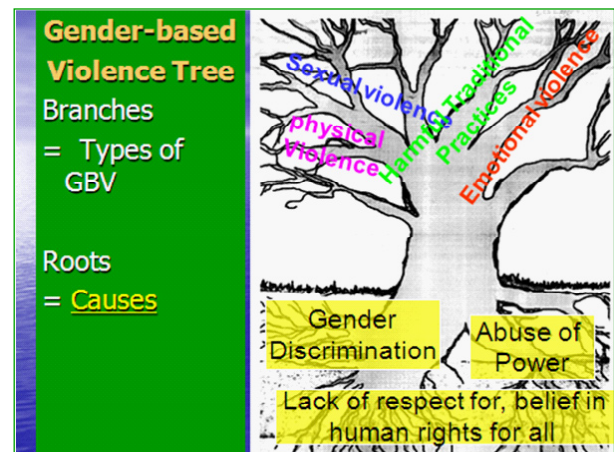
Gender-based violence is largely rooted in unequal power relations between men and women. The lack of social and economic value for women and women's work and accepted gender roles perpetuate and reinforce the assumption that men decision-making power and control over women. Through the acts of gender-based violence, whether individual or collective, perpetrators seek to maintain privileges, power and control over others.

- When there is gender inequality, other forms of GBV that occur may include:
 - Early and or/ Forced marriage
 - Female infanticide
 - Enforced sterilization or pregnancy
 - Domestic violence
 - Forced or coerced prostitution or other signs of sexual exploitation
 - Trafficking in women, girls and boys
 - Intentional HIV transmission
 - Rape, host/refugee community relationships
 - Sexual exploitation and the code of conduct
 - Female genital mutilation (FGM) and Traditional practices
- **Gender Inequality and How it Leads to GBV**
 - Gender inequality is an imbalance in access to political, economic, educational and social arenas based on sex or gender.
 - Gender inequality is often justified by people and institutions based on what they say are biological differences between men and women. It considers women as unequal in power, opportunities and resources.

DIAGRAM OF THE ROOT CAUSES OF GBV

ROOTS

- STEM - Contributing factors
- BRANCHES - Forms of GBV
- FRUITS - Consequences



Although Gender-based violence may occur in public contexts, it is largely rooted in individual attitudes that condone violence within the family, community and the state. The root cause of gender-based violence lies in a society's attitudes towards and practices of gender discrimination, which place women in a subordinate position in relation to men.



Example: The lack of social and economic value for women and women’s work and accepted gender roles perpetuate and re-enforce the assumption that men have decision-making power and control over women. Through acts of sexual and gender-based violence, whether individual or collective, perpetrators seek to maintain privileges, power and control over others.

5.2 Causes or Contributing Risk Factors of Gender-based Violence

While gender discrimination and inequality are the root causes of gender-based violence, there are other various contributing factors that determine the type and extent of violence in each setting. Therefore it is important for the religious leaders and institutions to understand these factors in order to design effective strategies to prevent and respond to gender-based violence.

The following table describes the causes or contributing risk factors that can increase the risks of becoming a victim/survivor or perpetrator of gender-based violence:

Table 9: Summary of the Causes or Risk Factors of Gender-based Violence	
Risk factor	Outcomes
Individual Risks	<ul style="list-style-type: none"> • Loss of security • Physical and mental disabilities • Inability to cope with changes in socio-economic status • Alcohol, drug use or abuse • Psychological trauma and stress • Disrupted roles between family and community • Ignorance/lack of knowledge of individual rights enshrined under national and international laws
Social Norms and Culture	<ul style="list-style-type: none"> • Discriminatory cultural and traditional beliefs and practices • Religious beliefs
Legal Framework and Practices within the Country	<ul style="list-style-type: none"> • Lack of legal protection for women’s and children’s rights • Lack of laws against gender-based violence • Lack of trust in the law enforcement authorities • Application of customary and traditional laws and practices that enforce gender discrimination • Lack of advocacy campaigns condemning GBV Under-reporting of incidents and lack of confidence in the administration of justice • Low number of prosecutions obtained in proportion to the number of cases reported • Police and courts inaccessible because of the remoteness areas to local courts and security officials • Absence of female law enforcement officers.
War and armed Conflict	<ul style="list-style-type: none"> • Breakdown of social structures • Exertion of political power and control over other communities Ethnic differences • Socio-economic discrimination
Refugees, returnees and Internally Displaced Situations	<ul style="list-style-type: none"> • Collapse of social and family support structures • Geographical location and local environment (high crime area) • Predominantly male camp leadership gender biased decisions • Unavailability of food leading to movement in isolated areas • Insecurity • Lack of individual registration and identity cards

5.3 When and Where does Gender-based Violence Occur?

Gender-based Violence occurs anywhere at any time. Just as the laws and structures that govern a society influence the behaviour of individuals, so too, can individual attitudes influence the way families, communities and societies respond to certain types of behaviour. The following diagram represents the clear linkages between the individual and the society.



- **At the Individual level**

The degree of knowledge, personal security, access to and control of resources, services and social benefits, personal history and attitudes towards gender can influence whether a person can become a victim/survivor or a perpetrator of violence.

- **At the Family Level**

This level represents the immediate context in which abuse can occur between individuals, even within families. At this level, existing power inequalities among individuals begin to reinforce subordinate/ privileged positions.

The family and households are the primary sites of GBV. However, this form of domestic violence is often seen as a “private” issue and it is very difficult to gather information about it.

From Christian point of view,



Ephesians 5:25 (Husbands love your wives, just as Christ also loved the Church and gave himself for her.



- **At the Community Level**

This level represents the dynamics between and among people that are influenced by socialization within such local structures as schools, health care institutions, peer groups and work relationships. For Christian-founded institutions this structure is found in the community setting where the availability of and access to social services can have a direct impact on whether or not incidents of GBV occur.

- **At the Society Level**

Society includes the cultural and social norms about gender roles, attitudes towards children, women and men, the legal and political frameworks that govern behaviour, and the attitude towards using violence as a means of resolving conflicts.

From Christian point of view,



Corinthians 7:7: For I wish that all of them were even as I myself ...



▪ At the Government

The government and its line ministries such as the police help to perpetuate GBV. During insurgency, security forces use rape as an indirect way of targeting the men of a particular community.

The Health System:

Health systems remain out of reach for the majority of poor women and the burden of care is shifted from the state to women. This is particularly true of HIV and AIDS where the state has placed the responsibility of care on women through Home-Based Care (HBC) which, despite the increasing recognition of the role women are playing remains unrewarded.

Gender-based Violence occurs at all levels including the individual level, family level, community, society as well-as the government level. It can also occur in all classes, cultures, religions, races, gender and ages.

5.4 Types of Gender-Based Violence

Appendix 1 describes some of the types/forms of GBV. It is a practical tool that can be used in each religious institution to help identify the different forms of sexual and gender-based violence that exist. Acts of GBV have been grouped into five types as follows:

1. Sexual Violence
2. Physical Violence
3. Emotional and Psychological Violence
4. Harmful Traditional Practices
5. Social-economic Violence

5.5 Consequences of Gender-Based Violence

Victims/survivors of GBV are at high risk of severe health and psycho-social problems, sometimes death, even in the absence of physical assault.

Understanding the potential consequences of GBV will help Christian leaders to develop appropriate strategies to respond to the after effects of GBV and prevent further harm.

Consequences of gender-based violence include:

1. Health consequences
 - Fatal health consequences
 - Non-fatal consequences
2. Psychological consequences
3. Legal/justice-related consequences
4. Safety and security

1. Health consequences

Gender-based Violence adversely affects victims, family members, perpetrators, communities and states on profound levels. GBV accounts for more death and ill-health among women ages 15-44 world wide than cancer, obstructed labour, heart disease and respiratory infections.

Some of the consequences of GBV include feelings of hopelessness and isolation, guilt and depression, or suicide.

The more longer-term the abuse and violence the greater the impact on women's ability to care for themselves and their children. In concrete terms, it may lead to bruises, cuts, broken bones or limbs, unwanted pregnancies, sexually transmitted infections (STIs) including HIV/AIDS), permanent disabilities or death (See Table 10 for Health Consequences of GBV).

- **Fatal health consequences**
 - Homicide
 - Suicide
 - AIDS related mortality
 - Infant mortality
 - Maternal mortality
- **Non-Fatal health consequences**

Table 10: Health Consequences (Non-Fatal health consequences of GBV)			
Acute Physical	Chronic Physical	Reproductive Health	Mental Health Outcomes
<ul style="list-style-type: none"> • Injury Lacerations Fractures Internal organ injury 	<ul style="list-style-type: none"> • Disability 	<ul style="list-style-type: none"> • Miscarriage 	<ul style="list-style-type: none"> • Anxiety
Shock	<ul style="list-style-type: none"> • Chronic pain 	Unwanted pregnancy	<ul style="list-style-type: none"> • Depression
Disease	<ul style="list-style-type: none"> • Chronic infections 	Unsafe abortion	<ul style="list-style-type: none"> • Eating problems
Infection	<ul style="list-style-type: none"> • Gastro intestinal problems 	<ul style="list-style-type: none"> • STI's including HIV and AIDS 	<ul style="list-style-type: none"> • Fear
	<ul style="list-style-type: none"> • Eating disorders 	<ul style="list-style-type: none"> • Menstrual disorders 	<ul style="list-style-type: none"> • Low self esteem
	<ul style="list-style-type: none"> • Sleep disorders 	<ul style="list-style-type: none"> • Gynecological disorders 	<ul style="list-style-type: none"> • Suicide, homicide
	<ul style="list-style-type: none"> • Alcohol and drug abuse 	<ul style="list-style-type: none"> • Sexual disorders 	<ul style="list-style-type: none"> • Post traumatic disorders

5.5.1 Consequences of Domestic Violence for Individuals, Families and Communities:

- **Consequences for Individuals**
 - Domestic violence hurts all of us.
 - Women in abusive relationships cannot participate fully in community life.
 - The ability to share ideas, skills, talents, and options, with their families, communities, places of worship, and in the political process is lost when their bodies and mind are subjected to domestic violence.

- **Consequences for Families**

- Domestic violence creates a frightening environment in that children born in a violent family learn to fear and worry about their parents.
- Children growing up in violent homes learn that violence and aggression are acceptable ways of expressing emotions or resolving conflicts. These children are more likely to leave home and commit acts of violence in their own homes as adults.

- **Consequences for Communities**

- The community also pays a high price for domestic violence.
- Businesses lose money due to the ill-health of female employees who are being abused.
- Financial and human resources are committed to domestic violence including health services, legal court proceedings and social services.

5.6 The Impact on Gender-based Violence on Women's Health

5.6.1 Physical and Psychological Health Problems

Gender-based violence has been linked to many serious health problems, both immediate and long-term. These include physical and psychological health problems:

- **Physical Health**

- ü Injury
- ü Disability
- ü Chronic health problems (irritable bowel syndrome, gastrointestinal disorders, various chronic pain syndromes, hypertension, etc.) Sexual and reproductive health problems (contracting sexually transmitted diseases, spread of HIV/AIDS, high-risk pregnancies, etc.) [See Gender-based Violence and Sexual Reproductive Health (SRH) 5.5.1]
- ü Death

- **Psychological Health**

Effects can be both direct/indirect

- ü **Direct:** anxiety, fear, mistrust of others, inability to concentrate, loneliness, post-traumatic stress disorder, depression, suicide, etc.
- ü **Indirect:** psychosomatic illnesses, withdrawal, alcohol or drug use.
- ▶ Socio-economic Health
- ü Rejection and social stigma at community level
- ü Reduced ability to participate in social and economic activities
- ü Acute fear of future violence, which extends beyond the individual survivors to other members in community
- ü Damage to women's confidence resulting in fear of participating into social activities (this can often curtail women's education, which in turn can limit their employment and consequently income-generating opportunities)

- ü Job loss due to absenteeism as a result of violence
- ü Increased vulnerability to other types of gender-based violence

5.6.2 The Impact on Women’s Family and Dependants

Ø Direct effects:

- ü Divorce, or broken families
- ü Jeopardized family’s economic and emotional development
- ü Babies born with health disorders as a result of violence experienced by the mother during pregnancy (i.e premature birth or low birth weight)
- ü Increased likelihood of violence against children growing up in households where there is domestic violence
- ü Collateral effects on children who witness violence at home (emotional and behavioral disturbances, e.g withdrawal, low self-esteem, nightmares, self-blame, aggression against peers, family members, increased risk of growing up to be either a perpetrator or a victim of violence).

Ø Indirect effects:

- ü Compromised ability of survivor to care for her children (e.g child malnutrition and neglect due to constraining effect of violence on women’s livelihood strategies and their bargaining position in marriage).
- ü Negative attitudes of a rape survivor towards the resulting child.

5.6.3 The Impact of Violence on the Perpetrators

- Sanctioning by community, facing arrest and imprisonment
- Legal restrictions on seeing their families, divorce, or the break up of their families
- Feeling of alienation from their families
- Minimizing the significance of violence for which they are responsible; deflecting the responsibility for violence onto their partner and failure to associate it with their relationship
- Increased tension in the home

5.6.4 The Impact of Violence on Society:

- Burden on health and judicial systems
- Hindrance to economic stability and growth through women’s lost productivity
- Hindrance to women’s participation in the development processes and lessening of their contribution to social and economic development
- Constrained ability of women to respond to rapid social, political, or economic change
- Breakdown of trust in social relationships
- Weakened support networks on which people’s survival strategies depend

5.7 Services to the Victim/Survivor

Action Aid and MIFUMI having had years of experience and expertise in managing GBV shelters were identified as lead Civil Society partners to support the development and establishment of these shelters. MIFUMI was contracted to get technical support to Masaka, Mbarara and Moroto shelters.

Services Offered at MIFUMI:

Services are offered in already existing government structures at the health facilities at all levels [*Regional Referral hospitals, District hospitals, Health Centers IV and III*], legal aid services, psycho-social support services, community awareness and mobilization, security, help-line services, referrals and skills empowerment; services offered at each of the referral levels are explained as follows:

- **At the Health Facility**

The health provider will take the survivor's history, screening, testing for HIV, administer Post-Exposure Prophylaxis (PEP) to prevent the victim from contracting HIV, and an Emergency Contraceptive Pill/s (ECP) to prevent the victim from unwanted pregnancy. Also surgery will be provided as required.

- **Seeking Legal aid Services**

Investigations, prosecution, legal representation, legal rights awareness, provision of Legal police form (III) where the doctor has to put the evidence.

- **Psycho-social Support Services**

- On-going counseling support services, following-up of the survivors
- Referral for rehabilitation — life skills
- Engaging the victim in income generating activities (IGAs) and economic empowerment through psycho-social activities like knitting.
- Enrolling the victim into the community theatre to engage him/self in dance, drama so that he/ she does not think so much.

- **Community Awareness and Mobilization**

Developing and disseminating IEC materials, using media, establishing/or strengthening community action groups made of women's groups, men's groups, Faith-Based Organizations, Village Health Teams (VHTs), to undertake community policing and early reporting at community.

- **Security (Temporary Shelters)**

Within the integrated services, provision is made for temporary shelter for survivors who would have assessed and recommended to stay as they recover from both physical and mental trauma as well as those survivors who are at risk of losing their lives if they returned to their homes or community.

- **Help line Services**

This is MIFUMI national Toll-free Domestic Violence helpline where survivors call in for confidential advice and counseling as well as referrals. The toll free helpline number is **0800 200 250**.



- **Referrals/Follow-ups**

Inter-sectoral collaboration is a key determinant of the quality of integrated services to be provided. Effective referral mechanisms will be established to improve integrated service delivery in a timely manner.

- **Skills empowerment for survivors**

Economic and social empowerment activities will be incorporated at the shelter including among others adult learning and skills training.

- **Who can access the GBV Shelter**

Adult males and females who have suffered extreme abuse (physical, emotional, sexual), or are at risk of re-occurrence of GBV and/or are threatened with death.

- **Coordination Mechanism**

Ø At National Level

The Ministry of Gender, Labour and Social Development (MoGLSD) coordinates the GBV shelters in close collaboration with key ministries and the government institutions including Office of the Prime Minister, Ministry of Health, Ministry of internal Affairs, Ministry of Local Government, Civil society organizations and the development partners. MIFUMI also works in close collaboration with the Regional Referrals Hospitals and the District Local Governments of Masaka, Mbarara and Moroto.

➤ At the District Level

Coordination is done by the District Community Development Officer (DCDO) representing the MoGLSD which is headed by a GBV Steering Committee composed of The Chief Administrative officer (CAO) as the chair. Resident District Administrator (RDC), Local Council V Chairperson, DCDO, DPC, Hospital Director DHO, Chief Magistrate, Chairperson NGO forum, Uganda Human Rights Commission, MUFUMI, and representatives of religious and cultural leaders.

5.8 Human Rights in the Context of GBV

National and International Instruments and Conventions for Addressing GBV

Numerous national and international instruments have drawn attention to gender-related dimensions of human rights issues, the most important being the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979.

The following text boxes depict the national and international conventions and protocols that address human rights in general with specific ones on women's rights: (See text boxes for UDHR, CEDAW, VAW respectively):

1. Universal Declaration of Human Rights (UDHR)
2. The International Convention on Economical, Social and Cultural Rights (ICECR)
3. The African Banjul Charter on Human and Peoples' Rights
4. The convention on Elimination of all forms of Discrimination Against Women **(CEDAW)**
5. The Declaration on Elimination of Violence Against Women **(DEVAW)**
6. The 1995 Beijing Platform for Action and the Convention on Rights of the Child
7. 1987 – Safe Motherhood Initiative
8. 1994 – International Conference on Population and Development

Gender-based violence is most prevalent in environments where there is a general lack of respect for human rights. Therefore the Universal Declaration of Human Rights (UDHR) describes the human rights and rights of particularly vulnerable groups such as women and children.

The Universal Declaration of Human Rights (UDHR)

After the terrible human rights abuses that happened during World-War II, the human rights commission of the United Nations (UN) drafted a Universal Declaration of Human Rights (UDHR).

- Human rights are universal, indivisible, interconnected and interdependent.
- Everyone is entitled to all the rights and freedoms, without distinction of any kind such as race, color sex, language, religious, political or social origin, property, birth or other status.
- Prevention of and response to GBV is directly linked to the protection of human rights.
- Acts of GBV violate a number of a number of human rights principles enshrined in international human rights instruments.

Article 3 of the Church of Uganda's provincial constitution (1972, amended in 1994) on the Dignity and Rights of the People, stipulates that;



“In conformity with established Christian doctrine, all people have equal value and dignity in the sight of God, and ... shall not allow discrimination ... in the church solely on the grounds of color, sex, tribe or religion” (Gender Policy, The Church of the Province of Uganda, 2012).

The convention on elimination of All Forms of Discrimination against Women adopted by the United Nations Declaration on the Elimination of Violence against Women.

CEDAW: The International Bill of Rights for Women

The Convention on the Elimination of All Forms of Discrimination Against Women defines the right of women to be free from discrimination. It establishes an agenda for national action to end discrimination, and provides the basis for achieving equality between men and women through ensuring women's equal access to, and equal opportunities in, political and public life as well as education, health and employment. CEDAW is the only human rights treaty that affirms the reproductive rights of women.

The Convention has been ratified by 180 states, making it one of the most ratified international treaties. State parties to the Convention must submit periodic reports on women's status in their respective countries.

CEDAW's Optional Protocol establishes procedures for individual complaints on alleged violations of the Convention by State parties, as well as an inquiry procedure that allows the Committee to conduct inquiries into serious and systematic abuses of women's human rights in countries. So far the Protocol has been ratified by 71 States.

The Universal Declaration of Human Rights (UDHR)

- Everyone is born free and equal
- Everyone has the right to life, liberty and security of persons.
- Everyone has the right to freedom of movement, assembly and association
- No body shall be tortured, detained or exiled.
- Every one has the right to work, rest and leisure.
- Everyone has the right to participate in the political and cultural life of the community.
- Every one has the right to form and join the union.
- Everyone has the right to equal pay for equal work just wages and good working conditions.
- Everyone is equal in the eyes of the law everyone is charged as innocent until proven guilty.
- Everyone has the right to own property .
- Everyone has the right to marry and own property.
- Human rights are universal ,inalienable, indivisible, interconnected and interdependent.
- Everyone is entitled to all the rights and freedoms, without distinction of any kind, such as race, colour, sex language, religion, political or other opinion, national or social origin, property, birth or other status.
- Prevention of and response to gender-based violence is directly linked to the protection of human rights.
- Everyone has the right to life, liberty and security of person.
- Everyone has the right to the highest attainable standard of physical and mental health
- Everyone has the right to freedom of opinion and expression, to educate to social security and to personnel development.
- Everyone has the right to freedom from torture or cruel inhuman degrading treatment.
- Everyone has the right to live in the society that respects and protects their freedom.
- Everyone has the right to life, bodily integrity and the means which are suitable for the proper development of life which are primarily, rest, medical care and social services.



The violation of fundamental human rights, and especially reproductive health rights of women, plays an important part in perpetuating gender inequity. It is therefore imperative that a rights based approach be taken across all developmental activities within the religious institutions.

Violence Against Women (VAW)

Violence against women refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual and psychological harm to women and girls, whether occurring in private or in public (**Article 1: UN Declaration on the Elimination of Violence, 1993**). Violence against women is a form of gender-based violence and includes sexual violence.

Sexual violence, is a form of gender-based violence that includes exploitation and abuse, and refers to any act, attempt or threat of a sexual nature that results, or is likely to result in physical, psychological and emotional harm.

- Sexual violence makes women vulnerable to HIV and AIDS, in cases such as rape and incest, women and girl children are made vulnerable because the perpetrator does not wear a condom, and his HIV status is unknown. The vulnerability is increased because the violent nature of the act leads to abrasions and bleeding -which provides a ready environment for HIV transmission. Due to ignorance or the lack of access to facilities for testing, it may take a long time before the rape survivor knows her status and by then it may be too late.
- Customary practices and beliefs also play a role in this regard. The belief that virgins can cure AIDS has put a number of girls and young women, especially in Africa, at risk. As a result more and more young women are succumbing to the disease with very little hope of survival. Studies conducted in Africa show that young women are the group most at risk of developing HIV/AIDS.
- **Rape in Marriage**



It is not recognized that rape in marriage exists and as such women have no protection from contracting HIV. HIV positive women also face pressure to abort before they can access health services.

God did not create a male as a superior to a female; they were both created in the image of God to complete and complement each other. The church should also continue to teach that the Biblical idea of a woman as a helper is not meant to say that she is less important or a subordinate but rather a helpmate, a complement, a mutual partner and fundamentally to be an equal.

- Women have the right from freedom against violence within the family, Banjul 18:3, DEVAW 2a.
- Women have a right to free of physical, sexual, and psychological violence in the family. DEVAW2a.
- Everyone has the right to life, and security of person UDHR 2, DEVAW 3a,c.
- Women have the right to the highest attainable level of physical and mental health and the right to equal access to health services, including family planning CEDAW 12, Banjul 6, DEVAW 3f.

What can the Church do to Promote Women's Rights?

- Educate friends, family, colleagues, and the community about women's rights and the conventions.
- Educate the women whose human rights have been violated.
- Respect the rights and the dignity of people.
- Lobby the elected officials who understand human rights to promote women's interests and equity.

From Christian point of view,



1 Corinthians 6:18 Flee from sexual immorality. All other sins a man commits are outside his body, but he who sins sexually sins against his own body. **19** Don't you know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? You are not your own; **20** you were bought a price. Therefore honor your God with your body.



If you know of a woman who is experiencing gender-related (sexual violence), guide her to access services from a community focal person in-charge of domestic violence. Let her know that you are there for her and that you will offer emotional support.

Remember she can make her own decision about her life.

The Common Wealth Integrated Approach to Eliminating Gender-based Violence

Addressing GBV: The Need for a Collaborative Efforts of all Stakeholders

Gender-based Violence (GBV) is a serious problem and one which we as Christians must tackle head-on. It is a cross-cutting and complex phenomenon that needs to be tackled on all fronts by various stakeholders.

Stakeholders that should be involved in addressing GBV include:

- Victims and their families
 - Communities
 - Institutions such as police
 - Cultural and religious leaders
 - Employees
 - Educational institutions
 - Perpetrators
- Since the church is operating in a resource-limited setting, it would be ideal to partner with all the stakeholder to avoid duplication and attain higher achievements.

Church Institutions need a Multi-sectoral Team to Address GBV Issues

Effective implementation of the strategies to address GBV interventions requires multi-sectoral, interdisciplinary, joint collaborative efforts where the Ministry of Health works with all sectors to ensure coordinated implementation with the community at the centre.

Table 11: Stakeholders and their Expected Collaborative Efforts

	Sector	Roles and Responsibilities
1	Ministry of Health (MoH)	To formulate policies and guidelines that address GBV and also provide the necessary support to the survivors of GBV
2	Ministry of Finance Planning and Economic Development (MoFPED)	To mobilize of resources and rational allocation of resources according to different priorities
3	Ministry of Gender Labour and Social Development (MoGLSD)	To ensure gender mainstreaming, advocacy, and prevention of Gender Based Violence (GBV); Community mobilization and developing policies for social protection of vulnerable groups.
4	Ministry of Local Government (MoLG)	To ensure good governance and accountability, to recruit and deploy appropriate trained staff (health workers), supervision and monitoring of health service delivery in the districts
5	Ministry of Education/ Universities/ Research Institutions. (MOE)	To ensure pre-service, in-service training of health workers and education of the citizens especially the girl child.
6	Ministry of Defence (MoD)	To ensure all the line ministries operate in an enabling environment and are protected from external aggression.
7	Ministry of Internal Affairs	To ensure security of life and property.
8	Ministry of Justice	To ensure law and order
9	Civil Society Organisations (CSOs)	To partner with the public sector and to ensure availability of funds.
10	Communities	Community participation and mobilisation

The Role of the Church in Preventing Gender Based Violence

What Actions should the Church undertake to Prevent GBV?

- Becoming informed about GBV is an important first step in addressing violence.
- Hence the church should learn about the GBV concept and share the knowledge with others.
- Working with the community members to brainstorm strategies to reduce GBV.
- Talk about GBV to family members, neighbors and the community at large.
- Being role models by teaching non-violent ways of resolving family conflicts.
- Parents need to show their children that GBV has bad effects to the family.
- The religious leaders should teach the community members.
- The religious leaders should refer the victims/survivors of GBV.
- The church should contact local organizations and find how they can help.

It is nearly impossible to consider sexual and reproductive health and rights without simultaneously considering the role of the church in shaping morality. Biblical teachings deeply influence personal conduct, especially in the areas of sexuality marriage, gender, child bearing, and parental-children relationships.

From Christian point of view,



The Church of Uganda upholds that the starting place for effective and fruitful ministry is within families, and as such attaches great importance to the role and impact of family values on building a healthy and growing church. The family shall be understood to refer to a Christian family comprising of one (1) woman and one (1) man [with or without children] who have solemnized their marriage in the presence of God, families, friends as witnesses and of an authorized minister in accordance with our Lords teaching on marriage found in the Holy Scripture and the Church's Doctrine on Marriage as set forth in the provincial Canons (Gender Policy, The Church of the Province of Uganda, 2012).



- Gender Based Violence like any other is a consequence of sin and the fall as a whole. Role number one of the Church in preventing GBV is repentance and ask for forgiveness both from God and one another. We (men and women) all have our weaknesses but we need to accept each other, care, love, and help each other to be better persons.

The husbands must be reminded by the church that they should love their wives like Christ loved the Church (**Eph.5:29** and **Mat.20:28**) and love calls for patience, kindness ... as Paul points out in (**1 Cor.13:4-9**). To help does not mean to be subordinate to the one helped. The gender difference therefore should not be emphasized as a means of exerting violence to one another but be seen as a means of complementing each other.

- As a body of Christ we are called upon to remind our societies that culture is good and must not be for enslaving anyone who was created in the image of God for anyone of any gender was/is -*"fearfully and wonderfully made."* (Ps.139:14) and so no forces such as traditional, cultural, legal, and religious should demean anyone created in the image of God based on gender.
- The Clergy and other Church leaders may be among the first people to hear about the violence or identify a victim. Not only can they help the victim access help, safety and resources, but can also hold people accountable for spreading violence and those with uncontrollable behaviour be checked. The Church must be the voice of the voiceless and advocate for their rights especially those who are harassed because of their gender inclination. *"Blessed are the peace makers for they shall be called the children of God."* (**Mat.5:9**).

The Church has a responsibility of counseling and establishing resettlement centers for the victims of violence where they could be well administered to spiritually and otherwise for instance be helped to access the means by which to survive such as training them to develop vocational skills by which they can live.

The church has a role of sharing a clear message that God is fair and never intends any human being to be abused or have his/her rights violated by another person. The victims can also be helped to live with others without being discriminated against, support them materially but above all strengthen their faith by showing them the love of God in Jesus Christ. **"I was sick, was hungry you gave me what to eat..."** (**Mat.25:36-40**). It is our responsibility as Church to reach out to them in love and with love of Jesus Christ and encourage them that God loves them and that their present status is but just for a season.

It should be noted that in this presentation a lot of concentration has been put on a man/ woman relationship. But it is imperative to note that there are situations/cultures where girls 'rights are simply violated because they are girls mainly but the reverse can also be true where some boys are discriminated against and their rights violated/denied because of their sexuality.

In all this, the best that can be said is that the Church needs to intensify her teaching programmes so that the people can really know the meaning of gender, the gender related issues as well as the misconceptions and the theological errors. Show joy and love to his/her gender and also appreciate the fact of various traditional, cultural and religious differences that should not be used to oppress and suppress one another. John Scott in *Issues Facing Christians Today-New Perspectives on Social & Moral Dilemma (1999:280-281)*, says:

Jesus never discriminated people because of their gender but dealt with them according to their needs and situations. Jesus dealt with the Samaritan woman in the gospel of **John 4** as well as Zacchaeus in **Luke 19:1-10** for both needed salvation which I hope the Church should know that it is the greatest need for the hour. St. Paul in **Galatians 3: 28-29** reminds us that;

From Christian point of view,



"There is no longer Jew or Gentile, slave or free, male and female. For you are all one in Christ Jesus. And now that you belong to Christ, you are the true Children of Abraham .You are his heirs, and God's promise to Abraham belongs to you."



This implies that we are all important and no one should despise and make an effort to violate another person's rights just because of any person's gender.

From Christian point of view,



There is no way we can stop violence without restoring man into God's image.

God created both men and women with equal rights so the role of the Church is to sensitize her members about the dangers of gender-based violence.



Women’s participation in Decision making and Leadership

There is a significant imbalance between the number of women and the number of men involved in all leadership decision-making organs of the Church of Uganda. This can be attributed to the social and cultural dynamics of the society (**See Table: XX below**). The current leadership status of the Church of Uganda by Gender).

Table 12: Synopsis of Involvement of Men and Women in Church of Uganda and Decision Making and Leadership Activities		
Decision Making	MEN (%)	WOMEN (%)
Decision Making		
Bishops	100	0
Treasurers	82	18
Diocesan Secretaries	100	0
Mission Coordinators	93	7
Development Coordinators	87	13
Youth Coordinators	95	5
Estate Officers	100	0
Health Coordinators	95	5
Leadership: Committees, Boards & Councils		
Provincial Board Members (2006-2010)		
PDR	82	18
Mission	88	12
Education	90	10
Finance	91	9
Health	97	3
Provincial Heads of Departments	86	14
Provincial Assembly Standing Committee	76	24
Members (2006-2010)		
Delegates to the Provincial Assembly (2006-2010 –Estimated)	80	20

Source: (Gender Policy, The Church of the Province of Uganda, 2012).

Key Points to Remember

- Gender discrimination and inequality are the root causes of GBV.
- Gender-based violence violates human rights.
- Women and girls make up the vast majority of victims/survivors of gender-based violence, although boys and men can also be victims/survivors.
- Perpetrators of GBV are sometimes the very people upon whom survivors depend to protect them.
- Gender-based violence occurs in all classes, cultures, religions, races, gender and ages. Interventions to prevent or respond to gender-based violence should target individuals, close relationships, the community and society, in general.

- Equal access to and control of material resources and assistance benefit and women's participation in decision-making processes should be reflected in all programmes.
- Understanding the cause of gender-based violence will help the Christian leaders to develop effective actions to prevent it; understanding the consequences of gender-based violence allows Christian leaders to develop appropriate response packages for victims/survivors.

6

FAMILY PLANNING

6.1 Need for Family Planning

Family planning is the practice of spacing children that are born using both natural (traditional) and modern (artificial) birth control methods. Birth spacing promotes the health of the mother, children and the father. In Uganda the challenge is that we still have very high levels of the unmet need for family planning (34.3%).

- Children are a gift from the lord and it is our responsibility to see how they are produced and taken care of hence our involvement in maternal and Child Health as a Church (**Psalms.127:3**).
- Children are God’s wonderful creations who are fearfully and wonderfully made. It would be failing her responsibilities if the church neglected them in maternal and child health (**Psalms 139:13-15**).

6.2 Status of Family Planning in Uganda

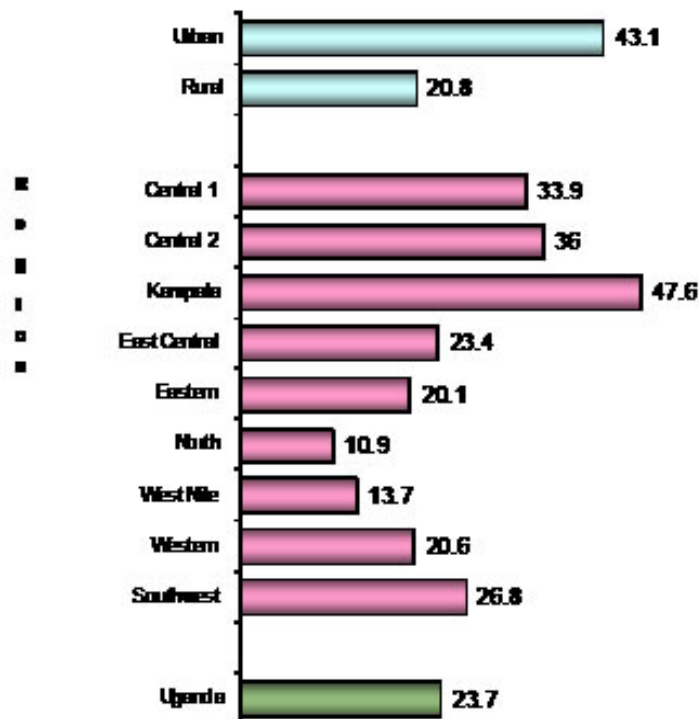


Figure 11: Chart indicating Contraceptive Prevalence Rate (CPR) by Region (%)

6.3 Family Planning Methods

There are two types of birth control methods: natural and modern (artificial). The modern methods are further sub-divided into short-term, long-term and emergency contraception methods.

6.3.1 Natural Methods

Natural methods include specific actions or **deeds** that people can do naturally to prevent an unwanted pregnancy. Natural family planning often does not cost anything and usually has no side effects.

1. Abstinence

Abstinence entails not having any type of sex play or intercourse with a partner. It is the only birth control method that is 100% effective in preventing pregnancy as well as sexually transmitted diseases.

2. Withdrawal

- Withdrawal is the behavioral action where a man pulls his penis out of the vagina before he *ejaculates*.
- It is not a reliable method because a male ejects *pre-ejaculate* fluid while he is aroused and still inside the vagina – this fluid can contain at least 300,000 sperms (and it only takes 1 sperm to **fertilize an egg**) Plus, it relies on complete self-control.
- Even if the man ejaculates outside of the vagina, sperm can swim, so semen anywhere near the vagina can still lead to pregnancy (this also means that a woman can **still get pregnant** even without penile penetration).

3. Fertility Awareness

- “Fertility awareness” is when a woman monitors her **fertility** and avoids unprotected intercourse during her *ovulation*. This method involves monitoring different body changes (such as basal body temperature (BBT) or cervical mucus variations) and recording them to establish when ovulation occurs.
- Before ovulation, BBT probably ranges from 97.2 to about 97.7 degrees Fahrenheit. But two or three days after ovulation, hormonal changes cause a rise of 0.4 to 1.0 degree in BBT, which lasts until the next period. A woman can also use the calendar method to determine ovulation, but this is not reliable. The woman then abstains from unprotected sex for 7 days before and 2 days after when she may have ovulated.
- **Cervical Mucus Variations:** Over the course of a woman’s menstrual cycle, the amount, color, and texture of cervical mucus will change, due to fluctuating hormone levels. Checking her cervical mucus and keeping track of these changes can help the woman to figure when she will ovulate.
- Here is what to expect throughout the cycle. Beginning with periods, there will of course be menstrual blood. When the periods are over, most likely the woman will be dry for several days. After that, they will start to have cloudy-coloured mucus that’s roughly the consistency of sticky rice. A woman is not likely to conceive on any of these days.
- As the woman approaches ovulation (typically a few days before hand), the mucus will become clear and slippery, very much like raw egg white, and they will have more of it. (Remember this type of mucus means it is baby-making time if you think of how it is clear, slippery quality makes it easier for the sperm to travel to the egg). The last day the woman sees this egg-white consistency is the day that she is most fertile— usually the day before or the day of *ovulation*.
- It is helpful for a woman to understand her menstrual cycle. This method also requires some careful effort and record keeping.
- The “moon beads” is one of the developments that has been designed to help women monitor their menstrual cycle. Moon Beads are a string of coloured beads based on the natural family planning method called the Standard Days Method (SDM), which helps women to know the days when they can get pregnant, through counting beads.



Women use moon beads to help count the days of their cycle, starting with the red bead on the first day of their period. There are different coloured beads used to represent the different phases of the menstrual cycle. This helps a woman to understand which days she is most likely to conceive during her cycle. Moon beads are a safe and low-cost contraception option for women.

4. Continuous Breast-feeding (Lactational Amenorrhea Method) [LAM]

Continuous Breast-feeding is a form of contraception that can postpone ovulation for up to 6 months after giving birth.

- It works because the hormone required to stimulate milk production prevents the release of the hormone that triggers *ovulation*.
- A woman should not rely on this method for more than 6 months or if she has had a period since giving birth.
- It is only effective if the woman feeds her baby at least 6 times a day on both breasts and does not substitute other foods for breast milk, and feeds her baby every 4 hours during the day and every 6 hours at night.

6.3.2 Artificial Methods

1. Oral Contraceptives (“The Pill”)

What is a Pill?

- Synthetic hormones (progesterone and/or estrogen) like those produced by the body to regulate the menstrual cycle.
- Reversible method of birth control given only by prescription.
- It thickens the cervical mucus by stopping sperm from passing through.

Effectiveness

- 95% - 99% chance of NOT getting pregnant.
- Between 1-5 per 100 women may become pregnant with proper use.



Advantages of the Pill:

- Does not interfere with sex.
- Regulates the menstrual cycle.
- Reduces menstrual flow and cramping.
- Decreases acne outbreaks.
- Reduces the risk of ovarian and endometrial cancer.
- Most popular method used.

Disadvantages of the Pill:

- Must be taken every day at the same time each day.
- Increased risk of heart attack, stroke, or blood clots (in lungs, legs, or arms),
- Especially in smokers
- Possible mood swings or depression.
- May decrease sexual desire.
- Cannot be used by women above 35 years.
- Does not prevent sexually transmitted diseases.

2. Emergency Contraceptive Pills (ECP)



- An emergency contraceptive method used after sexual intercourse to prevent pregnancy.
- Is most effective when used within 12 hours of unprotected intercourse or contraceptive **accident**.
- ECP can be used up to 72 hours or three days after unprotected sex.
- ECP only works if a woman is not already pregnant.
- Interferes with egg development.
- Prevents or delays ovulation.
- Inhibits fertilization.

Effectiveness: 74 % - 89%

Advantages of ECP or Emergency Contraceptive Pills:

- Only method of contraception used to prevent pregnancy after unprotected sex.
- Only method used to prevent pregnancy after breaking or leaking of a male condom.
- Only method used to prevent pregnancy after a woman’s diaphragm or cervical cap was inserted incorrectly, removed too early, or found to be torn.
- Only method used to prevent pregnancy after a woman has missed one or more of oral contraceptives.
- Only method used to prevent pregnancy when a female condom was inserted or removed incorrectly.

Disadvantages of ECP or Emergency Contraceptive Pills:

- Does not work if already pregnant.
- Limited time frame (ECP must be used within 72 hours or three days after unprotected sex). Is not an on-going method of contraception.
- Nausea occurs in 23% to 50 % of women who use this method (medications to prevent nausea are available).
- Ectopic (tubal) pregnancy may be a possible result.
- ECP changes the amount, duration, and timing of the next menstrual period in about 10 to 15% of women treated.
- There is still a chance of pregnancy. If menstrual cycle does not start in 7 days, consider pregnancy and contact your family planning clinician.
- Does not provide protection from sexually transmitted diseases.

3. Depo-Provera (“The Shot”)

What is Depo-Provera?

- It is an injection given every 3 months.
- It contains synthetic progesterone.
- It stops ovulation, and thickens the cervical mucus to prevent sperm from passing through.
- It is a reversible method of birth control given only by prescription.



Effectiveness More than 99%

Advantages of Depo-Provera:

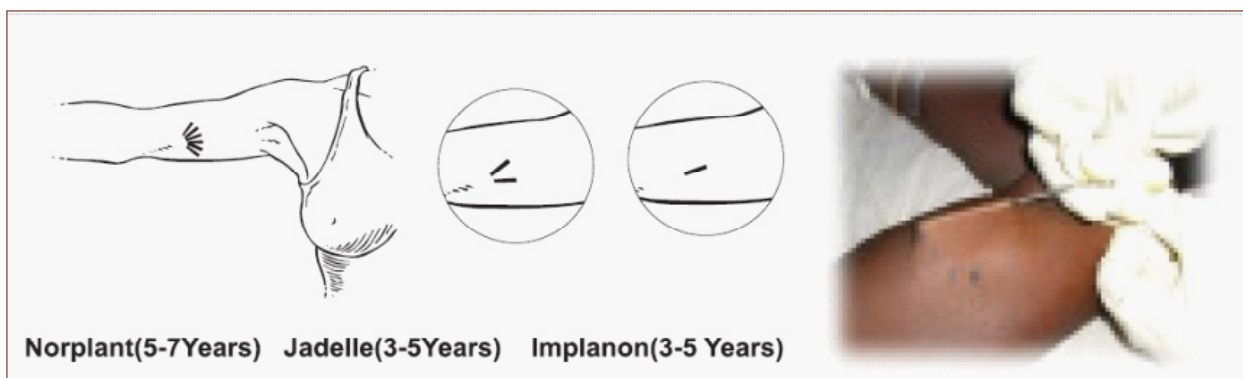


- Does not interfere with sex.
- Only need to get a shot 4 times a year.
- May stop menses or make them very light.
- Excellent alternative for women 35 and older who smoke.
- Reduces the risk of ovarian and endometrial cancer.

Disadvantages of Depo-Provera:

- Irregular or unpredictable bleeding or spotting.
- Possible hair loss.
- Weight gain, especially right after pregnancy.
- It may delay the woman's chances of getting pregnant after the shots are stopped. It can take between 6 and 18 months for menstruation and ovulation to return consistently. This does not mean that the woman is protected from pregnancy hence it is advisable that she uses alternate protection, such as condoms.
- Does not protect against sexually transmitted diseases.

4. Norplant



- Six capsules containing synthetic hormone inserted under the skin of the woman's upper arm.
- Capsules slowly release hormones into the bloodstream over a five-year period.
- These hormones stop the ovaries from releasing an egg each month.
- Hormones also thicken the cervical mucus hence stopping sperms from entering the cervix.
- Reversible method of birth control.

Effectiveness:

- More than 99% effective

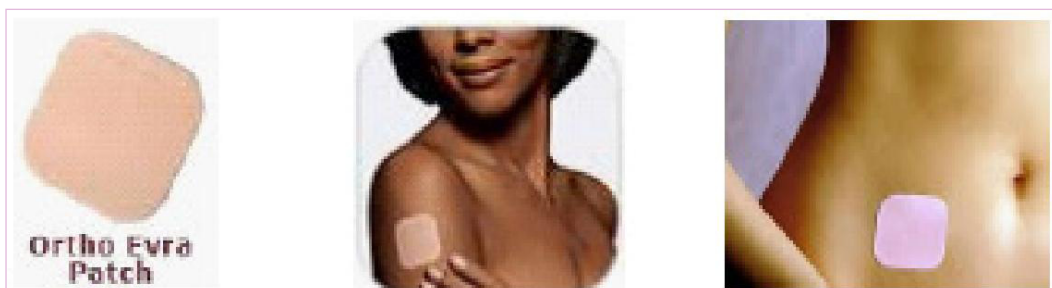
Advantages of Norplant

- Long term method can stay in five years.
- After 12 to 18 months of using this method, periods usually stop.
- Can be removed anytime, and the woman can become pregnant right away.
- Does not interfere with sex.
- Reduces risk of ovarian or endometrial cancer.

Disadvantages of Norplant

- Spotting between periods, light periods, longer periods, or no periods.
- Weight gain and hair loss.
- It is expensive anywhere between
- It requires minor surgery for insertion and removal of the capsules (done in the clinic or doctor's office).
- Effectiveness is lowered by most anti-seizure medications

5. Ortho Evra ("The Patch")



What is the Patch?

- The Patch contains synthetic hormones (progesterone and estrogen); these hormones are similar to those produced by a women's body.
- The patch is placed directly on the skin; these hormones are released from the patch directly through the skin into the bloodstream.
- Pregnancy is prevented because the patch stops ovulation and/or thickens the cervical mucus and stops sperm from passing through.
- The patch is a reversible method of birth control available only by prescription.
- The patch is less effective in women weighting more than 90 Kgs (198lbs).

Effectiveness

- 95% - 99% chance of NOT getting pregnant
- Between 1 and 5 per 100 women may become pregnant with proper use.

Advantages of the Patch

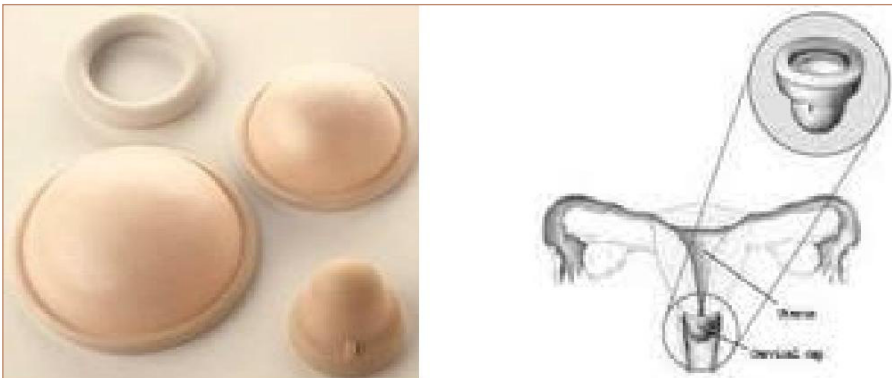
- Does not interfere with sex.
- No need to remember to put it on daily. Apply a new patch once a week.
- Reduces *menstrual flow* and cramping.
- Decreases acne outbreaks.
- Reduces the risk of ovarian and endometrial cancer.
- Ability to become pregnant immediately after discontinued use, if seeking pregnancy.

Disadvantages of the Patch

- May cause slight skin irritation at the patch site.
- Increased risk of heart attack, stroke, or blood clots (in lungs, legs, or arms), especially if you smoke more than 15 cigarettes a day, or are over 35 and smoke.
- Possible mood swings or depression.
- Women are encouraged not to use creams, lotions, or oils near the patch site these agents may cause the patch to detach.
- Does not prevent *sexually transmitted diseases* (STDs).

6.3.3 Barrier Methods

1. Cervical Cap



What is the cervical cap?

- It is a barrier contraceptive method.
- A soft rubber cup like device that fits snugly around the base of the cervix.
- It is used with spermicide for prolonged and additional pregnancy prevention.

Effectiveness (chances of NOT getting pregnant): 60-90 %

What are the advantages of the cervical cap?

- Simple to use.
- No serious side effects.

- Does not require partner involvement.
- Good for persons who do not have sex on a regular basis.
- May decrease risks of some sexually transmitted diseases.
- Provides contraceptive protection for up to 48 hours, no matter how many times lovemaking occurs.
- Does not interrupt lovemaking.
- Does not interfere with breast-feeding.

What are the disadvantages of the cervical cap?

- Consistent and correct use is required to prevent pregnancy.
- Persons with allergies to latex or spermicides cannot use.
- Remains in vagina for at least 6 hours after intercourse.
- Possible risk of toxic shock syndrome (TSS), if worn longer than 48 hours.
- May experience vaginal odor with prolonged use.

2. The Male Condom

What is a male condom?

- Made out of latex (rubber), but polyurethane and tactylon (both plastic) are available.
- Over the counter barrier method of birth control.



Effectiveness

- (Chances of NOT getting pregnant): 86 - 97%

Advantages of the male condom

- Easy to get and relatively inexpensive.
- Can be discontinued any time.
- Provides some protection from sexually transmitted diseases and HIV.
- Reliable method for people who cannot use hormonal birth control methods.
- Responsibility of both partners.

- Can be purchased without a prescription.
- Does not interfere with breast-feeding.

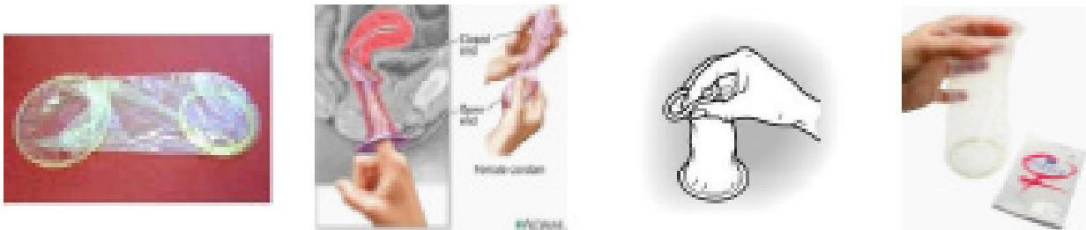
Disadvantages of the male condom; you may experience the following:

- Non-cooperative partner.
- Some irritation or sensitivity to latex may occur.
- Difficulty using condoms correctly.
- Must use a new condom with every sex act.
- Some men say it reduces sexual feelings.
- Must be rolled onto an erect penis before sexual intercourse and this can interrupt foreplay.
- Spillage or leaking of the sperm is possible if the condom is put on or removed incorrectly and this puts the woman at risk getting unwanted pregnancy.

3. The Female Condom

What is the female condom?

- Over the counter barrier method of birth control.
- It is polyurethane (plastic) sheath with an inner ring that fits inside the vagina, around the cervix (like the diaphragm) and an outer ring that covers the outside labia. Made from polyurethane plastic, which conducts body heat.
- After the man ejaculates, you must twist the end closed and gently pull from the vagina.



Effectiveness

- (Chances of NOT getting pregnant): 79% - 95%)

Advantages of the female condoms:

- Can be used with spermicides to increase STD protection.
- Provides protection against some sexually transmitted diseases and HIV.
- Can be purchased without a prescription.
- Does not interfere with breast-feeding.
- Some women and men have an increased sensitivity or “natural” feel compared to male condoms.
- Can be used by people allergic to latex or spermicides or by those who cannot take hormones.

Disadvantages of the female condoms:

You may experience the following:

- Difficulty inserting and/or keeping in place.
- Cannot be combined with male condoms as they pull each other off.
- May be noisy so the woman can add more lubricant if this is a problem.
- May irritate vagina or penis.
- More expensive than male latex condoms.
- Must be used every time you have sex.
- After the man ejaculates, you must twist the end close and gently pull from the vagina.

4. Diaphragm



What is a diaphragm?

- Barrier type birth control method prescribed by your family planning clinician.
- A dome-shaped rubber cup with flexible rim that covers the cervix and is inserted into the vagina before intercourse.
- Used in combination with spermicidal jelly or cream.

Effectiveness

- (Chances of NOT getting pregnant): 80-94% (during first year of use and whether or not you have delivered a child).

Advantages of the diaphragm:

- Simple to use.
- No serious systemic side effects.
- Does not require partner involvement.
- Good for persons who do not have sex on a regular basis.
- Decreases risk of some sexually transmitted diseases.
- Does not interrupt lovemaking.
- Decreases risk of cervical cancer.
- Does not interfere with breast-feeding.

Disadvantages of the diaphragm:

- Consistent and correct use is required to prevent pregnancy.
- Persons with allergies to latex or spermicides cannot use.
- Increased risks for developing urinary tract infections (UTI's).
- Remains in vagina for at least 6 hours after intercourse.
- Repeated sexual intercourse requires additional spermicide.
- Must remove within 24 hours to avoid risk of toxic shock syndrome (TSS).
- Must replace diaphragm every two years.

5. Intrauterine Device (“IUD”)



What is an IUD?

- Small plastic device which is placed in the uterus by a clinician to prevent sperm from fertilizing the woman's egg.
- Some IUDs contain synthetic progesterone others coated with copper
- It is a reversible method of birth control given only by prescription.

Effectiveness

- (Chances of NOT getting pregnant): 98% - 99%

Advantages of the IUD:

- Easy to use, low maintenance method.
- Easily inserted and removed in a clinic or doctor's office.
- Has no systemic side effects.
- Depending on the type they can be left in place 1, 5, or 10 years.
- Reduces the risk of tubal pregnancy.
- Does not interfere with breast-feeding.

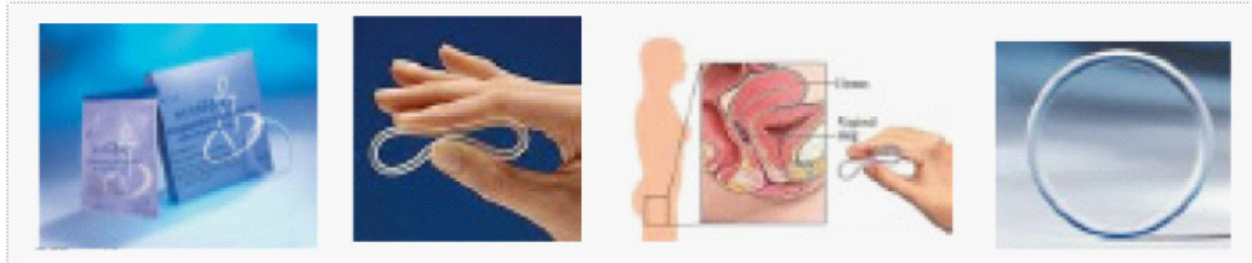
Disadvantages of the IUD:

- Must be inserted and removed in a clinic or doctor's office.
- Easily inserted and removed in a clinic or doctor's office.
- May be some cramping or pain at the time of insertion.

- May experience increased bleeding or cramping during periods.
- May experience spotting between periods.

Should not be used by women with multiple sex partners because this increases exposure to STD's, which significantly increases the risk of pelvic inflammatory disease (PID).

6 NuvaRing (“The Ring”)



What is the NuvaRing?

- The NuvaRing is a comfortable, flexible contraceptive ring that is about two inches in diameter and contains synthetic low dose hormones (progestin and estrogen); these hormones are similar to those produced by a women’s body.
- The NuvaRing is placed directly into the vagina; hormones are released from the ring and are directly absorbed through the walls of the vagina then distributed into the bloodstream.
- Pregnancy is prevented because the ring prevents the ovaries from producing mature eggs.
- The ring is a reversible method of birth control available only by prescription.

Effectiveness

- 99% chance of NOT getting pregnant
- Less than 1 per 100 women may become pregnant with proper use.

Advantages of NuvaRing

- Does not interfere with sex. Ability to remove the ring at leisure.
- No need to remember to put it on daily/weekly. Month long protection (3 weeks in, 1 week out)
- Exact positioning of the NuvaRing is not critical; however the ring should be placed high in the vault of the vagina.
- Muscles within the vagina allow the ring to stay in place during sex and/or exercise.
- Reduces menstrual flow and cramping.
- Decreases acne outbreaks.
- Reduces the risk of ovarian and endometrial cancer.
- Ability to become pregnant immediately after discontinued use, if seeking pregnancy.

Disadvantages of NuvaRing

- Not a good choice if the client is uncomfortable with touching herself.
- Increased risk of heart attack, stroke, or blood clots (in lungs, legs, or arms), especially if you smoke more than 15 cigarettes a day, or is over 35 and smokes.

- Patient may experience vagina discomfort and discharge.
- If the ring is kept out of the vagina longer than 3 hours on any day during the 21 day period (3weeks) pregnancy can occur; therefore a back-up method (condoms) is recommended for 7 days.
- Does not prevent sexually transmitted diseases (STDs)

7. Vaginal Spermicides

What are vaginal spermicides?

- A chemical birth control method that kills sperms and prevents pregnancy.
- Comes in the form of gel, foam, cream, film, suppository, or tablet.

Effectiveness

- (Chances of NOT getting pregnant): 50-95% (among users in the first year of use).



Advantages of vaginal spermicides:

- A relatively safe contraceptive method when combined with the barrier method (condom, diaphragm, cervical cap).
- May lower the chance of becoming infected with a sexually transmitted disease (STD).
- Can be purchased without prescription.
- Depending on the amount purchased is relatively inexpensive.
- Immediate protection is available.
- Good method for persons who have sexual intercourse infrequently or not very often.
- Simple back up method for women waiting to start the pill or have an IUD inserted, or for forgetting to take pill or running out of pills.
- Provides lubrication during intercourse especially with condom use.
- Male partner does not need to be involved in decision to use product.
- Does not interfere with breast feeding.

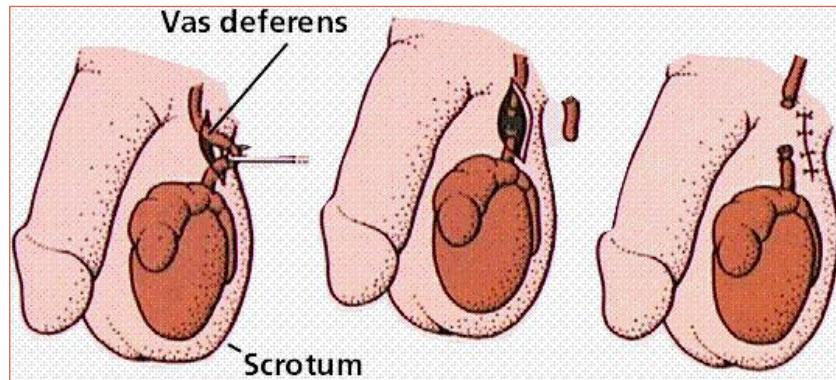
Disadvantages of vaginal spermicides

- Allergic reactions or hypersensitivity to ingredients may occur.
- Some health providers may have difficulty inserting properly.
- Abnormal vaginal anatomy (e.g. prolapsed uterus) may interfere with proper insertion.
- Poor protection from HIV exposure.

- Initial cost may be expensive, sometimes considered an elective procedure, and requires self-pay. However, the long term cost benefits are great.
- Although unproven, serious long-term effects are possible

II. PERMANENT BIRTH CONTROL METHODS

(a) Vasectomy



Vasectomy is a permanent birth control procedure where a small incision is made in the upper part of the man's scrotum. The two tubes (vas deferens) that carry sperm into the semen are cut apart and then tied off.

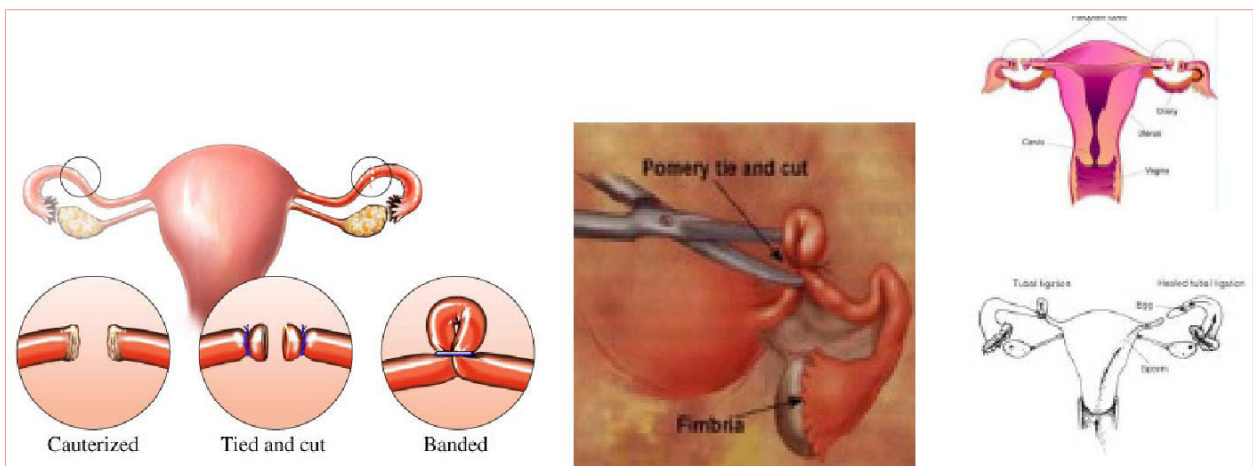
The incision is closed with stitches. Vasectomies are often performed in a surgeon's office; the client is awake, and the doctor will use local anaesthesia to numb the area. After the procedure, a man will still produce semen, but it will be free of sperm and will not cause pregnancy.

(b) Tubal Ligation

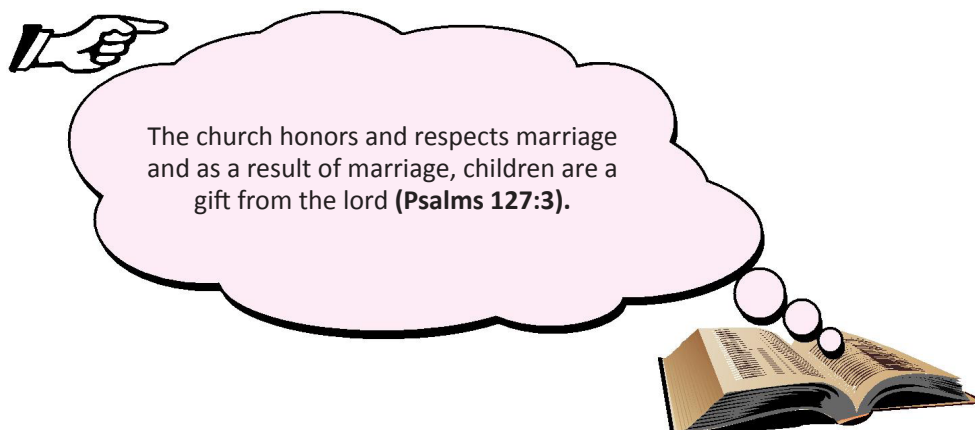
Tubal ligation (or tubal sterilization) is a surgical or non-surgical procedure that permanently sterilizes a woman by preventing an egg from travelling to the uterus; it also blocks sperm from being able to enter the fallopian tube, where fertilization normally occurs.

This permanent birth control method is performed in a hospital or outpatient clinic while the woman is under some form of anaesthesia.

In surgical procedures, one or two small incisions are made in the abdomen. The fallopian tubes are clipped, cut and/or sealed off (cauterized). The incision is then closed with stitches, as shown in the diagram below)



From Christian point of view,



Benefits of Using Family Planning

Benefits to the Mother

- The mother's body will recover hence she regains her immunity
- The mother has more time to pay attention to the children
- Controls the number of children
- Prevents teenage pregnancies
- Prevents anaemia as a result of the mother not conceiving frequently

Benefits to the Baby

- The baby can breast feed for a longer period since the mother is healthy
- The baby is happy and healthier
- Strong immune system

Benefits to the Father

- Will not be financially constrained
- Will be able to feed the family well
- Benefits to the Community and Nation
- Reduced maternal and child morbidity and mortality

Appendix 1: Types of Gender-Based Violence

1. Sexual Violence

Type of Act	Description/Examples	Can be Perpetrated by
Rape and marital Rape	The invasion of any body part (sexual organ, genital opening, anal canal) of the of the victim with any object or any other part of the body by force, coercion, taking advantage of a coercive environment without the person giving genuine consent.	Any person on the position of power, authority and control, including husband, intimate partner or caregiver.
Child sexual abuse, defilement and incest	- Any sexual relations with a child. - Any act where a child is used for sexual gratification.	Someone the child trusts, including parent, sibling, extended family member, friend or stranger, teacher, elder, leader or any caregiver, anyone in the position of power, authority and control over a child.
Forced sodomy	Forced/coerced anal intercourse, usually male-to-male or male-to-female.	Any person in the position of power, authority and control.
Sexual abuse	Actual or threatened physical intrusion of a sexual nature, including inappropriate touching, by force or unequal or coercive conditions.	Any person in the position of power, authority and control including family, community members, co-workers like supervisors.
Sexual exploitation	This includes coerced marriage, forced child bearing, engagement in pornography or prostitution, sexual extortion for the granting of goods and services, assistance benefits and sex slavery.	Any person in the position of power, influence and control including teachers and trafficking networks
Forced prostitution also referred to as sexual exploitation	Forced or coerced sex trade usually targeting highly vulnerable women or girls unable to meet basic human needs for themselves and or their children. It is done in exchange of material resources.	Any person in a privileged position, in possession of money or control of material resources and services, perceived to be powerful.
Sexual harassment	Any unwelcome, usually and unreciprocated sexual demand for sexual access for favors, display of pornographic material when it interferes with employment or creates an intimidating, hostile or offensive work environment.	Employers, supervisors or colleagues, any person in a position of power, authority or control.
Sexual violence as a weapon of war or torture	Sexual violence as a form of torture is any act or threat of a sexual nature by which severe mental or physical pain or suffering caused to obtain information or punishment from a victim.	Often committed, sanctioned by military police, armed groups or other parties of conflict.

2. Physical Violence

Type of Act	Description/Examples	Can be Perpetrated by
Physical assault	Beating punching, kicking, biting, burning, or killing without weapons; often used in combination with other forms of sexual and gender-based violence.	Spouse, intimate partner, family member, friend. Stranger or any one in position of power or control.
Trafficking slavery	Selling and/ trading in human beings for forced sexual activities, forced labour or services, slavery or practices similar to slavery, or removal of body organs.	Any person in the position of power or control.

3. Emotional and Psychological Violence

Type of Act	Description/Examples	Can be Perpetrated by
Abuse/Humiliation	Non-sexual verbal abuse that is insulting, degrading and demeaning; compelling the victim or survivor to engage in humiliating acts.	Any person in the position of power or control often perpetrated by spouses, intimate partners and family members in a position of authority.
Confinement	Isolating a person from friends/ families restricting movements, deprivation of liberty or restriction of the right to free movement.	Any person in the position of power or control often perpetrated by spouses, intimate partners and family members in a position of authority.

4. Social Economic Violence

Type of Act	Description/Examples	Can be Perpetrated by
Discrimination and/or denial of opportunities	Exclusion, denial of access to education, health assistance or remunerated employment; denial of property rights.	Family members, society, institutions, organizations and government actors.
Social exclusion based on sexual orientation	Denial of access to services, social benefits or exercise and enjoyment of civil, social, economic, cultural and political rights.	Family members, society, institutions, organizations and government actors.
Obstructive legislative practice	Denial of access to exercise and enjoy civil, social, economic, cultural and political rights.	Family members, society, institutions, organizations and government actors.

5. Harmful Traditional Practices

Type of Act	Description/Examples	Can be Perpetrated by
Female Genital Mutilation (FGM)	Cutting of genital organs for non-medical reasons, usually done at a young age; ranges from partial to total cutting, removal of genitals, stitching whether for cultural or other non-therapeutic reasons; often undergone several times during life time.	Traditional practitioners, supported, condoned, and assisted by families, religious groups, as well as the entire communities.
Early marriage	Arranged marriage under the age of legal consent (in Uganda the age of legal consent is 18 years).	Parents family members and the community
Forced Marriage	Arranged marriage against the victim's/survivor's wishes; often a dowry is paid to the family; when refused, this leads to violent and /or abusive consequences.	Parents family members and the community
Honor killing	Murdering a woman or girl as punishment for acts considered inappropriate for her gender that are believed to bring shame on the family or community. For example: Pouring acid on a young woman's face as punishment for bringing shame to the family for attempting to marry someone not chosen by the family.	Parents family members and the community
Infanticide and or neglect	Killing withholding neglecting female children because they are considered to be of less value in a society than male children.	Parents family members and the community
Denial of education for girls and women	Removing girls from school prohibiting or obstructing access of girls and women to basic, technical, professional or scientific knowledge.	Parents family members and the community

KEY DEFINITIONS AND REFERENCES

CHAPTER ONE: Key Definitions

- **Antenatal care** is medical care provided soon before delivery to assesses health of the mother and the child.
- **Child Spacing:** Is the use of contraceptive or behavioural measures to avoid pregnancy, to increase the time between pregnancies.
- **Heamorrhage** occurs as excessive bleeding a pregnancy-related condition that can result in death in merely two hours if no measures are undertaken e.g transfusion of safe blood. It is the leading cause of maternal death worldwide.
- **Maternal and Child Health:** Strategies to improving health of mothers and children particularly around child birth and soon after.
- **Safe motherhood** helps mothers remain healthy before, during, and after delivery, and protects child and family health and safety as well. It is a combined effort of health workers and community members in preventing maternal/infant morbidity and mortality by early preparation of the girl child for conception, provision of essential obstetric care during pregnancy, labour and after child birth (pueperium).
- **Skilled attendant** is a medically qualified provider with midwifery skills (midwife, nurse or doctor) who has been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric complications. Ideally, skilled attendants live in, and are part of, the community they serve. They must be able to manage normal labour and delivery, perform essential interventions, start treatment and supervise the referral of mother and baby for interventions that are beyond their competence or not possible in a particular setting. Developed countries like Canada, Sweden and China have reduced maternal mortality by training and ensuring skilled attendance during child birth.
- **Skilled attendance** refers to a skilled attendant operating within an enabling environment or health system capable of providing care for normal deliveries as well as appropriate emergency obstetric care for all women who develop complications during childbirth.
- **Maternal death** is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO).
- **Maternal mortality** is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management.
- **Maternal mortality ratio** is the number of maternal deaths related to childbearing divided by the number of live births (or by the number of live births + fetal deaths) in that year (same time period) (ICPD – 10).

Note: *The maternal mortality ratio in Uganda is 435 per 100,000 live births while that of Sweden is 1 per 100,000 live births.*

Maternal mortality rate the number of maternal deaths in a given period per 100,000 women of reproductive age during the same time-period (ICPD- 10).

- **The enabling environment** describes a context that provides a skilled attendant with the backup support to perform routine deliveries and make sure that women with complications receive prompt emergency obstetric care. It essentially means a well-functioning health system, including equipment and supplies; infrastructure and transport; electrical, water and communication systems; human resources policies, supervision and management; as well as clinical protocols and guidelines.

- **Placenta previa** is a condition during pregnancy when the placenta lies low in the uterus either partly or completely blocking the uterine opening.
- **Puerperium:** The time immediately after the delivery of a baby. (In Latin a “puerpera” is a woman in childbirth since “*puer*” means child and “*parere*...”
- **Fundal height**, or McDonald’s rule, is a measure of the size of the uterus used to assess fetal growth and development. It is measured from the top of the mother’s uterus to the top of the mother’s pubic bone in centimeters. It should match the fetus’ gestational age in weeks within 1 to 3 cm, e.g., a pregnant woman’s uterus at 26 weeks should measure 23 to 29 cm. This is valid from 24 weeks. (See figure 6 for the diagram depicting fundal height estimation).
- **Community organizations**, sometimes also included under the NGO category, usually are smaller and less formally constituted than an NGO, serve a limited geographic area, and are formed to serve the interests of their members alone (for example: mothers’ union, girls’/boys’ brigade groups).

CHAPTER ONE: References

Bergsjö, P.; what is the evidence for the role of antenatal care strategies in the reduction of maternal mortality and morbidity? Safe motherhood Strategies: a Review of the evidence. Eds. V DeBrouwere and Wim Van Lerberghe. Studies in Health Services Organization and Policy, 17.2001.: pgs 47-48.

Douglas McConnel (Etal) (2007); Understanding God’s Heart for Children. Toward a Biblical Framework London.

Colson Charles (1999); How Now Shall We Live ? Wheaton: Tyndale Health and wholeness work book UCU Foundation Studies & Health Science Departments. May 2010 Revision.

Maddocks Morris (1995); The Christian Healing Ministry. London: SPCK

Reproductive Health Strategy – to accelerate progress towards the attainment International development goals and targets, “the World Bank, WHO, 2004.

Reproductive Health Division; A Strategy to Improve Reproductive Health in Uganda 2005-2010. Ministry of Health-Uganda: pgs 2-11.

The National Policy Guidelines and Service Standards for Reproductive Health Services in Uganda, 2007.

UNDP, Uganda, MDG’s Progressive Report, 2007.

WHO, Making pregnancy Safer (MPS),1994.

Worldview workbook UCU Foundation Studies Department. 2010 Print. www.dfidhealthrc.org/publications/Country_health/Uganda.PDF

CHAPTER TWO: Sexual reproductive health Operational Definitions

- **Integration** is the process of opening a group, community, place, or organization to all, regardless of race, ethnicity, religion, gender, or social class.
- **Reproductive Health** is a complete state of physical, mental and social well-being in all matters related to the reproductive system, its function and processes.
- **A right** is an entitlement: moral, social or legal to something, or an action. The definition of rights starts with the development of the human being in the family.
- **Health Promotion** is “a process of enabling people and groups to increase control over, and to improve, their health and quality of life”.

- **Sexual Health** is part of reproductive health that entails healthy sexual development, equitable relationships and sexual fulfilment; freedom from illness, disease, disability, violence and other harmful practices related to sexuality.
- **Total Fertility Rate (TFR)** is the total number of children the average women in a population is likely to have based on current birth rates throughout her life. This number ranges from more than 7 children per woman in developing countries in Africa to around 1 child per woman in Eastern European and highly-developed Asian countries.

CHAPTER TWO: References

Alister E. McGrath (2007); Christian Theology. An Introduction. (Fourth Edition). University of Oxford; Blackwell publishing.

Gender Analysis in health (Pdf) the 20

Ministry of Health, National Health Policy, Health Priorities, September 1999

Uganda Law and Reproductive Health

Pat and David Alexander (1999); Zondervan Handbook To The Bible. Grand Rapids Michigan; Zondervan Publishing House.

[http://www.Surjournal.org/eng/contedo/Article 8.phpartigo_mattar.htm](http://www.Surjournal.org/eng/contedo/Article%208.phpartigo_mattar.htm) Viewed May 26, 2011

<http://www.un.org/womenwatch/daw/beijing/pdf/BDPfAE.pdf> Retrieved Wednesday June 22, 2011 at 6:00pm

CHAPTER THREE: Key Definitions

- **AIDS** short for Acquired Immune Deficiency Syndrome, is a combination of illnesses that come about as a result of reduced immunity.
- **Disclosure** means sharing of your HIV status with your partner or any other trusted members of your family or friends.
- **HIV** is short for Human Deficiency Virus is the virus that causes AIDS.
- **HIV Discordance** is when one partner of a couple is infected with HIV (HIV Positive) when the other is not (yet) infected (HIV negative).
- **Medical male circumcision (MMC)** is a surgical process that removes all or part of the skin that covers the tip of the penis.
- **On-going support** is the continuous support to couples after testing in order to help them cope with challenges often faced.
- **Prevention of mother-to-child transmission (PMTCT)** is a comprehensive approach that includes among other services; HIV counselling and testing, antenatal care, provision of Anti-Retro Virals, delivery in a health centre, infant feeding and family planning counselling.
- **Sexually transmitted infections (STIs)** are caused by bacteria and viruses spread through sexual contact.

CHAPTER THREE: References

Health and Wholeness UCU workbook Foundation Studies and Health Science Departments. May , 2010 Revision.

MoH, Couples HIV Counseling and testing Participants Handbook, 2009.

MoH, Early HIV Diagnosis, and Care for Infants, Guidelines for Health Workers, September, 2006.

Stott John (1990); Issues Facing Christians Today. New perspectives on Social and moral dilemmas. London; Marshall Pickering.

UNICEF, Eastern and Southern Africa Region Office (ESARO) , WHO, UNAIDS, August , 2008.

CHAPTER FOUR: Key Definitions

- **Gender** is the social and cultural construct of roles, responsibilities, attributes, opportunities, privileges, status, access to and control over resources and benefits between women and men, boys and girls in a given society.
- **Gender** is the term used to denote the *social characteristics* assigned to males and females. These social characteristics are constructed on the basis of different factors, such as age, religion, national, ethnic and social origin. They differ both within and between cultures and define identities, status, roles, responsibilities and power relations among the members of any society or culture. Gender is learned through socialization. It is not static or innate, but evolves to respond to changes in the social, political and cultural environment.
- The term **sex** refers to the *biological characteristics* of males and females. These characteristics are congenital and their differences are limited to physiological reproductive functions. Sex differences are God given, universal and unchangeable.
- **Sexual and gender-based violence** includes much more than sexual assault and rape. To understand its root causes and consequences, it is essential to define and distinguish between the terms *gender and sex*.
- **Sex roles**, arise from the biological differences between women and men and cannot be changed. Pregnancy is an example of a sex role for women, as only women have the ability to bear children.
- **Gender roles**, are the socially constructed and defined responsibilities for example child bearing is a female gender role rather than a female sex role as it can be done equally by men and women. Unlike sex roles, gender roles are not universal and differ in different places from time to time, changeable and interchangeable.
- **Gender Needs**, are requirements that arise from people's positioning in society, determined by the socially constructed attributes. Gender needs are normally classified as either practical or strategic.
- **Gender equality** is the ability of men and women, boys and girls to enjoy the same status and have equal opportunity to realize their potential to contribute to social-cultural, economic, political and religious development.
- **Consent** is when a person makes an informed choice to agree freely and voluntarily to do something. The phrase *against her/him will* is used to indicate an absence of informed consent. There is no consent when; agreement is obtained through the use of threats, force or other forms of coercion, abduction, fraud, deception, or misrepresentation.

The use of a threat to withhold a benefit, or a promise to provide a benefit, in order to obtain the agreement of a person is also an abuse of power; any agreement obtained this way is not considered to be consensual. There is also no consent if the person is below the legal (statutory) age of consent or is defined as a child under applicable laws (in Uganda the age of consent is set at 18 years).

- A **perpetrator** is a person, group, or institution that directly inflicts, supports and condones violence or other abuse against a person or a group of persons. Perpetrators are in a position of real or perceived power, decision-making and/or authority and can thus exert control over their victims.

It is a myth that sexual and gender-based violence is usually perpetrated by strangers. In fact, most acts of sexual and gender-based violence are perpetrated by someone known to the survivor, and many violent incidents are planned in advance.

CHAPTER FOUR: References

Amy E. Eyler, Sara Wilcox, Dyann Matson-Koffman, Kelly R. Evenson, Bonnie Sanderson, Janice Thompson, JoEllen Wilbur, and Deborah Rohm-Young. *Journal of Women's Health & Gender-Based Medicine*. April 2002, 11(3): 239-253. doi:10.1089/152460902753668448. Published in April, 2004.

Ministry of Labour Gender and Social Development, *the Gender Policy*, 2007.

Narayan D, Patel R, Schafft K, Rademacher A, Koch-Schulte S. Changing gender relations in the household. In: *Voices of the poor: can anyone hear us?* New York, NY: Oxford University Press, 2000.

www.worldbank.org/poverty/voices/reports/canany/ch5.pdf (accessed 15 Mar 2013).

Training Manual Facilitator's Guide, Multi-sectoral and Interagency Prevention and response to Gender-based Violence in Populations Affected by Armed Conflict, JSI Research and Training Institute/ RHRC Consortium Washington DC, 2004.

United Nations High Commissioner for Refugees; Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, *Guidelines for Prevention and Response*, May, 2003.

CHAPTER FIVE: Operational Definitions

- **Convention** is a document that defines human rights. It is a legally binding international agreement between countries. When a country ratifies to a convention, it agrees to ensure that all the citizens enjoy the rights described in the convention.
- **Discrimination** occurs when a person or group of people are treated less favorably than another person or groups of people in comparable circumstances. Sex discrimination — or gender-based discrimination— entails unfair and differential treatment meted out to persons based on their sex.
- **Gender** is the social and cultural construct of roles, responsibilities, attributes, opportunities, privileges, status, access to and control over resources and benefits between women and men, boys and girls in a given society.
- A **perpetrator** is a person, group, or institution that directly inflicts, supports and condones violence or other abuse against a person or a group of persons. Perpetrators are in a position of real or perceived power, decision-making and/or authority and can thus exert control over their victims.
- **Survivor**: The term **/survivor(s)/victim(s)** refers to individuals or groups who have suffered sexual and gender-based violence. While victims should be treated with compassion and sensitivity, referring to them as survivors recognizes their strength and resilience.
- **Violence** refers to use of force. "Force might be physical, emotional, social or economic in nature. It may also involve coercion or pressure. Force also includes intimidation, threats, persecution, or other forms of psychological or social pressure. The target of such violence is compelled to do what is being requested, for fear of harmful consequences.

CHAPTER FIVE: References

1. Action for Community Development – Uganda, Domestic violence Information and UDHR, CEDAW, DEVAW Related provisions, 2009.
2. *Atwine Arthur ; A paper presented to Bishop Tucker School Of Theology and Divinity :” Violence Against Women” on March 10th 2011.*
3. *Ignatius (1988); The Church And Women-A Compendium.* San Francisco: Ignatius Press
4. Mercy Amba Oduyoye () An Article in **The Circle Of Concerned African Women Theologians:** “Gender and Theology in Africa Today.”
5. *Stott John (1999); Issues Facing Christians Today. New Perspectives on social & moral dilemma. London: Marshall Pickering.*
6. United Nations High Commissioner for Refugees; Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, **Guidelines for Prevention and Response**, May, 2003.
7. Rev.Grace Ndyabahika An **Article On “Women’s Place in Creation.”** (Page 28)

CHAPTER SIX: Operational Definitions

- **Family planning** is the practice of spacing children that are born using both natural (traditional) and modern (artificial) birth control methods. Birth spacing promotes the health of the mother, children and the father.
- **Family planning** is a conscious effort by couples or individuals to regulate the number of children and spacing of births by using a family planning method of their own choice.

Current use of family planning methods is highest in the central region (38%), whereas the northern region has the lowest level of contraceptive use of about 12%.

CHAPTER SIX: References

Vill-Vicencio,1992, C,A Theology of Reconstruction: Nation Building and Human Rights (Cambridge University Press; Cambridge

Lucia Ann McSpadde 2006, Reaching Reconciliation Churches in the Eastern and Central Europe (Life and Peace Institute)