

**Adults' Perceptions of Adolescents'
Sexual and Reproductive Health:
Qualitative Evidence from Uganda**

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Executive Summary

Over the past 15 years, adolescent sexual and reproductive health (SRH) has increasingly received special attention in many African countries mainly due to the HIV/AIDS pandemic that has swept across the continent with devastating impact, particularly among young people (15–24 years old) who account for about half of all new HIV infections. However, adolescents frequently do not have access to appropriate sexual and reproductive health services due to a host of factors ranging from dysfunctional health care systems to stigma regarding seeking reproductive health care. While research has been done on adolescents' health-seeking behaviors, little is known about the attitudes and perceptions of adults who play a key role in adolescents' lives, adolescents' sexual behavior and access to reproductive health services. It is for this reason that the Guttmacher Institute, in collaboration with the Makerere Institute of Social Research, conducted 60 in-depth interviews with parents, community leaders, teachers and health workers in one urban and one rural setting in Uganda to learn about their perceptions, attitudes and experiences of adolescents' sexual and reproductive health issues.

Opinions on Major Adolescent Sexual and Reproductive Health Issues

Most key adults interviewed were of the view that teenage pregnancy and HIV/AIDS were the major sexual and reproductive health problems affecting adolescents. Teenage pregnancy was seen as a major problem, especially among girls, because it often leads to dropping out of school at an early age, which further increases girls' vulnerability to early marriages, more unwanted pregnancies and risk of HIV/AIDS infection. Yet some key adults did not perceive HIV/AIDS as a major problem among adolescents because they have not seen adolescents who have AIDS. Most key adults held the opinion that young adolescents (younger than 15 years of age) are not sexually active and hence not at risk for getting HIV or unwanted pregnancies, yet

studies show that 8% of girls and 15% of boys 12–14 years of age have had sexual intercourse.

Perceived Barriers to Adolescents' Access to Sexual and Reproductive Health Services

Major barriers adolescents face in accessing SRH services, according to health care providers, were the inability of youth to pay for services, an inadequate supply of drugs and contraceptives at health care facilities, particularly in rural areas, and young peoples' fear of seeking services. Delivery of sexual education in schools is dogged by similar problems: Teachers reported that they lack appropriate training in teaching sexuality education as well as teaching aids, such as condoms and dummy penises for demonstration purposes and other supplies like sanitary pads. Teachers said that if they do not provide these supplies to young people, young people are unlikely to be able to access them as parents are either unable or unwilling to provide them for their adolescents.

Adults' Experiences Working with Adolescents

Key adults generally reported facing similar challenges working with adolescents. The most prevalent challenge adults reported was adolescents' non-compliance with advice given and young peoples' reluctance to discuss sexual and reproductive matters with adults. Many health service providers, for example, expressed frustration over repeated cases of STIs, unwanted pregnancies and abortions. Health service providers also reported that many sexually active young people adamantly refuse to use condoms, giving excuses, such as condoms reduce sexual enjoyment. However, some key challenges were named only by certain categories of adults based on their professional responsibilities. For example, many teachers reported that they feel uncomfortable and lack confidence to talk to their students about sexual issues as this goes against local traditions, which still largely consider public discussion of sex a taboo subject.

Attitudes Toward Adolescents Receiving Information and Services from Modern Health Care Providers

Most key adults felt positively about adolescents receiving SRH information and services from modern health care providers largely because they believe modern health care providers are knowledgeable and experienced in dealing with ASRH issues. They went on to state that when adolescents feel less fear accessing such services, this increases the probability that they will seek treatment for SRH conditions. Parents were in support of adolescents' access to SRH services through modern providers because they thought modern providers would provide adolescents with information consistent with their own morals and beliefs, including messages on how to avoid sex and about the unreliability of condoms. Modern providers were generally perceived to provide useful information to help young people prevent STIs and unwanted pregnancies. Key adults were in favor of adolescents not getting pregnant and staying healthy (without STIs) so as to increase the probability that they will stay in school.

Policy and Program Implications

Protecting adolescents from STIs, including HIV, and unwanted pregnancies calls for a concerted effort from parents, teachers, health workers, the community and the government. Creating a social environment that enables effective communication between children and key adults, particularly parents and teachers with whom children spend most of their time, would be one way to improve information young people are receiving from key adults. Schools also need to be better equipped with relevant information-education-communication (IEC) materials on ASRH issues. Lastly, the government and other stakeholders should work toward addressing the acute understaffing at health facilities and ameliorating the widespread stockout of drugs and other goods, like condoms, so that health facilities can distribute needed health supplies.

Chapter 1

Introduction

HIV is increasingly affecting youth worldwide. In 2006, nearly half of all new infections occurred among people aged 15–24, and it is estimated that upwards of seven million people in this age group are now infected.¹ Sub-Saharan Africa suffers the greatest toll, where youth in many parts of the region face fast-growing rates of HIV and other STIs. In Uganda, HIV prevalence was, until the end of 2000, highest among 15–19-year-olds, with females three to six times more likely to be infected than males.² Presently, the prevalence rate among 15–19-year-old women is 2.6% compared with only 0.3% among their male counterparts.³ Unintended pregnancy is also a major reproductive health problem among young people in Sub-Saharan Africa. Evidence from surveys conducted in the early 2000s indicates that the proportion of recent births to adolescent women that were either mistimed or unwanted was 23% in Burkina Faso, 40% in Ghana and Malawi and 39% in Uganda.⁴

Understanding the sexual and reproductive behaviors of young people, especially young women, who are at particularly high risk, and the factors that protect or put them at risk of HIV infection, other STIs and unwanted pregnancy is critical. Youth aged 15–24 are a large part—one-fifth—of the population of Sub-Saharan Africa, and their state of health has significant implications for the future of individual countries and for the region as a whole.⁵ Given that their behavior is at a formative stage, through appropriate information and services, these behaviors can be shaped to be more protective, thereby providing immediate and long-term benefits for themselves and society.

Adults play a key role in shaping the attitudes and behaviors of young people. Through the intimate setting of the family environment, parents influence the opinions, behaviors and norms of their children. Interactions with adults who provide information and services to young people, such as health care providers, teachers and community leaders, also affect how young people view the world, and contribute to shaping their

knowledge, attitudes and behavior. This report examines adults' perceptions and attitudes toward adolescent sexual behavior, since they are often important gatekeepers of reproductive health information and services for adolescents. The data are from 60 in-depth interviews (IDIs) conducted with key adults: teachers, health care providers, parents and community leaders, in one urban and one rural location in Uganda. The main objectives were to explore

- adults' perceptions of issues related to adolescent sexual and reproductive health;
- adult-adolescent communication on issues related to sexual and reproductive health from adults' perspectives; and
- how adults perceive their role and responsibilities, as well as the role of other key adults regarding adolescent sexual and reproductive health.

The findings from this in-depth study of key adults in Uganda contribute substantially to knowledge about the situation of adolescent sexual and reproductive health in three ways. First, evidence of the role adults play in the area of adolescents' health-seeking behavior is scant—we know very little about how adults facilitate or hinder adolescents who are seeking help for a health problem, especially for problems like STIs that are often stigmatized. Describing the role key adults play in adolescents' attempts to seek health care enables a better understanding of how to address health care access and how to better equip and prepare both modern sector and informal sector healthcare providers to meet the sexual and reproductive health needs of young people.

Second, learning more about adults' perceptions of adolescents' sexual and reproductive health issues and experiences helps in the formation of policies and programs aimed at addressing adolescent sexual and reproductive health. Adults are in a position to establish health priorities, set policy and dedicate resources to

social issues of concern. Therefore, increasing the body of knowledge of adults' perspectives on adolescent sexual and reproductive health allows those individuals interested in influencing that debate an opportunity to better address adults' concerns.

Finally, the in-depth interview methodology used to gather this data allowed for a more in-depth treatment of the views of adults regarding the circumstances surrounding young people's lives so that their views can more clearly be described and understood. Ultimately, this improves our understanding of why some young people are at higher risk of HIV, other STIs or unwanted pregnancy, while others are able to avoid those risks.

Chapter 2

Methods of Data Collection and Analysis

Sixty in-depth interviews (IDIs) were held with key adults: parents, community leaders, teachers and health care providers. The IDIs covered four main topics: the respondent's perceptions of the current situation regarding adolescent sexual and reproductive health (ASRH), the respondent's perceptions of whose responsibility it is to meet the sexual and reproductive health needs of adolescents, the respondent's personal experiences in dealing with an ASRH issue (or issues) and the respondent's thoughts on possible solutions to common ASRH problems. The IDIs with teachers also aimed to gather information on the quality and comprehensiveness of the teaching of sex education in schools, their opinions on whether the current content and extent of sex education meets the needs of youth, problems faced in teaching the subject and ways to improve the situation.

Thirty IDIs were held in Mbarara district in Western Uganda, and thirty in Kampala, Central Uganda. Interviews were conducted with 20 health care providers, 16 teachers and 24 parents/community leaders. The adult IDIs were conducted in April and May of 2005.

Parents/community leaders were interviewed mostly in local languages—Runyankole in Mbarara District and Luganda in Kampala. The teachers and health workers were primarily interviewed in English but a few interviews took place in the local language if the respondent requested it. The discussions were audio recorded, transcribed and, when they had been conducted in local languages, translated into English.

Field Team

The field interviewers were selected according to their knowledge of qualitative data collection techniques and research experience. Determining who was sent to which study district was based on their knowledge of the common language spoken in that district: Runyankole in Mbarara district and Luganda in Kampala. Three of the four research assistants had participated in earlier data collection for the PNG study: phase one

focus group discussions and phase two (IDIs with adolescents). The assistant who had not participated in the earlier studies was selected based on his data coding experience with the project.

Training Methodology

The training of the research team was conducted in April 2005. The training was conducted by the principal investigator, Dr. Stella Neema. During the training, Dr. Neema presented briefly on the Protecting the Next Generation project, including collaborative partners, project goals, objectives, and study design. The main items discussed were social mapping, use of the screening and consent forms, and an in-depth treatment and discussion of the interview guide. The interviewer training guide, which accompanied the interview guide, was systematically followed during the training. After training, the team conducted a pretest in Kampala and Wakiso districts. After the pretest, the team convened to debrief about their experiences in the field. Questions raised by the research team were answered by Dr. Neema. Letters of introduction and other logistics, such as vehicles, tape recorders, batteries, notebooks, etc., were provided and the team set off to their respective districts for fieldwork. Dr. Neema visited the teams during the course of the data collection to check whether fieldwork was on course.

Selected Areas and the Screening for Respondents

Respondents qualified for inclusion in the study if they fit into the following categories:

- Parents/guardians of adolescents aged 12–19
- Community leaders (older than 25 years of age) who interact with adolescents in an advisory capacity
- Teachers of adolescents aged 12–19 who teach science or have had training in life skills education
- Health care providers who handle ASRH issues

A facility-based approach was used for teachers and health care providers in both Mbarara and Kampala districts. A social mapping approach was used to identify eligible parents/community leaders and community services (schools and health care facilities). A map was constructed with assistance from local council officials. Selecting parents of adolescents and community leaders was done with the help of local authorities. A screening form was used to select the parents/community leaders within each household.

The research team, with the help of the sub-county Local Council chairperson, compiled a list of known schools in the locality, including descriptors, such as primary and secondary, private and public, and single sex and mixed sex. Health care facilities were also identified and designated as private or public and faith-based or secular. Adults were selected from each of these different types of facilities. Health care providers were selected according to whether they provide ASRH information and whether adolescents go there for health care. Teachers were selected from schools within the vicinity where interviews with parents and community members were being conducted, following the criteria outlined above. Consent to interview the eligible adult was sought by the interviewer after screening.

Challenges During Data Collection

Fieldwork took more time than anticipated in Kampala because of the busy schedules of the eligible respondents, who would postpone appointments. In Mbarara district, it was challenging to find faith-based health facilities offering ASRH. Some of the selected sub-counties did not have enough schools and health facilities to sample the categories needed, so the team had to go to other sub-counties. Despite these challenges, the targeted number of adults to be interviewed was achieved.

Analysis

A node structure created in QSR N6 (Doncaster, Australia) was used to code the data that covered the main themes of the interview guide. The themes were major adolescent sexual and reproductive health issues in the community; the nature of communication with adolescents; the most difficult ASRH issue as perceived by that adult; major barriers adolescents face in taking care of their SRH; sources of ASRH information and services; actual and perceived roles of various types of key adults in providing ASRH information and services; suggestions to improve ASRH; and awareness of government policies, programs and services to pro-

mote ASRH. The transcripts were coded by two of the four interviewers and double-checked for accuracy by the project supervisors. The authors made matrices of the substantive points disaggregated by the gender of the study participant. Each interview was treated as a unit of analysis. Summary text was then written based on common themes arising from the matrices. At least one other author read the summary text and compared it with the matrix of themes to ensure that one researcher's subjective biases did not determine the conclusions drawn from the data.

Limitations of the Study

As with all qualitative data, the findings presented in this report reflect the views of a small purposive sample of key adults selected from only two locations of the country and thus may not represent the views held by other key adults in Uganda or even of all key adults in the communities where fieldwork was conducted. Secondly, the fact that the interviews were largely conducted in the local languages and then translated into English may have introduced errors into the data.

Chapter 3

Opinions on Major Adolescent Sexual and Reproductive Health Issues

Understanding what key groups of adults consider to be the major adolescent sexual and reproductive health issues in their communities provides insight into how adults perceive the lives of young people. Adults identified unintended pregnancy and HIV/AIDS as the two major sexual and reproductive health problems affecting young people in their communities. Other adolescent sexual and reproductive health problems adults considered important included other STIs, such as gonorrhea and syphilis, and sexual activity among young people.

Adults' perceptions of an adolescent's risk of unintended pregnancy, HIV and other STIs varied according to the age of the adolescent. For instance, most adults viewed older adolescents, those older than 15 years of age, as being more at risk of unintended pregnancy, HIV and other STIs compared with their younger counterparts (12–14 years of age) mainly because older adolescents are more likely to be sexually active.

The boys in this community of around 12 to 15 years have not really engaged in sex because we teach and they really listen...They ask questions and we explain to them. So they have not actually engaged in that...The problem we have is the older adolescents...Especially sixteen years and above...the moment they leave school and especially when parents do not talk to them.

—Rural, female primary school teacher, age 40

Unintended Pregnancy

Most adults reported that unintended pregnancy is common among young people in Uganda. Many identified unintended pregnancy to be a major problem because of the consequences they have on a young person's life, such as dropping out of school. Girls were thought to be particularly likely to drop out of school due to an unintended pregnancy compared with boys.

Unwanted pregnancy among young girls—this happens after you have counseled them about

avoiding unprotected sexual intercourse. You give them examples of girls who have persisted [in not having sex] and finished schooling, how to live a meaningful life. But they don't pay attention.

—Rural, female community leader, age 54

When they get pregnant, they drop out of school, in the end they suffer in the future.

—Rural, male parent, age 37

Adults perceived boys often deny responsibility when a girl becomes pregnant.

Girls are impregnated by fellow adolescents and they deny responsibility...The boys deny responsibility and it becomes the duty of the parents to fend for both the daughter and her child when the situation is bad.

—Urban, female community leader, age 50

However, some adults believe girls drop out of school because their family cannot afford school fees, and after dropping out of school, girls become pregnant.

In this community most parents are not rich so they really suffer to get school fees. So after educating a girl to the level of P7, S1 or S2 then that is the end of school; the girls then end up pregnant.*

—Rural, female primary school teacher, age 40

Many parents are unable to support their children to continue with education. They stop them at P7...When a girl or boy leaves school when he or she is young, there is a possibility of being idle and engaging in sexual activities. The girls get pregnant when they are very young...We have many drop-outs who leave school because their parents are poor.

—Rural, female primary school teacher, age 42

*P7 means grade Primary Seven, S1 and S2 designate Senior One and Senior Two, or the equivalent of years eight and nine in school.

A minority of adults mentioned that abortion was common when a young girl has an unintended pregnancy, particularly if she is not married.

Sometimes you find that they have done an abortion. Recently we lost a young girl who was found aborting...criminal abortion! Abortion is common.
—Rural, male health care provider (enrolled nurse), age 55

Key adults reported encouraging abstinence.

We tell them that having premarital sex is very dangerous. They're not supposed to have that kind of sex. It can lead to pregnancy which can make them drop out of school...It's the teacher's duty to tell them that it [sexual desire] is within their human make-up but as they develop such feelings, they must learn to have self-control to control sexual relationships between girls and boys.
—Rural, male secondary school teacher, age 36

Some respondents related communicating age-specific messages.

I advise them on how to protect themselves by using condoms and to avoid getting pregnant. I tell the younger ones to avoid sexual intercourse to abstain until they grow old enough. But the older ones who have already started on these things [sexual intercourse], you tell them to use the condoms to avoid sexually transmitted diseases and pregnancy.
—Rural, female primary school teacher, age 42

HIV/AIDS

Many adults also perceived HIV/AIDS to be a major problem among adolescents in their communities. Some adults felt HIV/AIDS is a major problem because of its potential to wipe out future populations since the disease has no cure. Others reported seeing youth die in their communities because of AIDS. However, a subset of health care providers, teachers and parents stated that AIDS is not common among adolescents. One of the reasons that some adults think AIDS is not common is because there is no proof that AIDS exists among adolescents.

AIDS is not common among adolescents. Haven't seen any [cases]—it is us, the adults, who have it. We have a good number who are bed-ridden.
—Rural, female parent, age 41

While some adults may not know about the latency period, others may have been inclined to interpret the question as asking about symptomatic AIDS since there is no distinction made between HIV and AIDS in local languages.

Most adults viewed older adolescents (15-19 years of age) as being more at risk of HIV compared with young adolescents (younger than 15 years of age) because they are more likely to be sexually active. However, a minority of adults viewed HIV/AIDS as less of a problem among older youth than younger youth because older youth are able to talk about issues relating to sex more easily and they are more aware of HIV. These adults argued that younger adolescents are simply not aware of the risks of HIV. According to some adults, this lack of experience and lack of knowledge of HIV risk makes younger adolescents particularly vulnerable to older people who may advantage of them.

For the younger ones, at times they don't know what they are doing. For example, a girl of 15 meeting a man of 30 years; the girl will not do sex because of wanting it. Because of money, she will agree and do sex and get infected. In contrast, older adolescents know what they are doing.
—Rural, female health care provider (enrolled nurse), age 45

Adults reported various reasons why adolescents are at risk of HIV infection. Some adults pointed to adolescents' dislike of using condoms as placing them at risk of HIV.

Adolescents don't like using protection. There is a saying that if you put on condoms you don't feel good...that is why they get infected. They know there is a disease, they know there is Protector [condoms] but they do not use them. They like body to body sex. And eventually they die.
—Rural, female health care provider (enrolled nurse), age 45

Other reasons for non-use reported by some health care professionals included an inadequate supply of condoms at clinics, the expensive cost of condoms outside of clinics, and the fear boys feel when they go out to buy condoms. Some adults, particularly health care professionals, advocated for adolescents to use condoms, with one health care professional stating that adolescents have a right to use condoms.

According to some adults, an adolescent's use of a condom is dependent on the power dynamic in a couple's

relationship. Females are considered to be particularly vulnerable because they are seen as not participating in the decision-making process regarding condom use.

Girls tend to leave all the responsibility of a relationship to boys when it comes to sex. The boys tell us that girls have nothing to contribute. When they get to bed, the girls cover their faces and now it is up to the boy to determine whether to use a condom or not.

—Rural, male health care provider (peer counselor), age 20

Lastly, poverty was identified as placing adolescents, particularly girls, at risk of HIV.

So they tend to go with men because they are poor hoping to get some money from them and end up getting HIV/AIDS.

—Rural, male community leader (parish priest), age 39

AIDS exists and it has been as a result of parents' failure to raise school fees to keep their children in school; we are poor, where we are sleeping the place is small, so during the daytime and night you can't know where the girls have gone.

—Urban, female community leader, age 50

Other Sexual and Reproductive Health Problems

Adults also identified other STIs, such as gonorrhea and syphilis, as well as sexual activity among young people as major adolescent sexual and reproductive health issues affecting their communities. Gonorrhea and syphilis were reported as a problem that affects adolescents because of their emerging prevalence among young people.

Last season, there was a lot of gonorrhea infection among adolescents. It can be cured but parents don't have enough money to buy drugs. It's the parents who suffer with these adolescents because the adolescents fall sick and are still young and they don't tell anyone they are suffering from an STD or they don't even know they have it.

—Rural, female parent, age 41

The consequences of not treating STIs early enough were also identified as a problem. Health care professionals discussed the implications of adolescents' failure to seek treatment for their STIs. Girls were thought to be vulnerable to infertility as a result of not obtaining treatment for an STI.

When girls get STDs, they may end up getting pelvic infections which don't get cured, they may become barren, they may be operated and get many other complications.

—Rural, female health care provider (clinic operator), age 47

You see, if they don't treat them early enough, they can damage the reproductive parts of these adolescents. Girls have problems with their uterus. Some boys may fail to urinate properly and may feel a lot of pain. Some of them may suffer from mental problems if they have these sexually transmitted infections, especially syphilis.

—Rural, female health care provider (drug shop operator), age 38

Older adolescents were seen to suffer more sexually transmitted infections due to their higher rates of sexual activity.

Syphilis is more of an issue for Senior Threes and Fours. The Senior Ones have never received any case.

—Rural, female secondary school teacher, age 30

Those who are above 15 years are the ones with most infection compared to younger ones. Those below 15 years have not yet engaged in sexual intercourse.

—Rural, female health care provider (drug shop operator), age 38

Many adults also felt sexual activity itself among young people was a major sexual and reproductive health problem. Adults often used words like “spoilt,” “get finished” and “wasted” to mean adolescents having had sex. Such language demonstrates that adults see nonmarital sex as taboo and “dirty.” According to some adults, sexual promiscuity leads girls and boys to become useless in society.

When a girl grows up properly and gets her own home, she builds herself. But if she misbehaves and becomes pregnant, she loses her place in society. She is almost useless. If she continues with such behavior, she may get infected and fall sick and may even end up dying...The same happens to boys. They get involved in sexual activities, get sick, come back home and disturb the parents. That is where we try to advise them but they just don't listen.

—Rural, female health care provider (traditional birth attendant), age 53

They all misbehave...these young boys, they are all wasted. She can fall in love with them and they waste her.

—Rural, male parent, age 37

The boy can deceive a girl and eventually the girl has to leave school. But the boy will continue schooling after he has spoilt the girl.

—Rural, female parent (farmer), age 42

Some adults perceived that behaviors such as going to boarding school and coaching other students until late in the evening increases the probability of engaging in high-risk behaviors.

They don't stay with their parents. They go to boarding schools and get spoilt there. I just do not know. Long ago, a girl would stay home until she is ready for marriage. Others would study and go to secondary schools when they are old enough...the world is spoilt. Our children get spoilt when they leave our home, before that they are good upright children. They get spoilt in schools where they go.

—Rural, female parent, age 48

Chapter 4

Key Adults' Most Difficult Issues Working with Adolescents

This chapter presents the most difficult experiences parents, teachers, health workers and community leaders have had in their interactions with adolescents. It brings to light challenges and barriers these adults have encountered helping adolescents in dealing with their sexual and reproductive health problems. Adults' perspectives on the most difficult issue they have had to deal with varied distinctly across groups with medical providers focusing on health care problems and teachers focusing on communication barriers.

Adolescents' Reluctance to Modify Their Behavior

Overall, most key informants, particularly health care providers and community leaders, reported frustrations regarding the apparent refusal of most adolescents to modify behaviors that put them at risk of HIV, STIs and unwanted pregnancies. Health care providers see this resulting in STI reinfections and repeat pregnancies. Health care providers perceived cultural barriers as well as attitudes, such as condoms thwart sexual enjoyment, to hinder adolescents' use of condoms.

If someone has an STI, you counsel them and when you reach the part of the condom, they have never used it. You counsel him to get to know how to use it and then he says, "Ha, will I manage?" Either culturally or what, they have that stigma. Maybe it is culture—because they are in the village...After all the counseling, you think they have taken it in. But from their faces, you can see that it is somehow shameful for someone to use it, or they think if they say they know how to use it, you will think they are promiscuous.

—Rural, female health care provider (nurse), age 41

Youth do not know what they want. For example, you treat syphilis and after treating them you tell them to bring their partners but they don't and yet

they continue having sex; reinfecting themselves. A person presents with a pregnancy at 13 years. You talk to her and she seems to have understood but at 15 years she comes back pregnant again.
—Urban, male health care provider (peer counselor), age 20

Many health service providers expressed frustration handling abortion,* post-abortion complications, including ruptured uteruses, and repeat abortions for the same adolescent.

They come crying that their parents have chased them away. Most of them come wanting to abort but I advise them against that. I tell them to be patient, go to their aunt's place and stay there until they deliver.
—Rural, female health care provider (traditional birth attendant), age 53

Teachers' Lack of Confidence in Communicating with Youth

Yet for teachers, lack of confidence and not having the appropriate skills to effectively communicate with pupils on sexual and reproductive health matters emerged as their most difficult issue. Many teachers reported that they or their colleagues, particularly the women, fear to discuss sexual issues in public, let alone with their students. They stated that many teachers cannot name the different parts of the genitalia or even explain issues such as menstruation to young adolescents. This is mainly because sex is culturally perceived as a taboo subject which should not be discussed in public. Many teachers reported that students, who look up to their teachers as role models, particularly with regard to decent social behavior, are shocked to hear them talking to them about such "bad things."

*Abortion is illegal in Uganda except for medical conditions that threaten the life of the mother.

These learners find it quite new hearing such things... There are some words which do not easily pass through the mouth. But now we have been told to say a word as it is; just like a radio cassette because for it, it doesn't try to hide things. This time, we are trying to say exactly what we want to say. However, these children we are talking to take us to be stupid because of what we say. We are using bad language and they are taking us to be stupid because we are calling a spade a spade.... And when you talk this language the pupils are not conversant with; they tell their parents that these teachers tell us such things. Then the parents quarrel; so they also think we are running mad.

—Rural, female primary school teacher, age 44

When students look at you, they assume a teacher should be holy and should not utter out any thing of the sort; so you will find it very difficult to bring up the topic.... They keep on wondering, "Uh, can that one also say that?"

—Urban, female secondary school teacher, age 27

I am a science teacher but when you talk of reproduction, when you are teaching about reproductive organs, some children feel shy. They actually shy away. We have a saying as teachers that facts should be facts. If it is A it should be A. For example, when you mention the word vagina they will feel embarrassed.... A female teacher would also fear to say such heavy words. A woman has to take a lot of courage to mention such.

—Urban, male secondary school teacher, age 26

Teachers revealed that some pupils even report them to their parents and this strains the otherwise cordial relationship and mutual respect teachers have with parents and the surrounding communities. This is especially so in rural areas where many parents still find provision of sexual education to young adolescents unacceptable. Teachers and community leaders expressed similar views regarding the uncooperative behavior and negative attitudes of parents toward the provision of guidance and counseling of their children on SRH issues. They complained that most parents leave the burden of counseling their children to teachers and yet side with their children when they are confronted with information on their child's risky behavior, claiming that their children are not engaged in such behavior.

Some parents come from broken families. For example, you see them running up and down to remove the fetus when their daughters become pregnant. And it seems they don't give them advice at home. They just send the girls to the teachers. So, they want all the discipline and all the guidance to come from the teachers yet they don't want a teacher to blame a child. When you invite them to the office, you see the parent accusing a teacher, "Maybe you don't do this and that. That's why she is behaving like that. She is good at home." When the parent says that in the presence of the girl, the teacher feels discouraged.

—Rural, female secondary school teacher, age 30

When you try to counsel the adolescents, they don't respond and when you report them to their parents, their parents claim they are innocent. So the children continue misbehaving.

—Urban, male community leader, age 49

A few parents interviewed concurred with the views given by the community leaders and teachers regarding the defiant behavior of their children.

Youth feel we are just wasting their time. They say AIDS does not enter anybody it finds, it is selective; it just appreciates a body. Others say they are not supposed to live on earth for a very long time like an Mvule† tree does. They look at me as an old, wasted person who has run out of ideas. My thinking is as old as my age, so they see no good from it. It becomes hard especially when you talk about AIDS; they do not even stop to listen what you are saying. So you leave them to do what they want.*

—Urban, female parent, age 60

Teachers also noted that there is information fatigue, especially on issues such as HIV/AIDS, which children continuously hear about from various sources, making it difficult for teachers to keep the students interested in discussing such issues. This further demoralizes teachers and many simply give up.

Keeping adolescents interested in what you tell them is a major challenge. They are already fed up being given the same type of information on con-

*This phrase means that not everyone gets infected with HIV because the virus is selective; you get infected only if the virus likes your body.

†Mvule is a type of a hard wood tree which lives for a very long time.

doms, abstinence, etc. Mind you, some of them are born-again Christians, so they are already biased about the subject of sex and condoms. We even find it sometimes a little bit hard to tell them that we have something new to tell them. And you see, if there is no interest, you are also turned off. You become disorganized and you don't deliver to the students what you intended to.

—Urban, male secondary school teacher, age 47

Adolescents' Reluctance to Seek Appropriate Care

Another major challenge reported by most key informants is the reluctance and fear among adolescents to open up and discuss their SRH concerns or seek appropriate and timely care when faced with an SRH condition that requires medical attention. Many health care providers, for example, reported that most adolescents—those who are brave enough to seek services—are often hesitant to disclose their actual condition, which sometimes results in the wrong diagnosis of their illness and then the wrong prescription. Pharmacists concurred, reporting that some adolescents go to pharmacies and drug shops to buy a specific drug and refuse to divulge the condition they are going to treat, which makes it difficult to advise them on the appropriate medicine to use.

You see when someone comes to buy a drug; you will know what they are going to treat. What somebody does is that they consult a friend who may have experienced a similar problem at one time who advises them on what to buy; then they come for that specific drug. And for us that is an indicator. Because someone will come to ask for Cotrimazole, even sometimes he comes with a sample; you will know what they want to treat. But when we try to interfere by asking what they want to use it for, they will either lie or speak to you in a manner that belittles you. Nevertheless, we still try to advise them by asking, "Why don't you use this other drug?" Then they will say, "Someone else sent me." Sometimes we even refuse to give them such drugs because what they explain is different from what they are suffering from.

—Urban, female health care provider (enrolled nurse), age 30

When they have an STD, they claim they have a stomach ache or fever and end up getting wrong medication.

—Rural, female health care provider (enrolled nurse), age 47

I think shyness is somebody's character. That is how he was brought up or grew up; and with sex matters in Buganda, it is a taboo to talk about them; so it is within our culture. Because as you grow up there are certain words you are not supposed to mention such that even when you get a disease and your private parts are affected you will shy away to talk about it...Because there are some cases we receive while in their advanced stages, meaning that such people had feared to come for treatment. Like syphilis has stages. So if it reaches the last stage, it becomes a struggle to get better. And in the last stage there are some irreversible damages that it can cause to a person.

—Urban, male health care provider (pharmacy technician), age 25

They don't want me to know what they are suffering from but when they are explaining to me, I can tell what they are suffering from. They try to hide so what I do is I guess from the little they have told me. They tell me just part of the pain they are having. They can't tell the whole truth.

—Rural, female health care provider (drug shop operator), age 38

Lack of money was often cited as a major factor limiting adolescents' access to SRH services.

Most adolescents do not have money for a complete dose. They fear to ask for money from their parents because they do not want them to know.

—Urban, male health care provider (pharmacy technician), age 25

Teachers also echoed similar views about the reluctance of their pupils to confide in them on SRH issues. They reported that pupils in general are afraid of talking to their teachers and since sexuality is a taboo subject, this further increases young people's difficulties in speaking about it. A number of factors were seen by teachers to be influential in determining whether a young person will confide in a teacher on SRH issues. Prominent among them were the pupil's own confidence; the pupil's judgment and trust in the teacher to provide appropriate advice as well as ensure confidentiality; the gender of the teacher; and the approachability and availability of the teacher.

The major barrier is that adolescents take long to judge who is trustworthy. They can take a whole year or two years - especially those students in

classes we don't teach. But even in classes which we teach, they still take long to develop confidence in us. They must first judge you: "How do I face this one? Is that man approachable?" You see, developing confidence is just a slow, natural process.

—Urban, male secondary school teacher, age 47

Some teachers reported that gender complicates student-teacher communications because the public imputes a sexual meaning to any close informal interaction between members of the opposite sex, particularly between a man and a young woman. As a result, teachers have to be mindful so that their actions are not misinterpreted.

Teachers' & Health Care Workers' Lack of Appropriate Materials

Another major challenge reported by teachers was lack of supplies and appropriate tools to use to educate youth. Most teachers reported that they lack information-education-communication (IEC) materials on SRH issues which would help enhance learning.

It is difficult to convince students when you don't have any IEC materials to back up what you are telling them.

—Urban, female secondary school teacher, age 29

They even lack condoms and aids (such as dummy penises) for demonstration purposes. Teachers in a number of schools reported that they do not have sanitary pads to give to girls and the majority of parents, for a variety of reasons ranging from poverty to ignorance, are unable to provide them for their daughters.

We lack materials to use to teach the adolescents. We lack funds to buy them. We do not have materials such as condoms to show children when we are talking about them. Sanitary pads are always not there to show girls what they look like or how to use them.

—Urban, male secondary school teacher, age 26

They observed that these are things they routinely tell young people to use, which are not available for demonstration purposes, let alone distribution to students. Many teachers also lamented that they are not given transport and per diems to attend refresher workshops/seminars on SRH issues, even though some schools lack resource persons/counselors who are knowledgeable on SRH issues.

Lack of resources was also cited by health workers, who reported that they often do not have drugs, including those to treat STIs, and other needed medical supplies, like syringes. A few stated that they lack IEC materials as well. Poor support, particularly in terms of field transport and lunch, was also lacking and this was cited as a constraint to conduct field outreach to sensitize young people to SRH issues.

We are unable to reach communities due to lack of facilitation. You go to a school for health education and you find you don't have food to eat there and no transport. It lowers your morale.

—Rural, male health care provider (enrolled nurse), age 55

We lack funds. When you organize a seminar, you have to provide eats for the participants. Even drama groups have to be given money to perform.

—Urban, female community leader, age 45

Other Barriers and Challenges

Adults interviewed voiced a number of other barriers and challenges impacting adolescent sexual and reproductive health. Poverty was frequently mentioned because it not only constrains adolescents' access to SRH services, it also makes them more vulnerable to sexual behaviors that increase their risk of HIV, STIs, unwanted pregnancies and early marriages. HIV/AIDS was also cited by respondents as having left many children orphans, without parental care. However, it was also noted that some children often do not receive even basic necessities from their parents.

AIDS has left many children orphans. Because of too much suffering, they ask for assistance and those people demand for sex in exchange for assistance.

—Rural, female primary school teacher, age 44

Parents do not provide their daughters with basics such as knickers and half slips. A good number of them have torn knickers. So when such girls get someone to give them, they accept and pay in kind.

—Rural, female primary school teacher, age 42

Parents do not budget for their families. If he [the father] has a goat, he can sell it and eat all the money. Instead of buying a younger goat and using the rest to meet family needs, he will take all the money to the bar and drink all of it until it's finished.

—Rural, female parent, age 41

Another major barrier mentioned particularly by the teachers was the community environments in which many adolescents live. They reported that many adolescents live in homes where they brew/sell beer or near bars and disco/video halls, which increase young people's vulnerability to risky sexual behaviors. They also complained about the lack of deterrent laws and inadequate parental control, as parents do not monitor the movements and behaviors of their children. Some of the adults were of the view that laws are needed to curb illicit sex and other behaviors/practices, such as watching blue movies in video halls, and drinking, which expose young people to all manner of risks. They felt that Local Councils have not done enough to curb unruliness and immorality among young people. They also accused the police of being corrupt because they say the police release defilement suspects after allegedly being bribed, while parents were also blamed for settling defilement and rape cases out of court and taking dowry from defilers instead of pursuing the suspects in courts of law.

Another thing is that this place is a trading centre. There are too many people around, especially in the evenings. There is a lot of music from discos and video halls. They play obscene music and show dirty movies. The Local Council leaders never check to chase away young people who may be watching; even the parents don't mind about their children. Some of these parents are the ones who sell beer. In the end, these young people are exposed to unprotected sex which leads to sexually transmitted diseases because of the nature of the environment.
 —Rural, female health care provider (drug shop dealer), age 47

Some children stay in areas where there are bad people who teach them bad manners, so even if you talk with them when they go back, the behavior is not good and there is nothing that we can do about it.
 —Rural, female primary school teacher, age 40

The community we are living in is one that has many social amenities, such as discos and film halls. These have spoilt the youth. Most of the time, many are watching films, including bad ones, while those who go to discos drink a lot of booze and end up messing with their lives.
 —Urban, male health care provider (peer counselor), age 20

Some teachers also blamed their colleagues for being poor role models. They revealed that some of the teachers have intimate relationships with their students, while others are drunkards. This gives teachers a bad image among their students, who otherwise perceive their teachers to be beyond such indecent social behavior, making it harder for students to take advice seriously from such teachers.

Some teachers are not good role models. So when they try to tell pupils not to do certain things, the pupils tell them, "But we also saw you with so and so, and now you are saying it is bad!"
 —Rural, female primary school teacher, age 44

Chapter 5

Attitudes Towards Adolescents Receiving Information and Services from Modern Health Care Providers

The attitudes of key adults, including health care providers, toward adolescents receiving sexual and reproductive health (SRH) information and services from modern health care providers are important, as this attitude may play a key role in determining adolescents' access to services that allow them to safely manage their sexual and reproductive health. The attitudes of health care providers themselves likely influence the nature and quality of the services being offered. The modern health care system in Uganda includes providers, such as doctors, clinical officers, nurses and pharmacist/drug shop attendants. They practice in settings that include hospitals, clinics, health centers and pharmacies/drug shops. Hospitals are more likely to be located in major urban areas, while in rural areas, the most advanced kinds of medical facilities are likely to be health centers and clinics. This chapter examines the attitudes of key adults toward adolescents receiving sexual and reproductive health services from modern health care providers.

Modern Providers Are Able to Provide Needed Services and Dispel Myths

Many adults across all of the groups represented viewed modern providers as a good source of SRH information for adolescents. Positive attitudes toward adolescents receiving SRH services from modern providers were based on the beliefs that seeking such services reduces young people's fear of obtaining treatment; that personnel at modern health facilities are experienced in dealing with these topics; and obtaining treatment keeps adolescents in school because they are in better health. Modern providers were thought to provide useful information for preventing STIs and unwanted pregnancies as well as dispel myths adolescents have about sexual and reproductive health issues.

At times, they [adolescents] are misled by the community...He [an adolescent] says, "They told me when I do not do this, this will happen." For ex-

ample, "If you do not play sex, you will become impotent," or that, "They told me if I do not play sex my penis may not grow bigger." So we try to talk the truth based on enough knowledge and correct these misconceptions.

—Urban, male health care provider (clinical officer), age 27

Services that respondents thought modern health care professionals could offer include treatment for SRH problems and HIV testing and counseling. Some key adults said that they encourage adolescents to seek HIV testing and counseling from modern medical facilities because "if they are not yet sick, they can protect themselves. If they are sick, they can be helped to go on these new drugs—antiretrovirals which can help them to live longer" (rural, female teacher, age 42). The majority of adults, including traditional healers, held positive attitudes toward adolescents receiving services and treatment from modern providers.

Modern providers acknowledged that even the education they provide is not being provided by parents.

I think we help them know such information related to sexual and reproductive health. Most of the parents I am sure cannot provide such information because when we ask them if they have talked to their parents about it, they say they fear their parents.

—Urban, female nurse, age 27

Even if I am to tell you that, "OK, let's tell parents to be teaching their children at home." My friend, you will accept but you will not do it. Why? Because what you are saying is not what you are doing.

—Urban, male health care provider, age not stated

The perception held by many of the respondents is that health care providers impart education consistent with what parents would want their youth to learn

about sex, including information about how to avoid sex and the unreliability of condoms.

When you go to the health center, they teach you how to use condoms. They say that condoms are not 100% effective and that the only sure way of avoiding AIDS is to abstain.

—Urban, male teacher, age 26

While it is true that condoms are not 100% effective, this message sounds more like a message meant to discourage condom use than a message meant to accurately represent condom failure rates. Whether it is the case that youth are getting SRH information influenced by health care providers' ideas of what is morally correct or if it is simply the perception of non-providers that this is the case is impossible to tell from the data, but it is worth noting that none of the health care providers said they imparted these types of moralistic messages to youth.

In fact, adults' perceptions of what youth need appear to be more liberal than what adolescents perceive adults to think is appropriate for them.⁶ Even when key adults discussed adolescents' access to condoms through the modern health care sector, it was touted as a positive.

Those who distribute condoms saw the necessity for them. So I don't see it is bad because if you don't distribute them, you will have brought a problem because there are people who cannot do away with sex or go without sex. It is in their nature, so such a person, when you give him a condom, it is a bit safer. And when you observe what's going on, condoms have done a great job. With the increased prevalence of HIV/AIDS, you can see that the availability of condoms is needed.

—Rural, male community leader, age 57

Some adults distinguished between different types of health facilities. For example, clinics promote good health among youth and are a better place for adolescents to obtain treatment and services because they are closer than hospitals; hospitals properly examine patients and distribute correct medications and drug shops provide the medication for youth that is not available at clinics or dispensaries (due to stockouts and distribution bottle necks). Yet, adults acknowledged, the drawback of obtaining services at clinics is that those services cost money. The role that each facility plays in providing needed health care to youth was seen as complementary.

Yet Modern Providers Are Not Seen As Addressing All Young Peoples' Needs

Many adults, particularly health providers, reported that young people often did not get the services or treatments they needed from modern medical providers due to cost barriers; accessibility barriers, particularly for hospitals (the sites are too difficult to reach—it's too costly to go there or it's too far away); resource barriers (lines for drugs from hospitals are very long and one might have to wait all day to get the needed dose); and fear of a loss of privacy. Poor working conditions of medical staff were seen, especially by medical staff, to be a barrier in their ability to provide adolescents with the care they need.

I will not talk for those hours without money. So I end up cutting the story short, yet the youth need the information. Like if I am talking about condoms to every individual I see I may not have a condom to open every other time I talk about them, yet it is important to demonstrate.

—Urban, male health care provider (clinical officer), age 27

Health centers don't give personal care. They [young people] get half the attention they should get. Moreover, most of the time the health workers are frustrated and they tend to be rude. The drugs are rarely available apart from Panadol and Aspirin...[At hospitals] one may even fail to get any services. These hospitals are generally overcrowded and corruption is the order of the day. Also, transport to that place can be afforded by few people.

—Rural, female health care provider (enrolled nurse), age 47

While care at hospitals can be inadequate, obtaining care at lower-level facilities can prove even more problematic. Lower-level health facilities may not be equipped to treat young peoples' health problems because of understaffing, lack of training and a lack of medical infrastructure.

If you go late, you may end up not getting a health worker, [like if you go] especially at 1:00 p.m. And if a patient needs a drip, they do not have such a facility.*

—Urban, female community leader, age 50

*Clinics frequently only function for limited hours.

They [clinics] are not oriented about the diseases. Secondly, there is misuse of drugs in clinics.... Thirdly, there is poor diagnosis in clinics, poor recognition of some issues.

—Rural, male health care provider (enrolled nurse), age 55

In most cases, they [modern health care providers] are [a] menace to the youth because they ill-advise because you may find in a clinic, there is just a mere nurse... Sometimes they [adolescents] end up being given a half dose or under dose for their sickness. Let me say usually for sexual infections... So by the time they go to a big hospital, they are about to die or just dying... And some of them end up dying in the clinics because now here the health worker will fear to [seek help] thinking she will contain the health problem. At the end of the day, the person dies.

—Urban, male parent, age 55

Abortion was discussed as a service that adolescents seek by health care providers and parents. Health care providers said that when youth come to them seeking an abortion, they turn them away. "Others who come with an intention of aborting may not be helped because we do not do that. So they go cursing" (urban, male health care provider (pharmaceutical technician), age 25). Yet some key adults thought modern medical providers provided abortions.

They misadvise the youth as regards to sexual relationships like for pregnancy when someone wants to abort with them they don't mind about the life of the person and their profession is dubious. They say, "Can you give me this amount? And I do the abortion."

—Urban, male parent, age 55

A Minority of Adults Hold Moral Objections to Adolescents Accessing Modern Care

Some teachers and parents morally objected to adolescents going to health clinics because they stated that providers at clinics teach youth about condoms and supply them as well, equating access to condoms with promoting sexual activity.

When you give these children condoms, that means you are giving them permission to have sexual intercourse.

—Urban, female parent, age 48

When the students go there, they were given condoms and when you are given condoms what are you going to do with it? [engage in sex]

—Urban, female teacher, age 35

Respondent (R): Sometimes they [adolescents] get on things which they have never known and then they go to their parents and ask them about it which may not be good for parents who do not want their children to learn such thing at an early age.

Interviewer (I): What are those things which are bad?

R: Like showing them [adolescents] condoms when they still young and how to use it [condoms].

—Urban, female teacher, age 27

A few respondents believed that the information that adolescents can get from modern medical care is detrimental, for example, finding out one's HIV status.

When these adolescents go there and they test positive, the sick will get frustrated and can leave school which means they may not study anymore. Also those who find they are positive, they can spread AIDS, especially if a boy has money he can spread it to young girls who are desperate for money. When you test, people may know about it and stories begin to spread. So people fear to test because of that.

—Rural, female teacher, age 42

Chapter 6

Key Adults' Solutions to Adolescents' Sexual and Reproductive Health Needs

This chapter examines the most important solutions identified by key adults to help adolescents avoid HIV/AIDS and unwanted pregnancies. It also looks at who key adults think should implement the solutions suggested and the adults' anticipated implications of the suggested solutions.

Sensitization, Education and Guidance Are Needed to Reduce Adolescent Risk-Taking Behavior

Nearly all adults perceived a lack of information to be the primary reason that adolescents engage in risky sexual behavior. All the groups identified continuous sensitization of youth about the dangers of risky sexual behavior as crucial to stemming the further spread of HIV/AIDS and unwanted pregnancies. They noted that this sensitization should be done using the ABC (abstinence, be faithful, use a condom) approach through the media and other audiovisual methods, such as educational films, workshops and seminars in school.

The government can also carry out campaigns like they did for polio. "Kick STDs/AIDS out of the country." And supply free drugs.

—Urban, male health care provider, age 25

A lot of interventions have to be made. If possible, let the government sensitize these youths. Then there will be reduced pregnancies and sexually transmitted infections. This will help the work we are doing.

—Urban, female health care provider, age 26

We can also get films showing AIDS. How the disease gets a person and how a person shrinks to death. If these adolescents look at such films maybe, who knows? They could change.

—Urban, female community leader, age 50

The third thing is to make sure they are not ignorant. When you are aware, then you can protect

yourself but when you are not aware, there is no way you can protect yourself.

—Rural, male parent, age 53

The majority of adults said that messages about ASRH should be similar for all, irrespective of age, marital status or sex.

Both (boys and girls) should be sensitized about HIV/AIDS, pregnancy and other STDs like gonorrhoea, syphilis, etc., since they are all young. I think there is also a need to sensitize both married and unmarried couples about HIV/AIDS, unwanted pregnancy and STDs. They are the same because if we are telling girls not to get into sexual intercourse, maybe to avoid bad touches, so boys should also avoid bad touches which would lead them into sex.

—Rural, female teacher, age 40

Some of the adults, however, suggested that the approach and information given should depend on the age, marital status and sex of the adolescent. For example, younger adolescents need special information such as how to delay sexual debut.

All these solutions we are coming up with, the most important one is sensitization. At all levels, everybody should be targeted whether below or above 15 years. For those below 15 years, abstinence should be emphasized for them to suspend or don't start sex until they are ready for it.

—Urban, male community leader and health care provider, age 42

Government should keep those below 15 years in school with much care though even those above 15 years need to be kept in school. Give those below 15 years seminars in order to delay sexual debut. The information to those below 15 years should be in phases. Do not talk much about condoms or sex

to a 10 year old. You are likely to make him think of things that were not in his mind.

—Urban, [gender not recorded] health care provider, age 20

If the government has to do something, it should start in schools where you find children from age 6 to 20 years old. That's where most adolescents are located and can easily be talked to. If you start in schools, all those children below 15 years will grow up with all the necessary information. Also those between 15 and 19 years will be aware of the problem.

—Rural, female parent, age 41

Those who are married should be sensitized differently from those who are unmarried because for those who are unmarried, while sensitizing you pretend as if they know nothing. And those who are married you sensitize them as if they already know something. That is why their sensitization should be different.

—Rural, male parent, age 53

Some respondents argued that girls ought to be given special information since they need to know more about their SRH compared to boys.

Oh yes. Young women need a lot. It is difficult to nurture a young girl. Girls require a lot from mothers, aunts. As boys, we never even used to mind about pants, or if your shorts have holes. But girls need to be educated about personal hygiene and they should learn to say “no.” In fact HIV/AIDS has mostly affected girls. They need parents to talk to them every day. They need the hand of the mother and aunt to be taught moral values.

—Urban, male teacher, age 33

A few of the adults noted that older adolescents could play a vital role in sensitizing younger adolescents if they participated in educating younger adolescents who have not yet started engaging in sexual activities.

The adolescents after growing up [could] join hands with the parents and sensitize the very young adolescents. In this way, we shall have covered a certain extent.

—Rural, female parent, age 43

Keep Adolescents in School, Monitored and Busy

Staying in school was another strategy proposed by adults to help adolescents safeguard their sexual and reproductive health.

They [adolescents] should be encouraged to stay in school because when they drop out below [age] 18 they are likely to get married and also have more chances of acquiring HIV/AIDS so they should be encouraged to continue in school.

—Urban, female teacher, age 40

Some adults, especially teachers, noted the importance of sensitizing parents about the need to encourage adolescents to remain in school, since school keeps them busy and exposes them to ASRH information that may protect them against STIs and HIV as well as unwanted pregnancies.

Parents were urged by other key adults to carefully watch and to tirelessly continue advising their adolescent children about their behavior.

*The parents should take great care to properly look after their children. The mothers should keenly put an eye on their daughters: They should not allow them to dress in a provocative manner. Meanwhile, the fathers should also advise their sons. If we had a project here for youth, they will not have time for idling, to go and watch films the whole day when others are working.**

—Urban, male health care provider, age 35

Some respondents noted that if youth were kept busy, then they would not have time to engage in risky sexual behavior.

The adolescents should get time to meet. Instead of going to bars, they can play games like football which can keep them busy so that they are not redundant and scattered.

—Rural, male teacher, age 46

The first thing to be done should be that people like you from above[†] should help us set up youth organizations or clubs to keep the youth busy because idleness has caused a lot of bad things to the

*Respondents spoke about how some youth are known to watch age-inappropriate films, especially in urban areas, thus exposing them to illicit information that is beyond their maturity level.

†In this situation, the interviewer was perceived to be someone from a government agency or nongovernmental organization with access to resources that could be used to develop ASRH-targeted programs.

youth including engaging in illicit sex. If an adolescent is busy from morning to sunset, the temptations will be curtailed to some level.

—Urban, male health care provider, age 35

A few respondents also argued that parents should endeavor to provide, to the best of their ability, the basic necessities of a growing adolescent, like food, underwear, hair and body oil, and soap. Not providing basic necessities could encourage youth to look for them elsewhere, (this typically manifests itself in girls seeking partners who can provide them with these goods) which could expose them to risky behavior. Additionally, income-generating activities for youth were also suggested.

Getting them some income-generating activities, especially for the girls, even for the boys, so that it keeps them busy and also earning that cannot push them to look for money in dubious ways. Even redundancy also causes a lot of problems for the young people which may lead them to think of getting money, which eventually leads to acquiring HIV/AIDS.

—Urban, female parent, age 39

Another thing I would like to say is to get for those out of school income-generating activities such that even when they come back in the evening, they will be tired and keep at home until the next day when they go back to work.

—Urban, female parent, age 44

The Important Role That Each Distinct Group of Key Adults Could Provide Was Acknowledged

Key adults stated that a concerted effort needs to be made by all stakeholders, including parents, teachers, church and community leaders, government, health care providers and the youth themselves in implementing viable solutions.

It should be a collective effort to involve different stakeholders like parents, teachers and the adolescents themselves.

—Urban, male teacher, age 26

Health care providers and teachers argued that it was the parents' responsibility to look after their children, meaning that parents should play a big role in implementing the suggested solutions.

Because the first person in a youth's life is a parent. The parent gives a foundation. The way the children are brought up might affect their future. We are told to fear and respect our parents. This means there is a lot we learn from them. Parents have an upper hand in dealing with a child's issues and being open to them compared to the community leader or a health worker.

—Urban, male health care provider, age 25

The parents must also be sensitized about the government policies that concern children's rights like defilement, rape and so on. The parents must also be sensitized not to harass their children. When they are harassed, they will go away to look for sugar mummies and sugar daddies and get those gifts which are unwanted and which will make them fall in trouble.

—Rural, female teacher, age 43

The community leaders or the parents, before the government comes in. You know we push everything to the government, yet as parents or community leaders we can do something. The government can just supplement.

—Urban, male health care provider, age 25

Some of the respondents, however, argued that since teachers spend a lot of time with adolescents and are trained to instruct them, and since young people tend to listen to teachers more than parents, then it should be teachers who educate youth about ASRH. But lack of adequate teacher training was cited by teachers as an impediment to this.

The teacher, because we spend more time with these children. They come here at 7:00 a.m. and leave here late and when they get home they are busy with household work. These children believe whatever the teacher tells them is correct.

—Urban, male teacher, age 26

Teachers are the right persons. Children listen to us better than they listen to their parents. In fact if you instill something bad in them they will carry it home. If a parent talks and a teacher talks, the children will listen more to what the teacher says.

—Urban, male teacher, age 33

They should have or train some specific people to handle such programs in schools or places where these adolescents can be found. They should also

provide schools with counselors and this should be facilitated by the government.

—Urban, male teacher, age 26

If the government were able to provide training, teachers thought that the trained teachers could then train other teachers on ASRH issues.

The government has to come in and ensure that all schools are trained in reproductive health issues, especially the teachers. Those primary teachers should in turn train other teachers and this thing should be put in teachers' curriculums such that the ones who trained will also train others to disseminate information to children.

—Urban, male teacher, age 30

Many adults argued that government should take the lead in implementing the solutions because it has greater resources at its disposal and it has already started implementing programs such as the Presidential Initiative on AIDS Strategy for Communicating to Young People (PIASCY), the main vehicle for reaching teachers and pupils since 2001. A few respondents noted that PIASCY has gone a long way in sensitizing the youth about the dangers of risky sexual behavior. It educates teachers using materials developed on ASRH and provides information to youth so that they become better informed about the danger of HIV/AIDS and how to prevent it. The respondents urged the government to piggyback on this success by giving teachers more materials to be used in guiding young people on how to avoid risky sexual behavior.

PIASCY has done good work towards this young generation. So the government should continue to give pictures, especially IEC materials, to help teachers in guiding these teenagers.

—Rural, female teacher, age 44

A few respondents argued that adults who are well-equipped with materials and knowledge on ASRH should be given the responsibility of teaching youth about the dangers of risky sexual behavior.

Some of us just understand these things naturally. For example, even if the father never went to school, he uses the natural knowledge to communicate. But the question is, is the information he passes on accurate? So the Ministry of Health needs to equip different stakeholders.

—Urban, male teacher, age 26

Health care providers noted that adolescents should be encouraged to seek help from medical care practitioners whenever they are confronted with SRH problems, such as STIs. At the same time, they argued, VCT should be made accessible to adolescents.

Chapter 7

Conclusions and Policy Implications

This chapter highlights the key findings from the 60 in-depth interviews conducted among key adults living and working with young people. It draws attention to some of the pertinent issues arising from these findings, which can be used to inform programs and policies in order to improve the sexual and reproductive health of young people.

Adolescents Do Not Take Adults' Advice and Are Reluctant to Discuss SRH Matters

All the key adults working with young people spoke about adolescents' noncompliance with advice given and their reluctance to discuss sexual and reproductive matters with adults. Noncompliance may be a result of many factors, including teenage rebelliousness, curiosity, inappropriate evaluation of risk, and structural and social barriers. Adolescents' fear of talking about SRH issues (such as condoms and treatment of STIs) is a major barrier to seeking SRH services.⁷ This fear is in part a product of Ugandan culture, which still largely considers public discussion of sex-related matters taboo. While adults acknowledge adolescents' reluctance to confide in them, adults cite their own lack of confidence and appropriate skills to communicate with youth on SRH issues. Hence, there is a need to promote open discussion of ASRH issues among teachers, parents and youth. One way of doing this is through strengthening and supporting ongoing efforts and interventions aimed at creating social environments at home, at school or in the community that encourage dialogue about ASRH between young people and adults. Efforts currently underway include schools organizing meetings to speak with parents and organizations like Straight Talk and DISH (Delivery of Improved Services for Health) (a collaboration between the Government of Uganda and the Agency for International Development) encouraging dialogue about ASRH among parents, teachers and children through their publications like Parent Talk, Teacher Talk and Health Matters.

Health Care Providers and Teachers Do Not Have the Support They Need to Be Effective ASRH Educators

When adolescents were asked who they most trusted for information on sexual health, they most frequently named modern health care providers, followed by teachers.⁷ This trust in the modern health sector is echoed by key adults. Most adults in all of the groups interviewed were in favor of youth getting information and services from modern health care providers. Most of the key adults saw this sector promoting social norms around sex that they felt should be imparted to youth. Even condom provision was seen as a beneficial service provided by the modern health sector, according to some key adults. Providers are able to see that they give a service that adolescents are not getting elsewhere as adolescents report to them that their parents are not speaking to them about SRH matters. As trusted sources of information about sexual and reproductive health, modern health care providers said that they are able to dispel myths held by youth about sexual behavior and its consequences. A minority of parents and teachers thought that modern medical facilities went too far and saw them as promoting sex by giving young people condoms or HIV tests. Helping adolescents abort was a modern health sector service not supported by parents.

Teachers were also seen by key adults to play a major role in addressing adolescent SRH. To keep youth in school, key adults thought it was important to sensitize youth about the dangers of HIV, other STIs and ways to protect themselves. Teachers are aware that youth look to them for information and trust what they say. They are aware that they are able to impart information that many times parents are not providing to their youth. Yet teachers feel constrained to speak about sexual matters with their students because of cultural inhibitions, potential backlash from parents, and fear of being ridiculed by their students. Teachers and health care providers are hampered in their desire to be effective educators by their lack of training in teaching

life skills education, as well as their lack of infrastructural support (transportation and meals) and materials.

Therefore, efforts should be made to foster the educational roles of modern health care providers and teachers. Health care providers identified resource shortages, particularly chronic understaffing and erratic and inadequate supplies, as a major barrier to adolescents getting the information and services they need from modern medical facilities. Inadequate training of clinic staff and teachers in ASRH was also identified as a major barrier to adolescents receiving adequate services and information. Scaling up school education programs such as PIASCY could involve training more teachers to teach sexuality education in a non-stigmatizing way; provide training, including refresher courses, for teachers to be better sexuality educators; mentoring programs so that trained teachers can teach other teachers; and providing educational materials so that they can be more effective in their lessons. Infrastructural support should be given to medical providers so that they can concentrate on teaching youth life-saving information rather than worrying about how they are going to travel between educational sites or where their next meal is going to come from.

Some parents voiced the dangerous perception that school leads girls to be “spoiled” by exposing them to sexual messages, giving them an opportunity to interact with boys, and giving them more independence, as their parents cannot supervise them when they are away from home. This perception may result in parents choosing to pull their daughters out of school. It also sends a negative message to youth who remain in school that teachers are saying “bad things,” and this hampers teachers’ ability to communicate effectively, especially about sex. Furthermore, adolescents’ fears that they might be pulled out of school because they might be exposed to “bad things” may hinder their or their classmates’ willingness to speak about SRH issues.

Poor Services and Stigma Are Perceived by Adults to Hinder Protective Behavior by Adolescents

Key adults named certain barriers particular to condom use: an inadequate supply of condoms at clinics, the high price of condoms outside of clinics and the fear boys feel when they go out to buy condoms. The first two can be addressed through structural changes and every effort should be made to do so. The latter is a much more complex social issue connected to the way adolescent sexual behavior is treated in society, with shame and stigma surrounding nonmarital sexual activity. While adults acknowledge the detrimental effect

of stigma, they also perpetuate stigma. One of the manifestations of the stigma against nonmarital sex which emerged from these data was the language adults use to describe adolescents who have had sex, using words such as spoiled or wasted: implying that nonmarital sexual intercourse reduces the value of the person. In a previous data collection component of this project, this shame and stigma was clearly expressed by adolescents when they were asked about why they had not sought contraception or care for reproductive health problems.⁷ It is encouraging that some adults—not just health workers—were willing to discuss condom use with sexually active young people, since condom use is of vital importance to keep sexually active youth healthy. Making condoms available in discreet locations, such as men’s toilets, would mean that boys could access condoms without others finding out.

Barriers to adolescents receiving appropriate STI care that were named by the key adults were cost barriers that prevented adolescents from getting care or filling prescriptions, and fear of asking for help and having it be known that they are sexually active. Again, these perceptions parallel the reasons youth gave for not seeking STI care.⁶ Reducing drug stockouts so that adolescents can receive free drugs at hospitals, and educating medical staff, especially at lower-level facilities (clinics in particular), to diagnose problems correctly and understand their severity so that they can appropriately treat or refer patients, would increase the probability that someone seeking care would actually receive appropriate medical treatment.

Ways to improve the quality of the services provided by modern health care providers as identified by the key adults include providing the resources modern medical providers need to educate their clients (dummy penises, enough condoms to do condom demonstrations with each client that needs one, etc.), offering refresher courses for clinic staff, having clinic staff hold youth clinics on basic sex education to impart needed information (including condom demonstrations) without having to take up providers’ time with individualized educational sessions, and addressing staffing shortages and corruption within medical facilities to improve the morale at these locations. All of these actions would result in better services for youth who make it to modern medical facilities. Lastly, dialogue should be encouraged among modern medical providers and parents and community leaders so that parents and community leaders can learn more about normal sexual development and the connection between pubertal maturation and sexual curiosity and

desire, as well as the prevalence of premarital sex, the kinds of SRH problems youth in their community are experiencing, and what health care providers are teaching young people. This will hopefully begin to address some of the stigma that adults attach to nonmarital sexual behavior.

Parents and health care providers were aware of abortion as an issue in the lives of young people. Many health workers reported handling cases of young girls seeking abortion, and complications from unsafe abortions. Although abortion is currently illegal in Uganda, it is widely performed but frequently in an unsafe manner, either by professionals under unsafe conditions or by untrained providers, which frequently poses a danger to women's lives.⁸ Short of legalizing abortion so that it can be carried out safely, there is a need to strengthen pregnancy prevention activities. First, adolescents need to be provided with accurate information regarding pregnancy prevention. Secondly, contraceptive methods, especially those that can be controlled by young women and therefore do not rely on their partners' cooperation, need to be made more readily accessible to young people free of charge or at a nominal cost. Thirdly, improved postabortion care services would help reduce the consequences of abortion complications. And lastly, there is a need to sensitize adults to the plight of child mothers, who are often treated as outcasts. These young women need to be offered a second chance to attain their full potential. Being supported in their desire to finish school would go a long way toward improving their long-term life chances.

Adults' Perceptions at Times Do Not Match Adolescents' Reality

While the majority of key adults identified HIV/AIDS as a major sexual health problem, many did not see it affecting adolescents, as they did not see adolescents suffering from the disease. In fact, young people have until recently been the fastest growing group contracting HIV in Uganda and adolescence remains a high-risk period in people's lives.² Many adults did not account for the latency period between the time of infection and the manifestation of the disease. Whether this is out of ignorance or because of the way the question was asked deserves further exploration. The fact that the impact of HIV/AIDS is not visible among youth doesn't necessarily mean that adults believe that adolescents are not becoming infected with HIV/AIDS. Rather, it may be that the most common way of speaking about HIV/AIDS is when the disease manifests. Yet a recent survey found that approximate-

ly one-quarter of women and one in five men in Uganda do not know that a healthy-looking person can have the AIDS virus;³ therefore, it is plausible that in fact, some of these respondents do not know about the latency period.

Another area in which there is a disjuncture between adults' perceptions and adolescents' reality is that key adults generally perceive younger adolescents (younger than 15 years of age) as not being sexually active, yet survey results show that in fact, 8% of girls and 15% of boys 12–14 years old have had sexual intercourse.⁷ Among those who neither had sex nor had a boyfriend/girlfriend, 18% of the females and 6% of the males had engaged in sexual behaviors such as kissing or fondling. Ignorance among key adults about the sexual activity of this segment of the population can be dangerous for the very young adolescents who may be at even greater risk than their older counterparts because they lack important ASRH knowledge. This points to the need to increase awareness among key adults about the risk very young adolescents are facing.

Action Is Vital to Protect the Next Generation

In summary, protecting adolescents from HIV/STI infection and unwanted pregnancies calls for a concerted effort from parents, teachers, health workers, the government and the community. Most pertinent is addressing the existing barriers adolescents face in accessing ASRH information and services. Creating a social environment that enables effective communication between children and key adults, particularly the parents and teachers with whom children spend most of their time, would be one major step. However, a lot more needs to be done by the government and other stakeholders to address structural barriers, such as the widespread stockout of drugs and other supplies, like condoms, as well as the acute understaffing at health facilities. Schools also need to be well equipped with relevant IEC materials on ASRH issues. Action from all key stakeholders is necessary to protect the next generation.

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