Qualitative Evidence of Adolescents' Sexual and Reproductive Health Experiences in Uganda

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Occasional Report No. 31
October 2007

Acknowledgments

Adolescents' Sexual and Reproductive Health: Qualitative Evidence of Experiences from Uganda was written by Stella Neema and Richard Kibombo, Makerere Institute of Social Research; and Ann M. Moore, Guttmacher Institute.

The authors thank their fellow research colleagues, Christine Ouedraogo and Georges Guiella, Institut Supérieur des Sciences de la Population (Burkina Faso); Alister Munthali and Sidon Konyani from the Centre for Social Research (Malawi); Kofi Awusabo-Asare and Akwasi Kumi-Kyereme from the University of Cape Coast (Ghana); Alex Ezeh, Eliya Zulu and Nyovani Madise, African Population and Health Research Center (Nairobi); Susheela Singh, Akinrinola Bankole and Ann Biddlecom, Guttmacher Institute; and Vanessa Woog, formerly of the Guttmacher Institute, for helping to develop the design of the guide for in-depth interviews with adolescents and providing feedback and insight on the interpretation of the results presented in this report. The interviews were conducted by Maxima Tibwita, Dennis Bataringaya and Peter Iranya.

The authors also thank Melanie Croce-Galis and Akinrinola Bankole, Guttmacher Institute, and F. Humera Ahmed, formerly of the Guttmacher Institute, Kathy Watson of Straight Talk, Uganda, and Stephen Kiirya of the Makerere Institute of Social Research for their constructive comments and suggestions.

Last but not least, the authors express their deep gratitude to the young people who participated in the interviews for the time they devoted to the exercise and more so for their insightful contributions. We learned a lot from them and we are very hopeful that their input will help improve the delivery of sexual and reproductive health services for young people.

The research for this report was conducted under the Guttmacher Institute's project Protecting the Next Generation: Understanding HIV Risk Among Youth, which is supported by the Bill & Melinda Gates Foundation, the Rockefeller Foundation and the National Institute of Child Health and Human Development (grant 5 R24 HD043610).

Suggested citation: Neema S, Moore AM and Kibombo R, Adolescents' sexual and reproductive health: qualitative evidence of experiences from Uganda, *Occasional Report,* New York: Guttmacher Institute, 2007, No. 31.

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Executive Summary

In the last decade, young people have emerged as the group with the fastest growing HIV incidence in Sub-Saharan Africa. Although, both HIV and adolescent pregnancy have been decreasing in Uganda over the last 15 years, HIV prevalence is still unacceptably high at 6.4%, and 25% of 15–19-year-olds in 2007 were pregnant or had already had a live birth. This report draws on 103 semistructured in-depth interviews with 12–19-year-old males and females, in school and out of school, from urban and rural areas, to learn about adolescents' risk and protective behaviors related to HIV and unintended pregnancy. Their narratives provide important contextual information to help us understand the behaviors that adolescents employ in reaction to risks of HIV and unintended pregnancy.

Adolescents' Perceptions and Experiences About Puberty

Most young women learned about pubertal body changes from same-sex family members: mothers, aunts, grandmothers and sisters. However, family members seemed to provide information reactively, that is, in response to events such as menstruation, after the young woman had already experienced fear and concern that something was wrong with her. School was another important source of information on puberty for both females and males. The majority of adolescents were aware of most body changes before they experienced them. Generally, young men welcomed the onset of the body changes, while most young women reacted negatively to some of the changes, especially menstruation.

Adolescents' Perceptions and Experiences with HIV/AIDS

Reactions to HIV/AIDS and people infected with HIV/AIDS

While none of the adolescents named HIV as their most pressing problem, when asked to compare their most pressing problem to HIV, almost all said that HIV was a greater problem because it has no cure and causes death. This demonstrates the difficulty for adolescents of comparing a disease that does not have immediate health implications with much more tangible problems, such as a lack of school fees or a need for food.

Adolescents exhibited fear of HIV. Some thought they may already have it; others thought that their husbands may bring AIDS home and infect them. Adolescents believed that HIV/AIDS leads to depression and reported knowing of people who had committed suicide when they found out they had HIV. Adolescents' most frequently cited reaction to people with HIV/AIDS was pity, especially toward women and children. Adolescents were encouraging of HIV-positive individuals seeking care. Expressing stigma against HIV-positive individuals was rare. The fact that everyone knew someone who had AIDS may contribute to this low level of stigma.

Risky and nonrisky sexual behaviors

Having sex without a condom and having multiple sex partners were commonly mentioned as risky sexual behaviors that could expose youth to HIV. Youth also named social influences which expose youth to HIV: peer pressure to engage in transactional sex for young women, and bars and alcohol for young men. Using condoms, abstaining from sex and reducing one's number of sex partners were commonly known to be nonrisky behaviors, although certain risky behaviors were also perceived to be nonrisky. For example, some adolescents said that having sex during one's menstrual period was not risky.

Actual and preferred sources of information

Education on HIV/AIDS came primarily from school. Families were less commonly named. Some said they had never been talked to about AIDS. The messages given were the traditional ABC messages: abstain, be faithful and use condoms. Females, in particular, were

encouraged not to engage in socially risky behavior such as going to discos, accepting gifts from men, and associating with "bad peer groups." Adolescents said the information was useful because it allowed them to protect themselves, but they desired more information.

Adolescents would have preferred to get more information about HIV from health workers. Well-known nongovernmental organizations working on HIV/AIDS, such as The AIDS Support Organization and the AIDS Information Centre, were preferred by young women, while young men preferred to talk with uncles and brothers. While most young people said they did not have trouble accessing HIV/AIDS information, the few that did have trouble cited not being able to access HIV/AIDS material on the radio or that the right person to talk to was not available.

Almost all of the adolescents attended religious services. They said that the most common messages they received from their church or mosque about HIV/AIDS was to practice abstinence and not to commit adultery. A few respondents said their churches spoke against the use of condoms.

Nonmarital Pregnancy and Childbearing

There is a great deal of stigma against nonmarital pregnancy. Young women are treated as if they are solely to blame for having a nonmarital pregnancy—the accusations rest with the fact that they exposed themselves to intercourse more so than accusations that they did not use contraception. An adolescent woman who gets pregnant was perceived to bring shame to her family and severely compromises her financial stability and her life chances by having a nonmarital pregnancy. Some of the negative reaction to nonmarital pregnancy was that it was a definitive demonstration of having had unprotected sex, which was equated with having exposed oneself to HIV and therefore, potentially being HIV-positive.

Actual and preferred sources of information

Information about preventing pregnancy came from same-sex family members and teachers. The messages focused on abstinence, but encouraged practicing contraception when abstinence was not achievable. Some information imparted about birth control was incomplete and incorrect, especially the information held by males. Perhaps this contributed to the general mistrust of methods in being able to prevent pregnancy and the belief that birth control pills can cause sterility. There were widely held misconceptions about when in a woman's menstrual cycle she is most fertile, which has major implications for those practicing the rhythm method. Contraception was seen as the woman's responsibility, in part because men were perceived to be untrustworthy by both men and women.

Young women preferred health care providers as sources for information on pregnancy prevention because they are seen to be knowledgeable and because they have treated people who have become pregnant and have treated postabortion complications. Family planning clinics, mothers and sisters were also named by young women as sources of pregnancy information. Young men preferred older friends because they trusted them, since they had passed through the same types of experiences. Although most adolescents had incomplete knowledge regarding contraception, they reported that they could easily obtain any information they wanted on pregnancy.

Adolescents' Health-Care Seeking Behavior

Most adolescents reported that they seek care for the health problems they experience, but the type of care sought often depends on the perceived severity of the health problem and the availability of financial resources to meet the medical costs. Consulting mothers or a trusted friend was frequently the first step; either home remedies or, if finances allowed, professional care, followed. For sexual and reproductive conditions, courage to tell one's parents or to reveal one's genitalia to a health worker and advice received from friends or siblings are important factors in determining the type of care sought. Although treatment for STIs is supposed to be readily accessible and free in public clinics and most prominent NGO health facilities, most adolescents believed that one had to have money to be treated. Some adolescents who feared receiving injections were deterred from seeking professional care due to the widespread use of injections for treatment of all sorts of ailments in Uganda's health facilities. Many of these youth resorted to self-medication or sought professional care only when the situation was no longer tolerable.

Adolescents' Intimate Relationships

Sexually inexperienced adolescents

Adolescents equated relationships with sexual intercourse, and fear of AIDS was the primary reason young women gave for not having had a relationship, not having had sex or having ended a relationship. Males were perceived to be deceptive and untrustworthy. Among young men, primary reasons for not having had a relationship or having had sex were because their religion forbade it, because they were scared of getting a female

pregnant and because they feared that if they got a female pregnant they would have to drop out of school. Most respondents who were not yet sexually active thought that they would have their first relationship or sexual experience when they finished school.

Sexually active adolescents

Pregnancy was a much greater fear among sexually active adolescents than HIV/AIDS. Adolescents felt the need to hide their relationships to reduce the probability that the young woman's parents would find out because the fear was if they did find out they would punish her by beating her or chasing her away from home. Most young women said they were deceived, forced or coerced with money at sexual debut. Females also experienced coercion and pressure not to use contraception and to become pregnant. A few males said they had been coerced at their sexual debut, as well.

In response to a general question on whether they had ever been pressured to have sex, young women said they were most commonly pressured by their boyfriends, while young men said they were most commonly pressured by their male friends to have heterosexual sex. In response to a hypothetical question about what they would do if pressured to have sex, a minority of both boys and young women said that they would give in to avoid conflict or offending the male's ego (young women's reasons) or out of love (males' reasons). Some young men said they would beat a woman who pressured them to have sex.

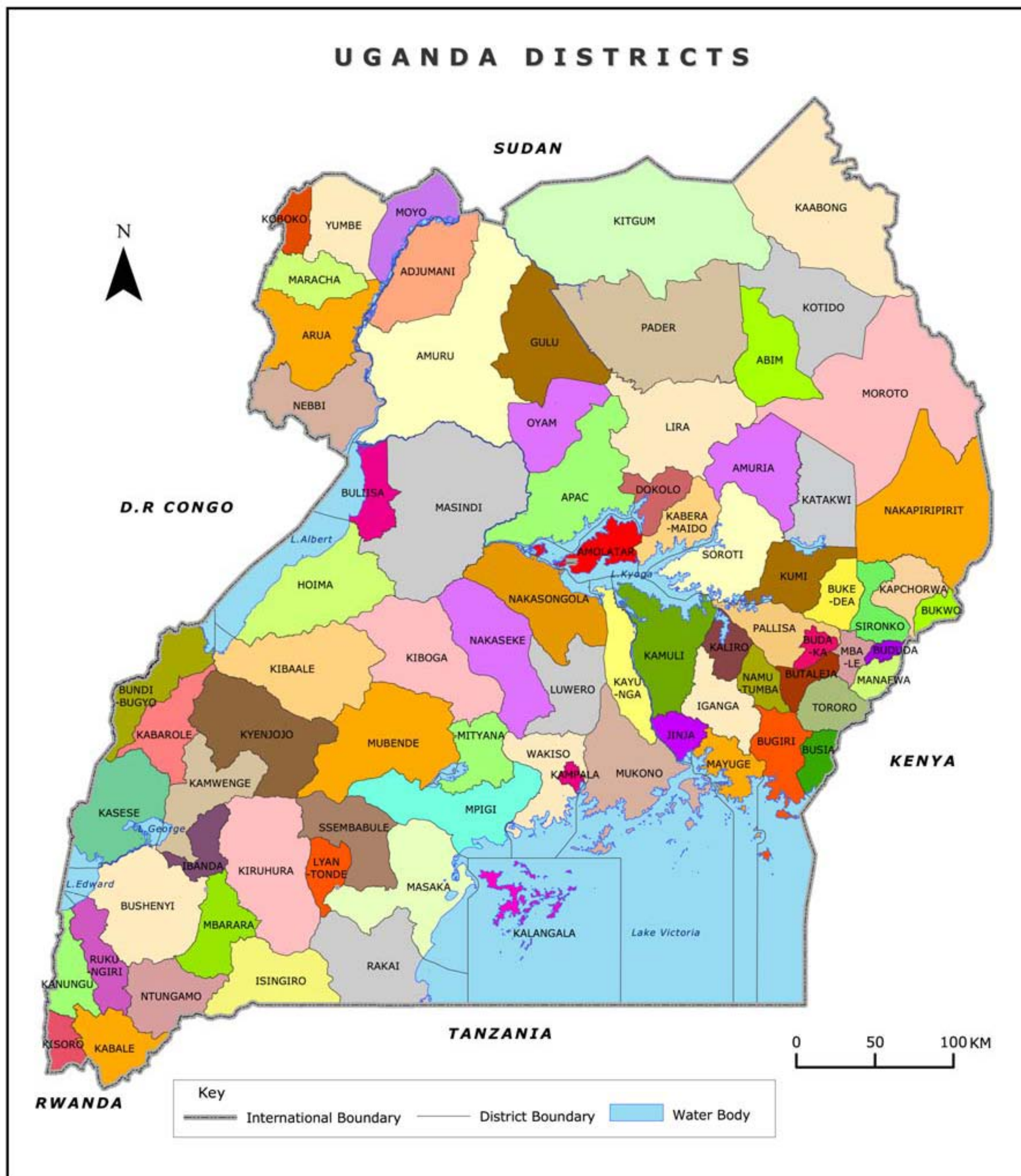
Some adolescents felt at risk of having an unwanted pregnancy or contracting HIV/AIDS or other STIs because their partners refused to use condoms. The reasons the partners refused to use condoms included that condoms cause them pain or were a barrier to intimacy. Those who did not feel at risk said they trusted their partners or they were using condoms, hormonal contraceptives or both. However, some who did not feel they were at risk were in fact at risk due to contraceptive sabotage, infidelity or having received incorrect information about what will prevent pregnancy.

Policy and Program Recommendations

Improved sex education, preferably imparted by health care providers and made available to in- and out-of-school youth may serve to fill in the gaps and misconceptions in young people's sexual and reproductive health knowledge. Yet this may not be practical due to the shortage of health workers in the country. Therefore, equipping teachers and parents with better sexual and reproductive health information and empowering parents to teach their children about such matters is also important. More complete and timely information from family members could address adolescents' fears about the unrecognized body changes they are experiencing.

Stigma against nonmarital sex hampers young people's ability to obtain modern contraceptives and treat STIs. If parents are willing to prioritize young people's health over social norms that prohibit conversing about sex, they may be able to reduce adolescents' fears associated with asking for assistance in seeking care to protect their sexual and reproductive health and treat the consequences of sexual activity. STIs in particular should be treated by modern medical providers to reduce adolescents' communicability of bacterial infections.

Map of Uganda



Chapter 1

Introduction

Twenty-five years into the HIV/AIDS epidemic, one of the trends that has emerged worldwide is that HIV/AIDS is increasingly affecting young people. Young people aged 15–24 account for about half of all new HIV infections.[1] Sub-Saharan Africa bears the greatest burden: Data from 2005 indicate that almost nine in ten children under the age of 15 living with HIV are in Sub-Saharan Africa (two million people).[2] The epidemic among youth in Sub-Saharan Africa is heavily biased towards young women: Among 15–24-year-olds, one male is infected for every three females.[3] In addition to HIV, unintended pregnancy is another major reproductive health problem which also takes a greater toll on young women.[4]

Understanding the sexual and reproductive behaviors of young people, especially young women, and the factors that protect or put them at risk for HIV infection, STIs and unwanted pregnancy is critical. Youth aged 15–24 are 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] During adolescence, young people are still forming many behavior patterns; these years are therefore a critical time for learning the skills that will allow them to protect themselves and their future partners.

This report provides an in-depth analysis of adolescent sexual and reproductive health in Uganda from adolescents' perspectives, focusing on HIV and other STIs and unwanted pregnancy. It draws on 103 in-depth interviews (IDIs) conducted with young males and females aged 12–19, with representation of in- and out-of-school adolescents, in two urban and two rural locations. The report also includes interviews with five specific groups that are often considered to be at higher than average risk for negative sexual and reproductive health outcomes: adolescents who work or live on the streets, refugees, physically disabled adolescents residing in institutions, residents at a juvenile remand institution and adolescents residing in orphanages.

Drawing on the qualitative data from adolescents, the main objectives of the report are to

- describe the different kinds of sexual and reproductive health problems that adolescents experience;
- determine how prepared adolescents are to take appropriate action when they experience such problems;
- depict the experiences of young people when they try to get help for a sexual or reproductive health problem;
- better understand what adolescents' relationships with the opposite sex are like, including those where sexual intercourse has not occurred; and
- identify the important sources of influence, positive and negative, on adolescents' ability to protect their sexual and reproductive health.

This report is part of a larger five-year study of adolescent sexual and reproductive health called Protecting the Next Generation: Understanding HIV Risk Among Youth. The project, which is being carried out in Burkina Faso, Ghana, Malawi and Uganda, seeks to contribute to the global fight against the HIV/AIDS epidemic among adolescents by raising awareness of young people's sexual and reproductive health needs with regard to HIV/AIDS, other STIs and unwanted pregnancy; communicating new knowledge to a broader audience, including policymakers, health care providers and the media, in each country as well as regionally and internationally; and stimulating the development of improved policies and programs that serve young people. In addition to the in-depth interviews covered in this report, the larger study involves focus group discussions with 14–19-year-olds, in-depth interviews with key adults (teachers, parents and health workers) and a national survey of 12–19-year-olds, all of which were conducted in each study country. The goal of the in-depth interviews is both to explore issues that do not fit well in a large scale quantitative survey that relies on close-ended and high-

ly structured questions, and to complement national survey data on youth by examining the “whys” that motivate adolescents’ behaviors. Combined, these sources provide information that can guide sexual and reproductive health policy and programs to best help youth protect their health.

The findings from this in-depth study of 12–19-year-olds in Uganda contribute substantially to knowledge about adolescent sexual and reproductive health in three ways. First, evidence on adolescents’ health-seeking behavior is scant—we know very little about the sequence of steps that adolescents take in trying to get help for a health problem, especially for problems like STIs that are often stigmatized. Describing young people’s attempts to seek health care (the sources, sequence of steps, and supports and barriers faced along the way) enables a better understanding of how to address health care utilization and how to better equip and prepare both formal and nonformal providers of health information (e.g., pharmacists and traditional healers) to meet the sexual and reproductive health needs of adolescents.

Second, much of what we know about adolescents’ intimate relationships is limited to a few specific indicators of sexual relationships. This study adds to existing knowledge by providing information about the full range of experiences that adolescents have in romantic relationships, from their first interest in the opposite sex to sexual experiences as a young, married person. By looking at relationships with the opposite sex—including those that do not involve sexual intercourse—these data elucidate what adolescents expect from relationships, how they form relationships, and what kinds of pressure they experience with respect to engaging or not engaging in sexual intercourse. Emphasis is given to those aspects of intimate relationships that either protect or place adolescents at risk for HIV, other STIs and unwanted pregnancy.

Finally, the in-depth interview methodology allows for detailed stories rather than short classifications of experiences, and often these stories include unanticipated links that help answer the primary research questions. Young people’s stories about their health problems and relationships improves our understanding of why some young people put themselves at possible risk for negative health outcomes, while others are able to avoid those risks.

Chapter 2

Background

This chapter provides concise background information on the political and economic history of Uganda and how the HIV/AIDS epidemic has affected the country.

History, Population Growth and the Economy

Uganda is a landlocked country bordered by Sudan, Kenya, Tanzania, Rwanda and the Democratic Republic of Congo. After gaining independence from the British in 1962, violence plagued Uganda for two decades. Between 1962 and 1986, national leadership changed seven times. The National Resistance Army assumed leadership in 1986 with Yoweri Museveni as president. In 2006, President Museveni won a third term in office. Since President Museveni has been in office, internal security has improved, except in the north, which is plagued by the insurgency and rebel activities of the Lord's Resistance Army.

Uganda's population has increased from five million in 1948 to 9.5 million in 1969; 12.6 million in 1980; 16.7 million in 1991; and recently 24.7 million in 2002. The population growth rate is estimated to be 3.4 %—the third highest in the world, after Niger and Yemen.[6] As one would expect with such a high growth rate, Uganda has a young population: People younger than 15 account for almost half of the total population, and one in every three Ugandans is aged 10–24.[7]

Uganda is one of the least urbanized countries in Africa, with almost 88% of the population living in rural areas.[8] At the time of its independence, Uganda was performing well economically. Between 1963 and 1971, the GDP grew at an average rate of 4.5% per year. However, Idi Amin's dictatorial regime reversed the gains, in part through its well-known expulsion of Asians. Between 1977 and 1980, the economy collapsed and the GDP dropped 18.8%. Growth since 1986 has been dramatic, largely as a result of an ambitious program of macroeconomic adjustment and structural reforms. In 1997, the government launched the Poverty Eradication Action Plan, a comprehensive national development framework. This program helped to reduce the proportion of Ugandans living in absolute poverty from 56% in 1992 to 35% in 2000. According to recent data, there was a slight increase to 38% in 2004.[9] Despite having reduced the proportion of its citizenry living below the poverty line, Uganda remains one of the poorest countries of the world. The overall economic growth that the country has experienced since 1986 masks the unequal distribution of welfare gains across regions, sectors and socioeconomic groups. For example, 61% of the population in northern Uganda live below the poverty line, compared with 16% in the Central Region.[10] Overall, disease (especially HIV/AIDS), poor health, limited access to land, limited education and skills, lack of markets and credit facilities, large families and insurgency are the main causes of poverty in the country.[11] Agriculture remains the most important income-producing sector of the Ugandan economy, especially in rural areas, though most of it is on a subsistence level.

HIV/AIDS and Unwanted Pregnancy Among Young People in Uganda

Uganda has been cited as a success story of HIV/AIDS prevention and control. In the early 1990s, when Uganda's HIV infection rate was 18%,[12] Uganda adopted a comprehensive behavior change approach commonly known as the ABC method (abstain, be faithful or use a condom). Survey data over time suggest that the rapid decline in HIV/AIDS in Uganda can be attributed to change in all three key behaviors.[13] The ABC strategy has since been expanded to ABC-Plus, which includes voluntary counseling and testing for HIV, prevention of mother-to-child transmission, antiretroviral treatment and HIV/AIDS care and support services.[14] HIV seroprevalence has declined from 25–30% among antenatal patients in the most affected urban areas in the early 1990s to 5–10% in urban areas in the early part of the current decade.[15] While there have been improvements in AIDS-related morbidity and mortality due to increased access to HIV/AIDS care, including antiretro-

viral therapy, the impact of HIV/AIDS has been felt at all levels of society through the morbidity and mortality of the most economically vital portion of the population, high levels of orphanhood and increased demands on Uganda's already strained health care system.

The country is now experiencing a mature and generalized epidemic, though the epidemic is affecting the population unequally. A recent survey on HIV and behavior carried out in 2004–2005 shows that there is higher prevalence among women aged 15–49 (7.7%) than among men of the same age (5.0%).[16] Although the overall proportion infected is lower among young people than all adults, the gap between young men and women aged 15–19 is greater than it is among adults. Young women's prevalence currently stands at 2.6%, compared with 0.3% among young men (Figure 1).

As HIV patterns have been changing, so has the prevalence of adolescent pregnancy. Prevalence has decreased in Uganda over the last decade: In 1995, 43% of 15–19-year-old females were pregnant or had already had a child, compared with 25% in 2006.[17] The median age at first birth has been increasing: Among 45–49-year-olds, their median age at which they had their first birth was 18.5, while the average 20–24-year-old had her first birth at age 19.1.[18] However, adolescent childbearing continues to be a public health problem in Uganda. In the five years prior to the last Demographic and Health Survey (2006), 37% of births to women younger than 20 were mistimed and 5% were not wanted at all.[19]

Special Groups of Adolescents At Risk

Some adolescents are especially vulnerable to negative sexual and reproductive health outcomes because they have a greater likelihood of being sexually exploited and thereby contracting STIs, including HIV/AIDS. The latest survey on HIV and behavior in the country showed that orphans and other vulnerable youth were more likely than their peers to have sex by age 15: Some 14.6% reported having initiated sex by age 15, compared with 8.9% who were not in this high risk category.[20]

Orphans

Many children have been orphaned in Uganda due to the civil conflicts, the most famous of which being the Luwero Triangle guerilla war waged by the National Resistance Army between 1981 and 1986 and the ongoing war in northern Uganda being carried out by the Lord's Resistance Army. HIV/AIDS has also been responsible for orphaning a significant number of young people. Current data show that overall, 14% of people younger than 18 (1.7 million youth) in Uganda have lost one or both parents: Twelve percent have lost their biological father, 6% have lost their mother and 3% have lost both parents.[21,22] The level of orphanhood has remained constant since 2000–2001 and is higher in urban areas (19%) than in rural areas (14%).[23]

Care of orphaned children in Uganda usually falls to the extended family, irrespective of their ability to care for another child. In most cases, the extended family cannot afford to absorb this additional burden.[24] Sometimes, this results in orphan-headed households.[25] A 2000 study in Rakai District found that adolescent women in such households have frequently been sexually assaulted, or have engaged in early sexual activities in exchange for basic necessities at home.[26]

Street youth

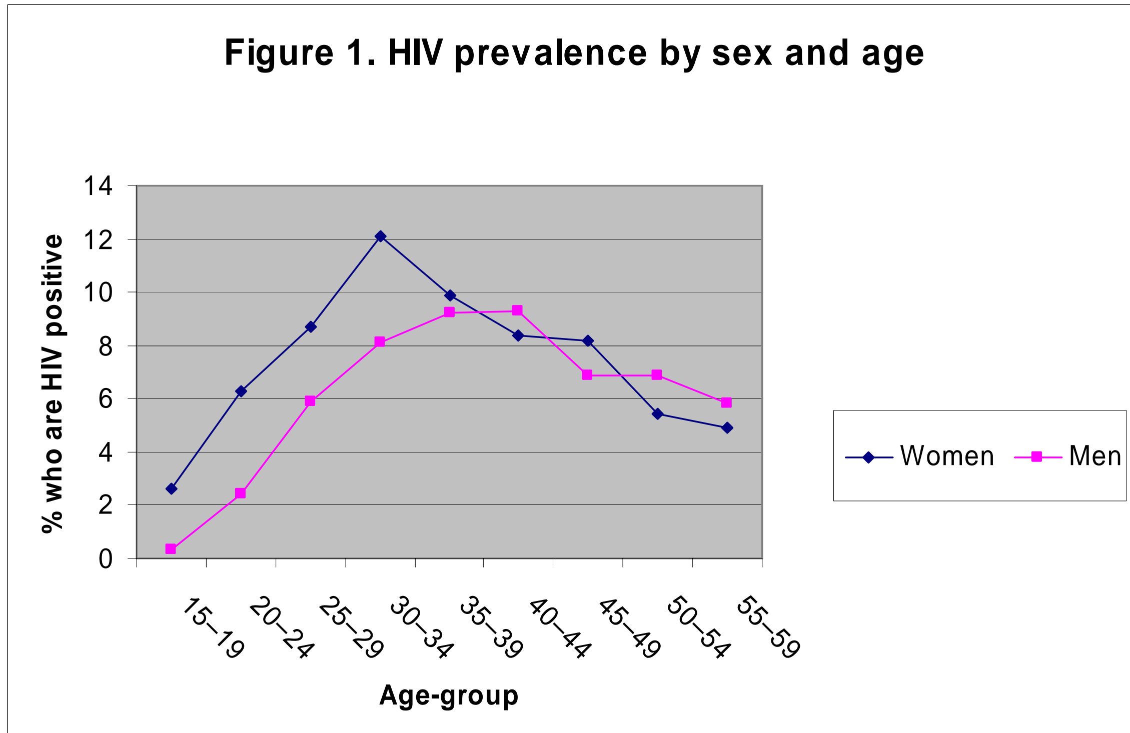
There are no good data on the number of youth who live on the street because this population is difficult to locate and track. Sometimes they are resettled or placed in remand homes (rehabilitation homes for juvenile delinquents). However, the number of street youth has been increasing due to civil strife, urbanization, general poverty, family disintegration and AIDS-related morbidity and mortality. In some cases, young people have taken to the streets to reduce economic pressures at home.[27] Street youth survive most commonly through selling manual labor, stealing (including pickpocketing), and performing sex work. Drug use, which occurs in this population, can serve to reduce inhibitions to engage in risky behaviors thereby putting these youth at greater sexual and reproductive health risk. This population is extremely vulnerable to sexual exploitation and consequent unwanted pregnancies, unsafe abortions and STIs, including HIV.

Refugees

Uganda has been a recipient of a quarter of a million refugees from various countries surrounding it, the largest contributors being the Democratic Republic of Congo, Somalia, Rwanda and Sudan.[28] Most of the refugees are women and children. They reside in densely populated camps that generally lack health services. Many arrive having already been sexually assaulted and an additional number are abused in the camps. Research conducted in an internally displaced people's camps in northern Uganda found that adolescents in these camps are vulnerable to sexual abuse: Some get pregnant at an early age and some become infected with HIV. Many experience long-term psychosocial trauma from the sexual abuse they experience.[29]

Youth with disabilities

The national youth disability prevalence rate is 4%.[30] Disability is defined as having difficulty moving, seeing, hearing or speaking, or any mental or learning difficulty, that lasts or is expected to last six months or longer. These individuals are marginalized due to social discrimination and a lack of infrastructure that prevents them from being independent. As a result, they are disadvantaged in many respects; for instance, they may not be able to attend school, obtain gainful employment or obtain appropriate health care. These individuals have frequently been overlooked in studies on sexual and reproductive health, yet due to their socially marginalized status, they are vulnerable to sexual exploitation and concomitant negative sexual health outcomes.



Ministry of Health and ORC Macro, *Uganda HIV/AIDS Sero-Behavioral Survey 2004–2005,* Kampala, Uganda: Ministry of Health; and Calverton, Maryland, USA: ORC Macro, 2006, p. 101.

Chapter 3

Methods of Data Collection and Analysis

This report is based on data from 103 in-depth interviews (IDIs) conducted in September and October 2003 with adolescents aged 12–19. The purpose of the IDIs was to provide a better understanding of the factors that influence adolescents' decisions and behaviors regarding protecting themselves and their partners from HIV/AIDS and unwanted pregnancy; they focus specifically on the nature of adolescents' sexual relationships and health care–seeking behaviors. Of the 103 IDIs, 35 were held in Mbale District, Eastern Uganda; 34 in Mbarara District, Western Uganda; and 34 in Kampala, Central Uganda. Overall, 17 adolescents who were considered to be at higher-than-average risk for negative sexual and reproductive health outcomes were interviews:*

- 6 street youth
- 2 refugees
- 4 disabled youth residing in institutions
- 1 resident of a remand institution
- 5 orphans in institutions

Field Team and Training

The field interviewers were selected according to their knowledge of qualitative data collection techniques and research experience. They were assigned to study districts on the basis of their fluency in the language commonly spoken in each district. Most of them had facilitated or taken notes during the Protecting the Next Generation focus group discussions conducted earlier among adolescents. The interviewer training covered lecturing, role-plays and plenary sessions in which the whole team met after group role plays to evaluate each interviewer. The team conducted a pretest in Kampala and Wakiso Districts and revised the instruments and consent forms accordingly. Letters of introduction were presented to the necessary authorities to enter the districts where the data were collected. While the fieldwork was in progress, the principle investigator visited each field team to check the quality of the interviews being collected and to help the field team troubleshoot any problems.

Screening and Selection

Participants were selected based on the following characteristics: age (12–19), residence (urban or rural), school status, gender, parity (with and without a child) and inclusion in a special group (street youth, refugees, disabled, residents of remand institutions and orphans). A social mapping approach was used to identify eligible adolescents. Social maps of study villages were constructed with assistance from local council officials, who have lists of all households and their members. In conjunction with the field team, the local council officials identified all households in the area that included adolescents. The field team systematically visited every sixth household screening for eligible respondents. Consent was first sought from adolescents' parent or guardian and then from the adolescents themselves. This was more cumbersome in urban areas where it was more likely for the parents not to be around, and interviewers would have to return numerous times before being able to obtain consent from the adult. In general, parents were willing to allow their children to be interviewed because they were supportive of the project's goal of addressing HIV/AIDS infection among young people. The study was carried out during school holidays so that in-school adolescents would be found at home. In general, adolescents seemed to understand the questions.

Interviews were conducted mainly in local languages—Runyankore in Mbarara District, Lumasaba in Mbale District and Luganda in Kampala. Sometimes English was used with members of the special populations in institutions who did not speak the three principle languages identified above. The discussions were taped recorded, transcribed and simultaneously translated into English.

*One was both orphaned and disabled.

Analysis

A node structure created in N6 (QSR International, Doncaster, Australia) that covered the main themes of the interview guide was used to code the data. The themes were puberty, sexual relations, health care–seeking, personal aspirations, perceptions of risks and social influences. The transcripts were coded by research assistants 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 researchers' subjective biases did not determine the conclusions drawn from the data.

Challenges During Data Collection

The team experienced a number of challenges while in the field. Some of the challenges were project-wide while others were unique to the specific area in which the team was fielding the study. Across the board, the study was received quite suspiciously. Some parents/guardians thought that the interviewers were recruiters attempting to recruit their children into the army to fight the insurgency in the northern part of Uganda. Consequently, the research assistants had to repeatedly assure the community members about the purpose of the study.

The Kampala team generally had a more difficult time recruiting respondents than the teams in Mbale and Mbarara. Potential respondents were frequently unwilling to take the time to participate in the interview because many of them were working in the informal sector and time spent in interviews was time taken away from their work. As a consequence, the team had to spend more time in the field in Kampala than in Mbale and Mbarara.

Some adolescents were reluctant to answer questions about sex perhaps in part, due to males' fear of being arrested for defilement if sex with a minor were reported. (According to the Ugandan Constitution of 1995, females' age of consent for sexual intercourse is 18.) When asking about what kinds of sexual behaviors the adolescents thought were risky, because the respondents had difficulty coming up with any, the research team often had to provide examples, so there is concern that the questions may have been leading. In addition, some adolescents found the hypothetical questions difficult to understand (e.g., what their reaction would be if their closest friend wanted them to use alcohol).

Certain populations were harder to find than others. Out-of-school adolescents aged 17–19 were difficult to recruit because many had left home to work. This was a challenge both in urban and rural areas. In Mbarara District, it was difficult to find married male adolescents, perhaps because since the introduction in 1996 of free universal primary education, most adolescents are in school which has lead to a delay in marriage, reducing the probability that adolescent boys are married.[31]

Interviewing street youth presented many challenges. Some of the street youth were juvenile delinquents. For example, one street youth in Mbarara hit a food vendor who had offered a venue for the interview. Another problem was that street youth were at times hard to find. In Mbale, shortly before the study team arrived, the street youth had been removed from the streets and put into remand homes. Currently, there are governmental efforts underway to rehabilitate street youth through counseling and familial reintegration. For example, there are many Karimajong street youth in Kampala that the government is trying to return to Karamoja, their land of origin. Another problem was that during the interviews, other street youth demanded to know what was happening to their peer and why the interviewer was talking to him. Because of the resettlement underway, they feared strangers who they suspected might capture them for resettlement back to their villages or place them in remand homes. It was also difficult to get the street youth to answer the questions completely, as the interviews took place while they were busy working and looking for food. Information obtained from one adolescent living on the street in Mbarara was felt to be inauthentic because he said that he had a number of wives. The research team suspected that he may have been on drugs and/or he was just answering to impress the interviewer, yet he was kept in the sample because he answered other questions reasonably.

Adolescents from other high-risk populations presented additional challenges. Interviewing orphans living in institutions was a challenge in Mbarara because there are few orphanages in that town. Adolescent refugees were also difficult to get because the adolescents requested from the research team a letter from the protection officer before they consented to be interviewed. There was also a language barrier between some potential respondents and the interviewers: Some Somalis did not know English and the interviewers did not know Somali. Hence, it required more time in the

field to interview adolescent refugees. Lastly, some of the disabled adolescents had problems as a result of their disability which made the interview more difficult. One disabled female adolescent had to urinate frequently. As a result, the interview had to frequently be halted and restarted which prevented the interviewer from eliciting in-depth answers.

Limitations of the Study

As with all qualitative data, the views described and discussed in this report reflect those of the young people who participated in the interviews. The IDIs were designed to capture the attitudes and experiences of males and females in urban and rural areas, who were both in and out of school, in the areas where the IDIs were conducted. However, the findings reported here may not represent the views held by young Ugandans in general or even of all young people in the communities where fieldwork was conducted. Secondly, the fact that the interviews were largely conducted in a traditional language and then translated into English may have introduced errors to the data.

Chapter 4

Adolescents' Experiences of Puberty and the Problems They Are Currently Facing

Puberty changes the way a young person is perceived and treated by others; amplifies the allure and importance of sex and sexuality; and consequently introduces to the young person's life various reproductive health risks, including early pregnancies and exposure to STIs such as HIV/AIDS.[32] This chapter considers adolescents' knowledge, perceptions and sources of information (including initiation ceremonies) regarding body changes experienced during puberty; the most critical problems adolescents say they face in their lives; and their most critical problems in comparison with HIV/AIDS. Locating HIV/AIDS in relation to the other problems adolescents are facing helps us understand adolescents' responses to HIV, including whether and how they choose to take protective measures to avoid contracting the virus.

Adolescents' Knowledge and Feelings About Puberty

Adolescents were asked about the types of body changes that occur during puberty; which of the body changes they themselves had experienced; and how they felt about those changes. Nearly all adolescents, regardless of whether they had experienced body changes or not, were aware of and correctly named most of the body changes that occur during puberty. The majority of adolescents interviewed had already experienced most of these changes.

The majority of female adolescents said that they had received some information on body changes during puberty. Most had received information from same-sex family members, primarily mothers, but also aunts, grandmothers and sisters. Aunts were a major source of information only among out-of-school young women from Central Uganda; a region where the *senga* (paternal aunt) has historically played an important role in imparting knowledge and skills on sex-related issues to young females. The importance of *sengas* may be diminishing due to modernization (i.e., the gradual adoption of western values and lifestyles that corrode local traditions); emphasis on the nuclear family over the extended family, which renders persons such as aunts less central to adolescent childrearing; and urbanization, which leads to less community interaction and weaker extended family ties, whereby rites which have been traditionally performed to initiate females into womanhood are becoming increasingly rare. Schools also featured prominently as important sources of information on puberty and body changes for females. A number of adolescents reported that they received information on puberty from their female friends.

Half of the males reported getting their information on puberty from school. Other important sources of information for males were friends and family members (both male and female). However, a small number of urban and out-of-school males reported that nobody had ever talked to them about puberty.

The information about puberty that adolescents received varied from source to source. Schools provided adolescents with basic information on most of the physical changes experienced during puberty including growth of pubic and armpit hair, voice changes among both males and females, the growth of breasts and menstruation among young women, and the growth of beards and the experience of wet dreams among males. Schools also taught how these body changes meant that young women could become pregnant and young men could impregnate their partners. In most cases, this information was taught via the human reproductive system by science teachers (who are usually male) and did not go into the specifics of how to manage the various body changes, such as menstruation and body odor. This is evidenced by the fact that many of the young women did not know what to do when menstruation began. Females also reported that there was no mention in school of menstrual cramps or the breast growth pains they experienced. Among adolescents who reported receiving information on puberty from school, the majority said that this happened when they were in Primary 6 or 7 (12–13 years old).

While family members, particularly mothers, were an important source of information on puberty, they often provided information reactively, for example, when their daughters came to them seeking explanation and guidance once menstruation began. The information received from mothers (and from family members in general) mainly concerned menstruation: how to manage it and its implications for sex and pregnancy. Even when approached for guidance, some parents/caretakers failed to explain what was happening to their children or the implications of those changes.

> *The very first time I had menstrual periods, I got scared seeing blood on my body in the morning. It happened at night. When I saw blood I called my mum and asked her what has happened. She told me to go and bathe. She never explained to me what had happened; she just told me that I was going to be an adult. That is all. I did not ask her what it means to be an adult because I feared. I did not know what to expect.*
> *—Urban, in-school 14-year-old female*

> *Pubic hair started growing when I was 15 years of age. I got scared because I had never seen them. I told my grandmother about it. Then she told me not to worry because I am growing up. She told me that I should get a razor blade and shave it off. But I did not ask her a lot [of questions] because she told me to ask my daddy.*
> *—Urban, out-of-school 19-year-old male*

Aunts/*sengas* appear to provide more detailed information about various issues relating to puberty, including body changes, body hygiene and sexuality. This is perhaps not surprising since this is one of the core activities they conduct while performing their traditional roles of initiating adolescent women into womanhood, at least in Central Uganda.

Because of lack of adequate knowledge, many of the females had a number of misconceptions regarding the body changes they were undergoing. Many felt they were too young to undergo such changes at the time when they first occurred. Some feared that pubic hair might grow as long as the hair on their head, and others feared that their breasts might grow to be too heavy for them. Most of them had very little knowledge about menstruation or how to manage it. Some thought menstruation was a serious illness and that the bleeding might be fatal. The majority reported that the onset of these changes, particularly menstruation and the accompanying abdominal cramps, scared them. This experience was particularly so for those adolescents whose first menstruation began when they were at school because they feared public ridicule.

> *I was at school, I never knew about it, only to see that my uniform was full of blood. I told my friend that my uniform is full of blood but I didn't know why. Then my friend told me that that was menstruation. I then went to the senior woman* who gave me some pads to use. I was feeling bad. I felt like I never wanted to walk and I feared that it would leak down and people would laugh.*
> *—Urban, out-of-school 18-year-old female*

> *For menstruation, I feared because I had stained my clothes. I was at school and not ready and I stained my uniform. My friends saw the stain on the uniform and told me to pad myself. I felt embarrassed. I went to the dormitory, cleaned my uniform and padded myself with a handkerchief.*
> *—Urban, out-of-school 19-year-old female*

Some females also reported that the growth of breasts made them uncomfortable, mainly because they felt they could no longer fit in with their old friends. Generally in Uganda it is considered inappropriate for a person to socialize with people who are perceived not be of his or her age. Because of the pubertal changes they had undergone, adolescents felt their peers and other people would perceive them as adults and therefore it would be inappropriate for them to continue associating with "younger" friends, even if they were agemates. Hence, for some adolescents, the body changes forced them to detach themselves from close friends and try to make new friendships with females they could associate with without being stigmatized by society.

> *The first time I went into menstruation, I was worried and scared. I couldn't believe it had happened to me because I thought that such a thing happens only to those who are very old. With the breasts, I knew I was growing into a woman; so I stopped playing with young girls who had not developed breasts.*
> *—Urban, out-of-school 18-year-old female*

*A senior woman is a female teacher chosen by the school to take the overall responsibility of counseling and assisting female students on reproductive health issues, such as management of menstruation, hygiene and avoiding sexual relationships.

I didn't welcome them [breasts] at all because some of my friends had not experienced such changes. So I was worried that I was growing old among my young friends.
—Urban, in-school 19-year-old female

Other young women were worried about the male attention, including unwanted advances, they anticipated getting because of having developed breasts. These fears and concerns led some of the adolescents to attempt to hide their growing breasts by putting on loose-fitting clothes and wearing sweaters. Growth of pubic hair also raised similar concerns among young women. Some adolescents attending boarding schools reported they would not remove their underwear while bathing because they did not want their peers to know that they had already grown pubic hair.

A minority of the young women, primarily those who were out of school and had prior knowledge of body changes, welcomed these body changes because they signaled maturation and hence the commencement of the opportunities that come with adulthood. Some had harbored fears that they were abnormal because the changes had taken a long time to happen. These young women reported that the changes enabled them to relate on equal footing with their peers who had already experienced these changes. Some revealed that the changes triggered thoughts of wanting to have sex, get married and have children.

When [my] breasts came, I felt happy because I used to envy those older girls who had them. I would even put some pieces of cloth or mangoes on my chest pretending that I had breasts.
—Rural, out-of-school 18-year-old female

When I grew up…I started smartening myself. I was not listening to my parents because I knew that I had grown up and could do everything for myself. Then a certain boy came, and I fell in love with him.
—Urban, out-of-school 18-year-old female

In contrast to the majority of female adolescents, most male adolescents had known about male pubertal changes and had expected them. They were elated when the changes occurred because they were an indication that they had finally grown into men—something they had eagerly awaited. Just as among the female adolescents, some male adolescents revealed that these changes prompted them to start thinking about having sex, getting married and having children.

I was very happy because I realized that I was becoming a man and I could now have my own children.
—Rural, out-of-school 16-year-old male

What I felt is that I started wanting to have a girlfriend at that age. I even felt proud. I thought I had now grown up, that I am mature now, so I could get a girlfriend.
—Rural, in-school 15-year-old male orphan

However, some male adolescents reported that some body changes took them by surprise, namely growth of pubic hair, body odor, pimples and having wet dreams, either because they did not expect the changes at the time they occurred or because they did not like the changes they were experiencing.

I felt bad about the sweating. At first I thought that it is those people who don't bathe who get such a bad body odor; so I was forced to talk to my teacher about it….Before talking to my teacher, I thought they had bewitched me because in my village there's a boy who was bewitched to sweat in his private parts….The second change was the growing of pubic hair. This time I asked myself why of all body parts it is growing there on private parts. Why not on my arms or legs?
—Urban, in-school 15-year-old male

When these things developed, such as pubic hair and the penis growing bigger, I started hiding whenever I was bathing. I felt I was not big enough to engage girls in sex.
—Rural, in-school 17-year-old male

Initiation Ceremonies

Initiation rites are not universally practiced in Uganda. Traditional forms of instruction about coming of age differ according to ethnic culture. In general, they are waning in importance in part because these traditional rites are being rejected by certain Western religions. For example, born again Christians do not encourage their children to perform initiation rites because they perceive some of the initiation ceremonies to be demonic.

Male circumcision

Male circumcision is performed mainly by the Bagisu

of Eastern Uganda. It is mandatory that every Mugisu* boy undergoes the initiation after which he is recognized as an adult. If he is not circumcised, he may be unable to marry a woman from the same ethnic group.

The circumcision period lasts up to seven days and takes place only in even years. The boy is traditionally supported by his father, uncles, brothers and other male relatives during the initiation rituals. A local "surgeon" carries out the ritual using a traditional knife. It has been shown that the Bagisu risk contracting the AIDS virus through their circumcision practices.[33] Furthermore, traditional ceremonies that accompany this initiation rite may expose adolescents (other than the initiate) to sexual intercourse, as the initiation ceremony is accompanied by dancing to traditional music, drinking alcohol and walking long distances to other villages, which are behaviors conducive to having sex.

Pulling the labia minora

The main initiation ceremony performed by most of the females of the Bantu ethnic group is pulling the labia minora to elongate them. This ritual begins just before the onset of menstruation but continues until the labia are the desired length. It is believed that if a woman performs it she will have an easy delivery, that men prefer it and that it will increase sexual pleasure for both men and women. Women are told that failure to pull the labia when they are young will lead to being forced to do it when they are married. Traditional lore says that if a woman does not have elongated labia when she marries, the male chicken, the cock, will be forced to peck at her labia and thereby elongate them. Other young women were told that if a female has not pulled her labia, she may be unable to find a man to marry her because men always demand women with elongated labia.

> *I was told last year in 2001 by my friends at school. They told me that you have to visit the bush because if you don't have those things [elongated labia], you will not get a man to marry. The friends then helped me to get some herbs which I used to pull [my labia].*
> *—Urban, out-of-school 19-year-old female*

Most young women reported that the aunt/*senga* was the main person who introduced them to the ceremony, i.e., the one who told them about pulling the labia and its importance, although mothers, grandmothers, friends and senior women school teachers are sometimes involved.

Most of those who performed it reported first feeling shy when they were told to do it, and when they did it they found it to be painful but they were satisfied with the result. Other instructions given to young women during initiation had to do with hygiene, such as washing one's body every day during menstruation.

Adolescents' Most Pressing Problems

The most frequently named problem adolescents said they were facing at the time of the interview was a lack of school fees. The majority who gave this response were out of school.

> *I don't have a mother….I don't have anyone to help me pay my school fees. My father got another woman and they mistreated me so much that I decided to leave home. Even before leaving home, my father wasn't paying my school fees.*
> *—Urban, out-of-school 18-year-old female*

The next most common problem adolescents said they were facing was a lack of money for other things besides school fees. Among females who gave this response, all of whom were in school, the items they lacked included underwear, clothes and bedding. One respondent said that a lack of money makes one get a boyfriend who can buy you nice things. Males who said they lacked money, both in school and out of school, commonly said that they needed money to buy food and provide for current and future family responsibilities.

Among females, other problems included not having a job, worrying about getting pregnant, not being loved by their parents, contracting AIDS, menstruating, boys and avoiding sex. Males presented a different set of problems: not having any clothes, studying and not having a job.

> *Here they help us to pay fees, buy uniforms, but I am now facing problems of supper, clothing, and those small things like soap, bed sheets, something to sleep on. There are so many things because it is difficult for someone like me….For someone like me it's bad. I will find myself taking glue [a drug], which I have so far avoided.*
> *—Urban, in-school 15-year-old male formerly homeless, now residing in a rehabilitation institution*

Only a small number of respondents, most of them female, said they had no problems.

*Ba specifies many, Mu specifies one.

When asked to compare their most pressing problem to AIDS, almost unanimously the respondents said that AIDS was a more important problem than the problem they had named spontaneously because AIDS has no cure and it kills. Respondents who said AIDS was a bigger problem gave the following reasons:

Because of the way it pains for almost 24 hours. The person is feeling cold with body sores/wounds/ rashes.
—Rural, in-school 18-year-old female

Because AIDS makes one have diarrhea and pass stool all the time. You also become very thin like a skeleton.
—Rural, in-school 15-year-old disabled female

Because you die the moment you have HIV/AIDS.
—Rural, out–of-school 16-year-old female

The perception among the respondents was that AIDS causes a great deal of physical distress and a quick death. Another reason AIDS was seen to be worse than the problems they were suffering from was because of the social stigma attached to AIDS.

[AIDS] kills people badly. People start talking about you behind your back. People dislike you. They wish not to touch you.
—Urban, out-of-school 15-year-old female

You die, but even your name gets spoiled because you died of AIDS.
—Rural, in-school 17-year-old male

A few respondents felt that their non-HIV-related problems could lead them to contract HIV.

When you have a problem of lack of parental love and your relatives don't care about you, you can be forced to get a man who can give you that love and solve your problems. But by bad luck the man can be sick of AIDS and you also die.
—Urban, in-school 17-year-old disabled female

The money problem may be more pressing because when you have your money, you may avoid women [who have money] and that way not get AIDS.
—Urban, out-of-school 18-year-old male

AIDS was also perceived to be a big problem because it was connected to many aspects of their lives.

[AIDS] has taken away my relatives who would be providing me with the basic needs, AIDS has taken away my friends, and AIDS has eaten much of our resources in terms of caring for the sick.
—Rural, in-school 19-year-old male

A handful of adolescents who described having a very hard life indicated feeling jealous of the support services offered to HIV-positive individuals and perceived AIDS to offer a reprieve from the difficulties they were facing.

It's better to have AIDS because I can see people with AIDS getting food from the World Food Program, and even when you have AIDS people can help you, someone can come to see you and give you some 500 shillings, but now like me someone will know, "That person is strong," and they can't help you, so it is better you become sick…because …if you compare yourself with someone who has AIDS, the way you are suffering someone with AIDS won't because you lack help.
—Urban, in-school 15-year-old male

Discussion

Traditionally, in some Ugandan cultures, information to adolescents about puberty was provided by aunts, but modernization has contributed to the erosion of this institution. Today, science classes are the main source of information about puberty and body changes for adolescent males while same-sex family members are the main source of information for young women. The classroom information adolescents described receiving covers only the biological changes without addressing the emotional or social aspects of adolescence; the information from family members is usually in response to a crisis. Even then, some parents/caretakers were unable to provide guidance to the adolescents. The majority of adolescents, especially young women, related feeling ill-prepared for profound body changes, particularly menstruation, because of lack of sufficient knowledge about the changes and how to manage them. This lack of information left adolescents fearful and embarrassed.

HIV/AIDS has affected all Ugandans. It has become part of the social reality in the country. Young people did not name HIV/AIDS as their biggest problem, possibly because it was still far enough removed from their

day to day existence when they were interviewed that it did not occur to them as their biggest problem. Food, clothing and shelter tended to take priority over other, more distant problems. However, when probed, they all said HIV was more important. Furthermore, due to its incubation period, AIDS generally does not kill young people and so the dangers of HIV may not feel imminent for youth. It could also be a product of the invulnerability that youth everywhere feel as most of them have not been physically affected by disease and ill health. A few adolescents perceived their most pressing problem could lead them to acquire AIDS because their financial needs could to lead them to have transactional sex with someone who might be HIV-positive. Therefore, at least for some, lack of financial support is a risk factor for adolescent sexual health.

It is striking that males generally reacted with happiness to the changes in their bodies while females were unhappy about having to leave behind friendships and experience unwanted male sexual attention. As the sexes become more differentiated, beginning during puberty, these different reactions to adolescents' body changes perhaps shed light on how both genders experience their sexuality. In chapters to come, other information will be presented on adolescents' transitions into adulthood which will help fill in the portrait of coming of age in contemporary Uganda.

Chapter 5

Adolescents' Perceptions About HIV/AIDS

In an effort to understand HIV within the context of adolescents' lives, this chapter presents adolescents' perceptions of people with HIV/AIDS and whether they know people with AIDS; what sexual behaviors they believe are risky and not risky; actual and preferred sources of information on HIV/AIDS; and barriers to accessing information. Understanding how youth think about HIV/AIDS provides insights into adolescent sexual decision making.

Respondents' Perceptions About HIV/AIDS

Death, in some cases an early death, was the first thing adolescents associated with AIDS. A few perceived death as an inevitability of having sex: If one has sex, one gets HIV/AIDS and dies. Others discussed how the AIDS-related deaths of those around them would affect them: "I think of losing my parents in case they got it, which may lead to my dropping out of school" (rural, in-school 19-year-old male). Fear of AIDS—suffering a painful death, orphaning one's children, having AIDS without knowing it, being infected by one's husband—and the fact that AIDS has no cure were also frequently cited. Sadness and suffering were another common theme: "Many people have committed suicide after knowing that they have AIDS" (urban, out-of-school 14-year-old male) and "I feel depressed because I have seen so many people dying of AIDS" (rural, out-of-school 17-year-old male).

Perceptions about people with HIV/AIDS

The most commonly cited feeling towards people who have HIV/AIDS was pity: They are going to die and orphan children and they will suffer. Women and children were singled out for particular compassion: "[Adults] disobeyed God. However, the children who get HIV/AIDS from parents should not be blamed" (rural, in-school 18-year-old female). Another respondent said, "The way these patients suffer is too much. It was last year when I saw an AIDS patient. She could not move from the bed, urinating there, defecating there.…She became thin, ah!" (urban, in-school 19-year-old female). Pity was sometimes mixed with other emotions, including anger: "At times I hate them because they spread the disease because they do not want to die alone" (urban, in-school 18-year-old male).

A common reaction towards people who have HIV/AIDS was that they should join The AIDS Support Organization (TASO), where they can receive counseling on how to "live positively".* "I know [having HIV/AIDS] is normal because I know it was not your wish that you get it. Someone gave you the sickness. The only thing they [HIV-positive people] need is counseling, advising and treatment" (urban, in school 17-year-old male). A small number of male respondents discussed how HIV-positive people needed to be cared for: "At first I used to think that [it would be better] if they could be eliminated, but now it has become something that is common.…I just think they could be cared for and not treated as unnecessary in public" (rural, in-school 19-year-old male), and "They just made a mistake and so they should be helped" (rural, in-school 13-year-old male).

In the only overt expressions of stigma, a few older, urban males said that HIV-positive individuals should be quarantined.

> *I feel bad and sorry for them but I don't want to associate with them. I think it is better to put all the people with AIDS in one place, a special place, to stop the spread of AIDS. At least when doctors find out that someone has AIDS they [should] capture him or her and take them to that place. This will help to prevent AIDS.*
> *—Urban, in-school 15-year-old male*

*"Living positively" is a euphemism for not being afraid of the disease, eating well and taking care of oneself.

Knowing and recognizing someone with HIV/AIDS

Most of the respondents knew someone who has HIV/AIDS or who died from AIDS. While a few had lost parents, aunts, brothers-in-law or neighbors, the majority either did not specify who they knew or referred to the person as a member of their community. Almost all of the diagnoses happened through recognizing the physical symptoms of AIDS, including herpes zoster, skin rash, loss of weight, coughing, diarrhea, scanty/"funny" hair and red lips. One rural, out-of-school 18-year-old female whose neighbor had AIDS explained, "The way she fell sick told it all. The woman felt cold all the time and got boils.…The same applies to my sister now." While the majority of respondents were quite definitive about the signs of AIDS, only two respondents spoke about how healthy-looking people can have HIV/AIDS.

> *These days AIDS people are in The AIDS Support Organization, TASO, on medicine, so they look healthy. It is really difficult to know who has AIDS and who doesn't have it. Unlike those days before TASO, people could show signs like coughing, having wounds, growing thin, but nowadays you cannot know.*
> *—Urban, in-school 17-year-old disabled female*

Risky and Nonrisky Sexual Behavior

Risky sexual behavior

Most adolescents reported that having sex without using a condom puts one at risk of contracting STIs (syphilis and gonorrhea were identified by name), including HIV/AIDS. A few adolescents also mentioned that condom breakage and slippage can also put people at risk of all the same dangers as not using a condom.

Another risky sexual behavior mentioned by most adolescents was having several sexual partners.

> *When an adolescent has multiple sexual partners that is when he plays sex with this girl and that one or she plays sex with this boy and that one. This is risky because one of them could have AIDS and he infects all of you.*
> *—Rural, out-of-school 18-year-old female*

Some respondents talked about how you can avoid contracting HIV by not sharing sharp instruments, including syringes. One female spoke about the dangers of cultural practices that put people at risk for AIDS:

> *During circumcision they use the same knife on different people and in the process they share blood. This is risky because you cannot know who has AIDS. Another cultural practice that may lead to the spread of AIDS is inheriting widows. They say that some tribes in Western Uganda, is it the Bakiga or Bahima, I'm not sure, but they say that they take widows as their wives if the deceased was a brother to that person.*
> *—Urban, in-school 19-year-old female*

Another behavior named by a few respondents as risky was being around HIV-positive individuals, since they are seen as inclined to rape. "One should not stay near those people with AIDS, especially the male victims. They see you, they feel bad and they think they are going to die alone. . . . That's why those people rape the young ones" (urban, in-school 19-year-old female). This provides insight into one of the sources of stigma against HIV-positive individuals.

Some adolescents named as risky behaviors that did not have to do with HIV infection directly, but that were perceived to put individuals at risk for dangerous sexual behavior. Peer groups were the most commonly mentioned noninfection risk factor. It was noted by the respondents that youth are influenced by their peer groups and are likely to do what their peers do in order to fit into the group.

> *When you hang out with a group of friends who enjoy having sex, they can influence you to do the same. Like if your friends drink alcohol, you also try to drink to fit into the group. Another thing about groups is that you can see your friends changing clothes, putting on good fashions and you also want to put on the same clothes. So you decide to get someone to buy them for you who in return wants to be paid in kind with the favor of sex.*
> *—Urban, in-school 19-year-old female*

A number of males added that alcohol and bars should be avoided since these can tempt individuals to have unprotected sex.

Other noninfection risky behaviors named by the respondents included drinking alcohol and using drugs, going to bars and going to discos, since these behaviors are seen to increase the likelihood of adolescents having unplanned sex, which in most cases is unprotected. "Indecent dressing" such as tight mini skirts that expose young womens' thighs, "bad touches" (meaning unwanted sexual touching by the opposite sex) and ac-

cepting gifts because once the girl accepts gifts she is expected to pay the giver back with sex were also named.

Nonrisky sexual behavior

The most commonly reported nonrisky sexual behavior was having protected sex (sex with condoms). Abstinence was the next most commonly mentioned nonrisky behavior. Some respondents acknowledged the protection that abstinence provides but did not feel that it was achievable. As one rural, out-of-school female said when asked how to avoid contracting HIV, "Abstain from sex, but I don't think that is possible. Condoms are the best way to prevent AIDS [she laughs]."

Having one faithful sexual partner was regarded by some as nonrisky sexual behavior. Reducing one's number of sex partners was also commonly mentioned. A number of respondents said that the best way to avoid HIV is to go for testing before having sex or getting married. Testing for HIV (frequently in addition to other strategies) was named by some adolescents as an important step in practicing nonrisky sexual behavior.

> *First and foremost you should test for HIV/AIDS before having sexual intercourse. When you all don't have it, stay faithful to each other, or if you can't test, use a condom with your partner.*
> *—Rural, out-of-school 18-year-old female*

While most of the definitions of abstinence given by the respondents were correct, some respondents defined abstinence as avoiding sex during one's menstrual period.

Actual and Preferred Sources of Information On HIV/AIDS

Who has talked to adolescents about HIV/AIDS

Adolescents named several places where they accessed information on HIV/AIDS. Since the late 1980s, school health education has incorporated HIV/AIDS information in its curriculum so it is not surprising that adolescents, even those that had dropped out of school, reported that teachers at school were the main source of information, in particular senior women teachers and science teachers.

> *The senior woman teacher is the one who told us about AIDS. She said if you do not use protection—condoms—you risk contracting AIDS. She told us that if you find abstinence hard, then you must use protection.*
> *—Urban, in-school 16-year-old female*

> *It was a teacher. This teacher told me of course how dangerous it was. He gave me advice to abstain as that would be a sure way of not acquiring it.*
> *—Rural, in-school 19-year-old male*

Adolescents said they also received information during school assemblies and from invited guests from nongovernmental organizations including TASO, the AIDS Information Centre (AIC), Youth Alive, Bushenyi Medical Centre, Aids Care Education and Training and the Straight Talk Foundation.

Family members, notably mothers, grandmothers, sisters, brothers, uncles and aunts/*sengas,* were reported by some as sources of HIV/AIDS information. A few mentioned friends as people who talked to them about HIV/AIDS.

There were some adolescents who had never been talked to by anyone about HIV/AIDS.

> *No one [has talked to me] but I just hear people saying so and so has silimu—AIDS. They talk about changes in that person like losing weight and having red lips. They say, "That person was sleeping with so many girls from town and that is why he got the disease."*
> *—Rural, in-school 13-year-old female*

What was discussed and its usefulness

The information passed along revolved mainly around issues of HIV prevention through abstinence, faithfulness and condom use. Other, less frequently covered topics included care and support for the infected, admonitions not to stigmatize the infected, the importance of voluntary counseling and testing, proper conduct to avoid HIV/AIDS infection, one's future being in jeopardy as a result of the infection, the fatality of the disease and the fact that it has no cure and leads to death.

> *My mother told me that AIDS is a very dangerous disease in all countries in Africa. Because when you get AIDS at the age of 14, 15 or 16, or when young, you will die.*
> *—Rural, in-school 15-year-old female*

Avoidance of risky situations such as going to disco dances, accepting gifts from men and avoiding bad peer groups were also talked about. These messages were mainly reported by females.

> *She talked about HIV. She said we should be careful with special gifts; another one she said we*

should be careful with bad touches.
—Rural, in-school 14-year-old female

All the adolescents who said that they had been talked to about HIV/AIDS reported that the information was helpful because they now know what causes the diseases, how it is spread and how they can avoid getting infected. After being talked to, some adolescents reported changing their behavior by being extra careful, abstaining from sex and using condoms and said that they now feel safe because they have the requisite information to protect themselves.

Ok, the first time I had sex, I did not know of any dangers, but it was after such talks that I came to know the dangers of having sex. That is why I have not done it again.
—Urban, in-school 15-year-old male

In general, adolescents said they wanted more information on the origin of HIV, causes of AIDS, how HIV is transmitted, prevention measures, AIDS symptoms, how to care for those who have AIDS and how to live longer once one is infected. Male adolescents wanted more information on how to use condoms.

I would like to know if you put only one condom on, you can get it on, but how about if you use two condoms. What happens? Will it be okay if a girl put on her female condom also? There are female condoms, right? In Sudan, we masturbate so that sperms come out. But here you use condoms on women, yet you do not enjoy it. Why don't you do it here like we do in the Sudan?
—Urban, in-school 18-year-old male refugee

A few wanted information on where to get tested, the types of medicines available for treatment and whether there is a cure.

Preferred sources of information on HIV/AIDS

While females got HIV/AIDS information from various sources, including health workers, organizations dealing with HIV/AIDS, teachers, sisters, mothers and counselors, they trusted information from health workers the most. Doctor and nurses were preferred because of their expertise in HIV/AIDS. Young women perceived doctors and nurses to be well-trained to handle HIV/AIDS because they have studied a lot and are consequently knowledgeable, and they know how to teach people how to protect themselves. Organizations dealing with HIV/AIDS, such as TASO and AIC, were also preferred by most females as sources of information and services because they are seen as professional and they have experience in treating and caring for HIV-infected people. A few of the female adolescents said they prefer receiving information from relatives, mothers, grandmothers and sisters because these individuals are approachable and provide trusted advice. Only a few cited preferring information from teachers.

Males obtained HIV/AIDS information from various sources, including doctors, nurses, organizations dealing with HIV/AIDS, counselors and relatives. The most trusted source of information and services was doctors because, males said, they are knowledgeable about HIV/AIDS and the problems of those living with AIDS. Males cited uncles and brothers as trusted relatives from whom to get information.

Barriers to Getting HIV/AIDS Information

Both males and females reported that they did not have problems getting HIV/AIDS information. For the few females who had been unable to get information, they reported not being able to access HIV/AIDS material on the radio, while some indicated that the right person to talk to was not available. A rural, out-of-school 19-year-old female wanted to be tested to know her status and receive counseling, yet she had been unable to get tested because she did not know where to go. Another rural, out-of-school 19-year-old female had tried to know how she could protect herself from getting HIV/AIDS, but reported that she had failed to obtain this information from school. An urban, in-school 17-year-old male reported that when he was in Senior One he wanted information about HIV/AIDS, but did not know where to get it.

The Role of the Church and Religion Regarding HIV/AIDS

Nearly all the adolescents belonged to either the Catholic Church, a Protestant sect (primarily born again sects) or Islam. Adolescents reported that their church teachings on HIV/AIDS consisted of preaching in support of abstinence and against adultery. Apart from sermons, adolescents reported that their churches conduct seminars and show films depicting HIV/AIDS issues. Some clergy reportedly encourage their parishioners to go for voluntary counseling and testing. Some religions, such as the Catholic Church and Islam, were, according to the adolescents, preaching against the use of condoms.

Male adolescents reported that the religious teach-

ings have helped them to abstain from sex. They reported that they have followed the church's teaching on avoiding bad peer groups, being obedient to their parents, being careful with their lives and being good examples in their communities. Most females also reported that their religion or their church has helped them avoid sex, be obedient and disciplined, and abstain from alcohol.

Discussion

Over the past few years, access to antiretroviral therapy (ART) has been increasing rapidly. At present, Uganda has over 50% coverage.[34] Nevertheless, the fact that this level of ART coverage is a recent phenomenon means that for the vast majority of HIV-positive Ugandans, AIDS has meant death. The ubiquity of AIDS in the respondents' environment perhaps helps inform why the majority of adolescents spoke about people with HIV in a compassionate way, although this compassion was sometimes only reserved for the most vulnerable—children and women. The idea that HIV-positive people do not want to die alone—and that this might cause HIV-positive men to rape women—was mentioned a few times. This culturally constructed idea of not wanting to die alone is potentially very dangerous because it could incite individuals to intentionally spread HIV and it could also lead to stigma against those that are HIV-positive. Stigma was voiced by a few of the respondents. As ART becomes more widely known and accessible, it is possible that HIV/AIDS will no longer mean death to the respondents and that stigma may decline.

Given the high level of HIV in the country, it is not surprising that most respondents knew someone with HIV. What was less commonly discussed is that healthy-looking people could have HIV. While strategies for avoiding contracting HIV were commonly known, not all of the appropriate strategies were named by everyone. Individuals may be at risk of contracting HIV if they are not aware of all of the ways to avoid contracting HIV.

Very few adolescents said that they had never been talked to about HIV/AIDS and similar numbers stated that they experienced barriers trying to get information on HIV/AIDS. Those that had been spoken to were able to state how that information, including information they had received from their church, had served to help them protect themselves against HIV. Churches seem to predominantly support abstinence, something that adolescents say is hard to adhere to. Nevertheless, adolescents' satisfaction with the information they have received from all of the different sources that provided information is a testament to the importance of sexuality education. Yet adolescents' incomplete knowledge of HIV/AIDS underscores the need for improved information to be imparted through pathways that are already in place to teach adolescents about HIV/AIDS.

Adolescents' preference for doctors and nurses as sources of HIV information has previously been confirmed.[35] This qualitative information is able to explain why: Doctors and nurses are seen as the most knowledgeable and they know how to teach people how to protect themselves. Since modern health care provides are the preferred source, it would behoove the modern medical community to invest more time in imparting prevention messages to young people.

Chapter 6

Perceptions of Nonmarital Pregnancy and Pregnancy Prevention

Other than HIV and other STIs, the primary physical consequence of unprotected sexual activity is pregnancy. Some adolescents are married, and frequently a child is welcome and expected shortly after marriage; however, a nonmarital pregnancy is disapproved of in Ugandan society. In this chapter, we examine adolescents' perceptions of the reasons for and the social stigma attached to nonmarital pregnancy, actual and preferred sources of information about pregnancy, what adolescents would like to know about pregnancy and any barriers they have experienced in getting information on the subject.

When adolescents were asked what was their most important problem, very few named premarital pregnancy as their biggest concern. Among those who did, they stated they were very worried about pregnancy because it could lead to them dropping out of school (stated by females) or possibly going to jail on defilement charges (stated by males): Since pregnancy is proof of sexual intercourse, making a minor pregnant can lead to the males' imprisonment. A few other respondents said that avoiding sexual intercourse was their biggest problem because they were curious or had sexual desire.

Perceptions of Nonmarital Pregnancy

Nonmarital pregnancies are not socially acceptable in the locations where the data were collected. The most common reaction among both males and females to nonmarital pregnancy was that "it is a bad thing": The young woman might suffer because she has to drop out of school, she will have no way of supporting herself, the male might deny responsibility, her parents might abuse her out of anger, the community may gossip about her, she may have contracted HIV through having unprotected sex, and it looks bad for the community to have this happen. Having a pregnancy while unmarried reduces the female's marriageability and it is a source of shame to her parents. A few females perceived that a young woman's life is shortened if she has a premarital pregnancy either because of a difficult delivery that may lead to complications or because she may contract HIV while having unprotected sex. Males were much more likely than females to say that they feel sorry for the pregnant female (only one male—rural and out of school—said that he felt bad for the male who caused the pregnancy because the male will face problems of money and imprisonment), while females were much more likely to say that premarital pregnancies made them think about suffering. Females and males described young mothers suffering because they will have no money.

Males are not perceived to be held accountable for causing the pregnancy, except in rare cases. The responsibility is largely placed on the female for not protecting herself, "not being responsible" or "being promiscuous." A small number of both males and female said that a nonmarital pregnancy means that the young woman was "enjoying herself," implying that she is a prostitute. There seemed to be some confusion regarding the term adultery among the respondents as some of them said that a female with a nonmarital pregnancy did not obey the law that says do not commit adultery (marital status had not been discussed). A few urban females talked about the belief that having a premarital pregnancy is bad luck for the family:

> *Premarital pregnancies are an embarrassment. It brings bad luck in the family. If you are the oldest girl in the home, all your younger sisters also get the bad luck and they produce from home [have nonmarital pregnancies]. People think that you were just loose, an easy target for men. That is why you ended up producing when still under your parent's care.…The parents are embarrassed more because it means they failed to control you.*
> *—Urban, out-of-school 16-year-old female*

A minority of both male and female respondents were completely nonjudgmental about nonmarital pregnancy, saying that a nonmarital pregnancy means

only that the female had sex with a man. A few females expressed how they themselves felt vulnerable to a nonmarital pregnancy: that it could happen to them at any point and that it is normal. Yet in spite of saying that it is normal, one male respondent still laid the blame squarely on the female:

> *Nothing comes to mind [regarding nonmarital pregnancies] because that thing has become normal because many girls get babies before marriage. I believe they get pregnant when they want and when they feel they are big enough. Okay, partly I blame the parents because they are supposed to be responsible and take care of their girls. Parents should be strict to their girls by threatening them that when they get pregnant before marriage they disown them. I think after that, the girls will fear to get pregnant.*
> *—Urban, out-of-school 14-year-old male*

Actual and Preferred Sources of Information About Pregnancy

What adolescents know about preventing pregnancy

It is noteworthy that more males than females said they had been spoken to about preventing pregnancy. Yet this information was not always welcome. An urban, out-of-school 14-year-old male expressed surprise that anyone would talk to him, a male: "Why should anyone talk to me about pregnancy? I'm not a girl and I don't want to know anything about pregnancy."

Most youth had gotten information on pregnancy from more than one source. The sources of information young women named were primarily their mothers and teachers, followed by nurses, aunts, sisters, boyfriends, grandmothers and the radio. All the females who got information from health care professionals had already been pregnant and had utilized the health care system during the course of their pregnancy. The sources boys named were teachers, friends, brothers, sisters, fathers, aunts, uncles and the nonprofit organizations GOAL and Straight Talk.

At school, adolescents were told to practice abstinence, but if abstinence was not possible, to use birth control pills or a condom. Boys were warned about the danger of being imprisoned if they caused a pregnancy. Yet information gained in school was incomplete: "[Senior woman] told us to use pills. Yet she did not tell us how they are used. She just stopped at telling us that there are pills that can be used to prevent a girl from getting pregnant" (urban, in-school 16-year-old female), and "They told us of this kind of pill, coils, but they insisted and said these were for married [women]" (urban, in-school 19-year-old female).

The way males spoke about female-controlled contraceptive methods indicated that they did not have experience with those contraceptive methods themselves (i.e., they had not seen or learned how to use the methods). A rural, out-of-school 17-year-old male said, "I hear that a girl can use tablets," and an urban, out-of-school 15-year-old male said, "For women, I hear they swallow certain tablets which can prevent them from getting pregnant." The rest of the information shared by males on these methods was equally superficial.

There was misinformation among both males and females about how contraceptives worked.

> *[If they cannot delay having sex] they can join family planning. In family planning you cannot get pregnant because you will have killed the egg [ovaries].*
> *—Rural, in-school 19-year-old female*

> *[Avoid unintended pregnancies] by use of condoms, not being alcoholic and avoiding early relationships, especially for girls. For boys we're advised to use vasectomy, tubal ligation, spermicide, which are probably drugs. Also delaying sexual intercourse was an alternative given.*
> *—Urban, in-school 19-year-old male*

Possibly because of incomplete information, there was a general mistrust of methods:

> *[My aunt] recommends me to keep myself holy until the end because if I start to use condoms or pills, these are not safe.*
> *—Rural, in-school 18-year-old female*

> *[I was told] when you are to play sex with a girl, please use a condom because you can easily impregnate her. . . . They even told us about pills. However pills can make you barren and you will never produce a child.*
> *—Rural, in-school 15-year-old male orphan*

The most commonly repeated misinformation adolescents had been taught was when in a woman's menstrual cycle she is most likely to conceive. One respondent's mother told her, "A week after menstruation, if you have sex, you will not become pregnant" (rural, out-of-school 18-year-old). Another

mother told her daughter, "If you see blood, don't love men who are older than you because you will get pregnant" (rural, out-of-school 17-year-old). "[My teacher] said that if a girl goes in her menstrual periods, she should avoid having sex with boys because you can become pregnant" (rural, out of school 19-year-old female) and a rural, in-school 14-year-old female said, "[Senior woman] told us that if you are a girl in your periods you should not have sex before eight days elapses." A rural, out-of-school 18-year-old female said that one can avoid pregnancies "through using the safe period. She should not play sex seven days after menstruation, that is after menstruating, spend one week before having sex," and an urban, out-of-school 18-year-old said, "When you finish your periods, don't get near men. Wait until after a week, and if you get a man immediately after periods you can get pregnant." A rural, in-school 16-year-old disabled male said to avoid pregnancy, "Use condoms and not play sex during the menstruation period." A number of respondents spoke about the viability of the rhythm method yet if adolescents misunderstand when ovulation is occurring, they will not be able to abstain at the critical time. Therefore, these misconceptions have the potential of exposing women to an unintended pregnancy. Furthermore, the fact that young women's menstrual cycles are frequently irregular was not discussed.

There was an attitude held by both males and females that females were responsible for contraception. "[A friend] told me to go for family planning and use the injection or tablets because a man can use a condom for few days but then demand live sex" (rural, out-of-school 19-year-old female). An urban, out-of-school 15-year-old male street youth's friends advised him: "A woman can abstain.…A woman can refuse men." An urban, out-of-school 17-year-old male learned from his teachers at school "that [virginity] was very good for the girls." A rural, out-of-school 14-year-old male explained, "[Sister-in-law] told me that you can prevent pregnancy by having the woman injected [meaning taking her for family planning]." An urban, in-school 18-year-old male refugee said, "The parents told me once that girls know their menstruation cycle. The girl can know when she can get pregnant in case she has sexual intercourse with a man." An urban, out-of-school 18-year-old male said he thinks it was only young women who were taught about contraceptive methods at school. Another reason why contraception was seen as the woman's responsibility by both males and females is because men are perceived to lie to women. A few males and females said that the best way for young women to avoid unintended pregnancies is to avoid males who deceive them: "Girls should know that boys are liars" (urban, in-school 15-year-old male).

A few of the males' comments implied that their understanding of abstinence only encompasses female abstinence. One male said females should avoid peer pressure to have sex; an urban, in-school 18-year-old male refugee said, "Let parents tell their daughters to avoid such things as premarital pregnancy." These messages imply that boys are not assuming responsibility in causing a pregnancy.

Preferred sources of information on pregnancy prevention

Females preferred receiving information on pregnancy prevention from doctors and nurses. They trusted doctors because they felt doctors were knowledgeable as they had studied a lot and because they had treated women who had had abortions. Those who trusted information on preventing pregnancy from nurses said that nurses know how to counsel people and have dealt with young women who have become pregnant. Family planning clinics were also named as a trusted source because they are the primary supplier of contraceptives and have trained personnel who understand issues regarding pregnancy. Some female adolescents preferred information on pregnancy from their mothers because they said mothers love their daughters and so give them the best information they have and because mothers have experienced pregnancy. Sisters were also a trusted source of information named by a few of the young women because they are older and some have passed through such situations and are easy to talk to.

Aunts'/*sengas'* information was trusted by a number of female adolescents because they feel comfortable with them and because the aunts/*sengas* are old enough to know about these matters and are seen as knowledgeable. Most young women in school trusted teachers, especially the senior women teachers, because these teachers have been trained in adolescent life skills development and in counseling and are therefore knowledgeable. Most young women do not prefer information from friends/peers because they said they do not trust it. Those who do prefer this source indicated they would go to agemates for information because they feel free to talk with them. Very few preferred pastors and grandmothers, although in some cases, grandmothers were trusted because their age suggests they must know a lot about pregnancy. Finally, some females said they did not want information, either be-

cause they already knew a lot or because they were young and shy.

Among males, friends were the preferred source of information because respondents said they could trust them. The reasons given included that some are older and have had similar experiences, and that is why they can help when there are problems (types of problems were not specified). Health workers, especially doctors, were also named because of their knowledge about reproductive health issues. Clinics were cited as preferred sources of information concerning pregnancy by some adolescent males because they are staffed by knowledgeable professionals. A few male adolescents preferred information from their brothers and uncles. The reasons given were that these men are older and respondents feel free to converse with them. A few males said they trust teachers because teachers' information is reliable.

What Adolescents Would Like to Know About Pregnancy

Very few females reported that they could not get needed information on pregnancy. Females who reported that they needed more information about pregnancy mainly wanted to know how to prevent it and also what to do immediately after unprotected sex. A few wanted more information on relationships (for example, "how a boy can start being your boyfriend"), sex and how to avoid having an abortion. One wanted to know the local herbs used to prevent pregnancy. Others wanted to know "under what circumstances a girl can or cannot get pregnant," "how to take care of babies," "how to count safe days," "what it feels like to have a boyfriend," "how to get the right person and if sex is painful" and "why some girls have sex but they do not get pregnant."

Most males reported needing information on how to "avoid making someone pregnant." Information on specific methods such as condoms and the pill was requested. An urban, out-of-school male street youth, age 15, wanted to know whether it was true what his friends told him that a girl can get pregnant even if a condom is used. He also wanted to know how to have sex without using a condom so that his partner does not get pregnant. An urban, in-school male, age 19, said that he wanted information about homosexuality. Most 12–14-year-olds reported they did not need information because they are still young. While female and male adolescents said that information on pregnancy was easily accessible, younger adolescents said they felt timid to request information.

Discussion

Adolescents described how stigmatized nonmarital childbearing is in Uganda: A female with a nonmarital prengnacy is seen as out of control, of less value and pitiable. The only problem nonmarital pregnancy presents for the male is that he could potentially be jailed for defilement for having had sex with an underage woman. The responsibility for avoiding pregnancy including contraceptive use is placed entirely on the female to the point where some males wondered why they were even told about pregnancy prevention.

Most adolescents felt that they were able to get the information they wanted on pregnancy, yet much of the information they had was incomplete or incorrect, particularly regarding use of the rhythm method. There was mistrust of contraceptive methods, as they were perceived to be ineffective or capable of leaving the woman infertile. Young women wanted more information about what to do to avoid getting pregnant after having unprotected sex, while some males expressed a desire to learn more about pregnancy prevention. Dual method use was discussed by no one. While adolescents know the primary ways to avoid an unintended pregnancy—abstinence and contraceptive use—abstinence was seen as something only women could ascribe to and contraceptive use was frequently described incorrectly. Therefore, even though most adolescents said that they did not experience barriers to accessing information on pregnancy, their incomplete knowledge demonstrates they are not aware of what they do not know in this realm.

Although the majority of respondents were not getting information on pregnancy prevention from health care workers, just as with information about HIV/AIDS, most of them wanted to receive their information on pregnancy prevention from health workers (friends also ranked highly among males.) This finding is again substantiated by quantitative data gathered in the country.[36] The potential of health care providers to impart preventive education to adolescents through the provision of accurate information about contraception and women's fertility cycles should be explored. Parents frequently control access to the resources adolescents need to get to clinics or to cover the cost of seeing a provider and obtaining medication. Therefore, parents' support of adolescents getting information from health care providers would help adolescents access their preferred source of information.

Chapter 7

Sexual and Reproductive Health-Seeking Behavior

Sexually active adolescents need regular contact with the modern health care sector to be able to take care of their sexual and reproductive health problems, such as STIs, and to obtain modern contraceptives. In this chapter, we present the general health problems that adolescents in Uganda recently experienced for which they sought care, sexual and reproductive health problems they have ever had, the actions they took to address the problems; and the common barriers they faced seeking help. Finally, we discuss the differences between adolescents' sexual and reproductive health-seeking behavior and health care–seeking behavior in general.

General Health Problems

About half of female and male adolescents in both urban and rural areas reported that their most recent health problem for which they needed care was malaria/fever. Other health problems that were commonly reported included headaches, stomach aches and the flu. A minority of young women, with greater representation from those in rural areas, reported a sexual and reproductive health–related problem as their most recent health problem for which they needed care.

Most adolescents sought care from a clinic or hospital to deal with the health problem they were experiencing. Both rural and urban females sought professional care, but rural males were less likely to have sought care than urban males. Many adolescents who sought professional care first informed their parents/caretakers—usually mothers—about the health problem. In most cases, that adult took the adolescent for medical care.

Some rural adolescents, both males and females, did not seek professional care but applied home remedies, such as traditional herbs or drugs from drug shops. In some cases where home remedies were applied, parents/caretakers made the decision to use them, while in other cases it was the adolescents' decision, often after consulting with friends. Use of home remedies was particularly common for minor illnesses such as headaches, the flu and stomachaches. Some of the individuals who later sought professional care first attempted home remedies and only went to a clinic/hospital when their condition failed to improve.

> *I first kept quiet, but when the sickness intensified, I told Aunt that I was sick. . . . I fear injections. So, I first bought Panadol [a pain killer] for myself without telling anybody, but I did not get cured. Then I told Aunt and she took me to a clinic where I was given an injection and tablets.*
> *—Urban, out-of-school 16-year-old female*

A few individuals did not seek care of any kind.

Sexual and Reproductive Health Problems

Quite a few adolescents, primarily females, had experienced a sexual and reproductive health–related problem in their lifetime. The most common symptoms were itching and/or a rash around their genitalia. The males reported experiencing pain when urinating, sores/abscesses on their genitalia and a rash/itching on their genitalia. A few females also reported pregnancy-related problems. The majority of affected adolescents could describe the symptoms but could not diagnose the illness.

Most of the affected adolescents, both male and female, reported that their first course of action when they realized that they had an STI was to seek advice from family members, primarily mothers and older same-sex siblings. Other adolescents only consulted their sexual partners or very close friends regarding their condition. Who was consulted depended on the level of trust and confidence the adolescent had in that person.

> *When I checked myself I found a wound on my private parts.…I went and told my boyfriend. We went to a clinic without my parents' knowledge.…The*

clinic we went to for treatment belongs to my uncle. My uncle is a very good person. He knows that Mummy is a very tough person. He can never tell her because if she knows she would kill me.
—Urban, out-of-school 15-year-old female

Adolescents' decisions to seek professional care often depended on the type of advice they were given by the family members and friends whom they had consulted. While some adolescents were told or taken to seek professional help, others were advised to use herbal remedies. In most cases where parents/caretakers were approached, they responded by taking the adolescent to a clinic or hospital, but a few adults opted for home treatment using herbal medicine and only sought professional care after the home remedies had failed. Sometimes herbal and home remedies were used concurrently with professional care.

I got boils/abscesses around my private parts. . . . I first told my bigger brothers and one of them told me that I should apply petrol and another one advised me to go to a health unit. I applied both pieces of advice by going to a health unit and applying petrol. I got better after about two weeks.
—Rural, out-of-school 17-year-old male

Some adolescents reported that they resorted to home or herbal remedies after failure to receive appropriate treatment from professional health providers. A few parents/caretakers did not offer assistance when they were approached by their sick children, which may have been because the parent may not have had money to pay for care. A few respondents did not seek any care for their sexual and reproductive health problems. The reasons for not seeking treatment included being too shy to reveal their condition and being unable to pay for care.

There were a few cases of adolescents describing their attempts to terminate a pregnancy. Since abortion is illegal in Uganda, the described attempts sometimes took place under dangerous conditions. The attempts did not always result in a successful abortion.

He [the boyfriend] asked me to sleep with him without a protector [condom]. After I became pregnant, he told me that the coming Monday we should go and remove the pregnancy. . . . He bought for me local medicine to drink, but it failed to push out the pregnancy. So I just left my pregnancy and gave birth.
—Rural, out-of-school 17-year-old female

Common Barriers to Getting Medical Care

Lack of money to meet medical expenses was the most commonly cited problem that hindered young people from seeking immediate professional care for both general health and sexual and reproductive health–related problems. This was especially the case among vulnerable youth, such as orphans and those living on the street.

I normally get problems when urinating; there is always urine obstruction.…I have had this problem since childhood and I do not know what caused it.…There is no pus that comes, but I just feel pain and at times blood comes when I try to urinate.…I told my parents about it, but they have not taken any steps. I have not told it to any other person because I think they will laugh at me.…I went to hospital and a doctor prescribed some medicine but I did not have money to buy it.
—Rural, in-school 14-year-old male

My health problem was pimples and ringworms. I was advised by my friends to use Protex [medicated soap]. I tried to buy it, but because I did not have enough money, I did not continue using it even though when I was, I was seeing some change. I am still waiting for money because I was advised to go for an injection for ringworms and swallow tablets, but I have no money. I am waiting until I finish my ordinary level [schooling] so that I can get some money and go for treatment.
—Rural, in-school 17-year-old male

Another barrier is the perceived lack of drugs in public health facilities, where services including medication are supposed to be offered for free.

I was bleeding nonstop. I almost died at home. My mother could not look after me because she is also sickly. I could not go to the government hospital because they lack medicines. They prescribe medicine for you and you look for it from clinics [where it costs money]. I had no help from anyone. I started working in people's gardens for money. When I got the money, I went for treatment and I got cured.
—Rural, out-of-school 19-year-old female

In addition, the service queues in public health facilities were reported to be very long, which further discouraged would-be clients from seeking services.

Fear of injections was also a common barrier to seeking care for both general and sexual and reproductive health problems. It is worth noting that when professional care was sought, an injection was almost always part of the treatment regimen.

There were a number of other barriers specifically related to seeking care for sexual and reproductive health problems. For example, some adolescents—both male and female—revealed that they did not seek care because they were either too shy to disclose their condition or feared embarrassment.

> *Since they used to teach us about symptoms of STDs, you may feel you are experiencing it, but you just keep quiet with it anyway. . . . Somehow I had signs like a rash on my private parts and abdominal pains, but when I tried to tell other people, I found it difficult so I just had to stay with the problem.*
> *—Urban, in-school 15-year-old male*

Some of them said that they did not have anyone to confide in. Other adolescents did not seek care because they thought that the conditions were just temporary and would disappear on their own.

> *Okay, the pimples [on respondents' genitalia] were just itching me. I…didn't go for treatment. They went away with time.…I didn't take it seriously because even my sister had those pimples and they healed without treatment. I also didn't want to be checked by those doctors because I am shy. I think they [the pimples] have no treatment because there was a time they came when I was at home, the pimples came twice and cured without me going for treatment. So I think those things just come and go.*
> *—Urban, out-of-school 18-year-old female*

Married adolescents described more complex barriers to seeking care than the unmarried adolescents. One married woman who was experiencing continuous itching in her genitalia could not seek care because the husband, whom she suspected to be the source of the problem, refused to go with her to a health facility. She wanted them both treated at the same time to avoid reinfection. Seeking care with her husband would have also helped minimize her embarrassment and suspicion regarding the source of the infection, she said.

Intentions to Seek Care for a Hypothetical Problem

All young people who reported never having had a sexual and reproductive health problem were asked what steps they would take if they experienced STI-related symptoms, such as sores or itching in their genitalia. A large proportion of both male and female adolescents expressed confidence that they would immediately seek professional care from a clinic or hospital or see a doctor.

> *I would just go to the hospital. . . . I cannot tell my husband because he can quarrel and fight saying that I am cheating on him. If I have money I go to hospital; if I don't have [money], I borrow.*
> *—Rural, out-of-school 17-year-old female*

Others said that they would first talk to parents/caretakers. Some adolescents, however, reported that they would attempt to self-treat after consulting their friends or close relatives (primarily mothers and older same-sex siblings). A few others, mostly females, said they would self-treat without consulting others. The common self-treatment named was to apply home remedies such as herbs or wash the genitalia with warm salt water.

> *If I got sores in my private parts I would treat myself by getting warm water and pressing [the water on my sores]. Otherwise, I would ask Mummy to take me to the health unit. . . . I would not fear asking her to take me to the health unit because she is my mother.*
> *—Urban, in-school 12-year-old male*

A few young males said that they would first wait to see if the condition cleared up on its own and only seek help if it persisted or got worse. Reluctance to seek help was grounded in fear of parents' reactions and fear of showing their genitalia to a health worker, particularly if the health worker is of the opposite sex.

> *If I had a problem with my private parts, I would go to a nurse and tell her.…I cannot go straight away to a nurse as soon as I notice the problem. But if it persists, then I can go there. I cannot just rush to show my gear [penis] to a nurse when it might not be a serious problem, so I would first take time before approaching her for help. If it was a male, not a female, nurse, that one I would not fear, I would feel very free to show him my gear.*
> *—Urban, in-school 14-year-old street male*

Others said that they do not know what they would do.

Nearly all of the street youth said that they would do nothing about a health problem because they do not have the money to pay medical expenses.

> *With no money, [I would do] nothing. [If I had money] I would buy drugs. . . . I would ask other people to direct me where they buy their drugs when they are sick and I would go there.*
> *—Urban, in-school 12-year-old street male*

Similarities and Differences in Health Care–Seeking Behavior Between General and Sexual and Reproductive Health Problems

The majority of adolescents, male and female, rural and urban, said that they usually seek professional care whenever they are faced with a health problem that they consider serious, but for mild illnesses such as headaches and the flu, they apply home remedies, often after seeking assistance from parents/caretakers. There appear to be more home remedies to treat sexual and reproductive health–related problems than to treat other diseases, such as malaria. This is perhaps because many young people experiencing sexual and reproductive health problems may not assess that their condition warrants seeking professional care, they are reluctance to expose their genitalia to a stranger who might be of the opposite sex, and they fear parents' reactions to sexual and reproductive health problems. Unlike for general health problems, most young people were unaware of which STI they suffered from—they could only describe what the symptoms were. Lack of money to meet medical expenses and the perceived unavailability of free treatment is a common barrier to seeking professional care for both general health and sexual and reproductive health problems.

Discussion

The majority of young people seek care for health problems they experience. However, the type of care they seek depends to a great extent on the perceived severity of the health condition and the availability of financial resources to meet the medical costs. While professional care is often immediately sought for severe illnesses such as malaria, home remedies are often considered the first line of treatment for illnesses that are not deemed severe, including STIs. Courage to either tell one's parents about an STI or to reveal one's genitalia to a health worker and advice received are important factors in determining whether care is sought for sexual and reproductive health issues. Shy adolescents, for example, are less inclined to seek professional care because they fear disclosing their condition to anyone, including health workers, or they do not feel they can approach their parents who could provide them with the funds necessary to meet medical expenses.

Although treatment for STIs is supposed to be accessible and free in public and prominent NGO health facilities providing family planning and HIV/AIDS services, the perception is widespread that this is not the case. Those with money seek care from private clinics, while others visit public facilities to get diagnosed and obtain a prescription, but because of a perceived lack of supplies at public facilities, they can only get the needed medication if they have the money to buy the drugs from clinics or drugstores. Many of those without any money do not seek professional care because the perception is that one needs money to obtain care even from public facilities. As a consequence, many either use herbal remedies, self-prescribe drugs or—like in the case of street youth—simply live with the problem.

The apparent widespread use of injections for treatment of all sorts of ailments in Uganda's health facilities dissuades some adolescents from seeking appropriate and timely care because some do not like receiving injections. This avoidance of treatment may cause irreversible health complications, such as sterility and drug resistance. There is a need to sensitize young people about the importance of seeking immediate medical attention for sexual and reproductive health problems because, even though they may not appear to be severe, STIs are contagious and not only increase the risk of HIV infection; they can have irreversible effects on the adolescent's reproductive health. Furthermore, just treating the symptoms of STIs is not enough as STIs can be contagious even when they are asymptomatic. Therefore, for STIs in particular, modern medical treatment should be encouraged among adolescents to reduce the possibility of further transmission.

Chapter 8

Adolescents' Intimate Relationships

Adolescence is the time that young people begin exploring their sexual selves. This exploration marks the onset of exposure to the health risks associated with sexual behavior. This chapter explores the details and sequences of adolescents' intimate relationships with the opposite sex that may or may not involve sexual intercourse. It is important to examine how these relationships develop, adolescent's expectations of the relationship and what kinds of pressures the respondent felt while in the relationship.

Adolescents Who Have Never Had Sex

Generally speaking, adolescents equated relationships with having sexual intercourse. Most respondents who had not had a relationship said that they had not because they were afraid of AIDS: "My aunt told me to avoid men. Men are very treacherous and they can kill you with AIDS" (urban, out-of-school 16-year-old female), and "Most girls are sick with syphilis, gonorrhea and even AIDS" (urban, in-school 16-year-old male orphan). A rural, in-school 17-year-old male said that he had come close to having girlfriends "but because of the fear to be caught for defilement and getting infected with STDs, I withdraw."

Females without relationship experience said that they had not had a relationship because they were still young. Some of them said they feared getting pregnant and others said their parents forbade it. An out-of-school, rural 12-year-old female respondent's father warned her, "I should not play with boys because they will hurt me." This distrust of men was echoed by other females, who said that males are deceptive and may demand sex and deny paternity.

Males were more likely than females to have not had a relationship because they had tried unsuccessfully to get a partner. A few males said that they were not interested in having a relationship because of religious reasons, fear of getting a girl pregnant and fear of dropping out of school (as a result of getting a girl pregnant). An urban, in-school 15-year-old explained, "I never thought of getting a girlfriend since they tell us to get saved. It is Jesus controlling our lives." A rural, out-of-school 13-year-old stated, "There are associated problems, for example being arrested. I am still young and cannot go in for girls. . . . I have seen people in love with problems, for example making a girl pregnant and being imprisoned or running away from home." One male resident of a rehabilitation institution for former street youth, the Child Restoration Operation (CRO), explained that if a male at CRO impregnates someone, the organization stops paying that young man's school fees. A few said their parents forbade them from having relationships, while others said they fear young women.

> *They [young women] could abuse us, they say we are lumpens [ne'er-do-wells] and also you fear. Though the big boys could send me girls or I could go and call them, I did not get one. There are some women who could even make fusses at me but I feared.…These women are big and maybe I could not manage.*
> *—Urban, in-school 17-year-old male*

Among respondents who had never had a relationship, most intended to have a girlfriend or boyfriend when they completed their studies. An urban, in-school 19-year-old female explained, "Sometimes I feel it's okay to get a boyfriend when I go to the University . . . because by that time I will be able to reason him out and resist in case he tries to force me into doing something I don't want to do, like having sex." Other responses from females were that they intended to have their first boyfriend the following year, when they get married, when they grow up, at age 22, at age 25 or when they are old enough. Males said that they intended to have their first girlfriends when they grow up, when they got more money, at age 17, at age 18 or if God helps them in the future.

Reasons for not being sexually active

Half of the sample, more females than males, had not had sexual intercourse. Some of these individuals had had romantic relationships, others had not. The primary reason both sexes gave for not having had sex was because of fear of contracting HIV/AIDS and other STIs. Among the respondents who gave this answer, there was a distrust of condoms with respondents saying, "Condoms are risky because they are not 100% safe" (urban, in-school 19-year-old female), and "You can also get AIDS when the condom slips off, and they also say that a condom is not 100% safe, that it has small holes we cannot see but the virus can pass through and you get infected and even some condoms are expired" (urban, in-school 15-year-old male). Another primary reason given by these respondents for not having sexual intercourse was because of the fear of an unintended pregnancy: "As a youth, when you get pregnant before marriage it looks queer. You become ashamed because wherever you pass, they say that you are no longer a girl because you got pregnant, which gives you a hard time" (urban, in-school 19-year-old female), and "I fear to impregnate somebody's daughter and according to my financial stand, I cannot ably provide support for the baby" (rural, in-school 17-year-old male).

Other reasons given by females for not having had sex were because they were still young and because having sex would create problems at home. Females who gave this response said that having sex could result in getting beaten, chased from home or killed by one's parents. A few said that having sex could affect school performance, that it is against their religion and that they do not want to because they don't like boys or they do not like "those things."

The following fears were other reasons given by males for why they had not had sex: being sexually inexperienced (and therefore getting laughed at by ones' partner for not knowing what to do); contracting STIs; not having a big enough penis; having a condom slip off during sex "and remain in the girl's vagina…it's only the doctor who can help you pull it out, but this can bring problems to both of us because the doctor might tell our parents" (urban, in-school 15-year-old male); being arrested and imprisoned for defilement; and being seen naked and seeing a girl naked ("Even if we do it in the dark, I cannot face her the next morning," (urban, in-school 15-year-old male)). A few said that they had not had sex because they are still too young, because it could affect their school performance or cause them to drop out of school because of making someone pregnant, and because having sex would create problems at home.

Respondents said they felt good about not having had sex because they do not have HIV and, for young women, because they are not pregnant. When asked when they intended to have sexual intercourse for the first time, females largely anticipated that they would have sex when they got married. A rural, out-of-school 18-year-old female said, "Because I know [then] that I can't avoid it." An urban, in-school 17-year-old disabled female spoke about planning on having sexual intercourse after Senior 4 with her current partner: "But for sure I don't know when I will be ready because it is hard to trust someone, especially boys. They are not trustworthy so I have to first study him to see and be sure that he will never deny me [say that he is not responsible for the pregnancy if she becomes pregnant]." Males said that they did not know when they anticipate having sex for the first time. Some men who did not intend to wait until marriage said they intended to have sex when they finished their education.

Initiation of relationships that did not involve intercourse

Among those who had not had sex, a minority of the females of all ages had had a romantic relationship that did not involve sex. The most common way that these young women met their boyfriends was at school. While there were a few cases of girls relating that they were coerced into relationships, most of the relationships began consensually, although not always for romantic reasons.

> *[He told me] that he would give me whatever I want and you know us girls have many needs and problems. You can't keep begging from your father all the time. You can tell your boyfriend what you want and he buys for you, so I accepted.*
> *—Rural, out-of-school 17-year-old female*

Friends were the ones most likely to know about young women's relationships—some specified that their friends who knew had boyfriends as well. Those who said their mothers knew were younger than 15. Perhaps younger adolescents' mothers knew because these girls had less autonomy than older adolescents to carry on a relationship in secrecy, or perhaps because they were closer to their mothers and shared more with them. Those who said that no one knew about their relationship explained that it was out of fear of word getting back to their parents—the fear being that if a

young woman's parents found out, they would chase her away or beat her.

In half of the cases where young women had had relationships but had not had sex, the females said that the male had requested to have sexual intercourse with her. An urban, in-school 19-year-old female related, "That boy of mine could demand sex. . . . He could say, 'How can you deceive me that you love me while in actual sense you just say it in words without putting it in action?'" A few respondents related that they said "no" to their boyfriends' requests.

PROFILE OF A ROMANTIC RELATIONSHIP THAT DID NOT INCLUDE INTERCOURSE

An in-school, urban 17-year-old female explained her strategy for avoiding sexual intercourse with her boyfriend as follows:

> ***Respondent (R):*** *I never accept to go with him to his home or a lodge because I know what would happen.*
> ***Interviewer (I):*** *What would happen?*
> ***R:*** *It is hard for boys to resist having sex and he might entice me to have sex if I were to go with him to a secret place. . . .Boys get girls into a lot of problems like getting pregnant. He can get you pregnant then deny responsibility. At times he may not have money. At times they do it intentionally for pleasure purposes but are not ready to father a child.*
> ***I:*** *Why do you think they do that? Could it be that they are punishing you for something you did?*
> ***R:*** *They do it with malice even when you have never done anything wrong to him.*
> . . .
> ***I:*** *Is it possible to refuse having sex?*
> ***R:*** *You cannot refuse because my sisters have told me that whatever you say, he will find a way of getting you to accept. He might romance you until you get the feeling as well. . . . Nobody has ever forced me [to have sex], though my boyfriend tried to convince me to have sex, but for me I did not want and that is why I did not want to go with him in secretive places.*

This respondent stopped seeing the male in question based on advice from her brothers and friends.

> *R: Whenever he [her boyfriend] asks me to have sex with him, I refuse. [He had asked the respondent three times.]*
> *I: What happens when you refuse?*
> *R: When I refuse he gets angry. For me, I just keep quiet. Sometimes he walks away when he is angry with me when I have refused to yield to his demands.*
> *—Urban, in-school 14-year-old female*

In some relationships, the young man's demands to have sex led the young woman to end the relationship.

Fewer males than females related having had a romantic relationship that did not involve sexual intercourse. Most of these males met their girlfriends at school. More people knew about young men's relationships that knew about young women's relationships. The people most likely to know were siblings (primarily brothers) and friends. It was uncommon for males' parents to know, since males feared being punished if their parents found out. The reaction from those who knew was generally supportive.

Sexually Active Adolescents

Half of the respondents had experienced their sexual debuts by the time of the interview. Most of the sexually active adolescents had had sex within the context of a relationship. The few respondents who spoke about having sex outside of a relationship were male. Two experiences happened when the male was still a child (before he had experienced puberty) and one of these experiences was involuntary. These same two males lived at CRO, indicating that they were in a high risk category. The fact that no females related having had sex outside of a relationship may be more a product of the greater degree of stigma attached to females than males who have sex outside of a relationship than an actual difference in behavior.

Initiating romantic relationships in which sex occurred

Most adolescents had met their partner at school or they were from the same village. They became acquainted playing or studying together. A few of the males who were soccer players met their girlfriends through playing soccer. Relationships most frequently began when males or an intermediary approached the female with a verbal message of love or a love letter. The relationship was sometimes started by the young man bringing or promising gifts such as money or clothes. A minority of male adolescents related how

they had to work to convince the female to be their girlfriend through persistence and repeated requests. Initiation of the relationship by the female proposing was rare but sometimes occurred, according to the males. Young women were generally excited and happy to be in the relationship and young men were unreservedly happy about the relationship. It was common for these relationships to last a year or more.

Many respondents reported that no one knew about the relationship, including their parents. The primary reason given for parents/guardians not knowing was that the respondents and/or their partners would be beaten if parents found out they were in a relationship. The following quote demonstrates the social norm in Uganda that casual relationships not leading to marriage do not warrant being brought to the attention of one's parents: "It was just a mere relationship and not marriage, so no other person could know about it" (urban, in-school 17-year-old male). A number of females reported that their parents learned about the relationship when they became pregnant. One girl described what happened when her guardian found out that she was in a relationship:

> *He [Uncle] was very disappointed and confronted me when the boy left. He said he was going to imprison the boy. He went to his [the boy's] parents and told them that he was going to imprison the boy. They pleaded and offered some money to pay for my school fees. I told a friend to tell my uncle that if he imprisons the boy, I would do something harmful to myself.… I was planning to just disappear from home. But ever since then the boy comes home freely and even if my uncle finds him, he does nothing. It is like he paid the bride price for me and is free to take me if he feels ready for marriage.*
> *—Urban, in-school 16-year-old female*

When someone knew about the relationship, friends and siblings were most likely the ones to know. Friends were reported to be most frequently happy about the relationship because they had girlfriends and boyfriends themselves.

The primary activities that the respondents described engaging in as a couple were chatting and making love. Regarding what they chatted about, one respondent related:

> *He doesn't want me to put on miniskirts or tight clothes and I want him to respect my parents. So if I tell him that I cannot go to his place because my parents are around he has to understand and wait until I get time [to come see him]. I also told him that I don't want to be abused or yelled at. Good enough—he has not abused or yelled at me.*
> *—Urban, out-of-school 18-year-old female*

Very few respondents said that they talked about sex in their relationship, while a few respondents specifically said that they did not talk about sex, HIV/AIDS or pregnancy.

According to young women, decisions made with their first sex partners included the decision to have sex; to use condoms during sex; to be lovers; that he would decide where to take her for an outing; and that he was not controlling her because they were not married. Examples of decisions that were made in the relationship according to males included young women refusing to have sex; visiting one another; the female controlling any money the male had; and the female advising him not to talk to other young women looking for sex. A few respondents of both sexes said no decisions were made in the relationship.

Among females, most sexual debuts occurred around 15–17 years of age. It was most common for the first sexual partner to be a few years older than the young woman. Most were unhappy with their sexual debuts (see discussion below on sexual coercion for further elaboration on females' coerced experiences). The majority of females said they used condoms at first sex, even though one female who used condoms expressed reservations that the condom could get stuck inside her. The relationship usually ended because the young woman moved away or became pregnant.

Young men's sexual debuts generally occurred a few years earlier than females' sexual debuts. The majority of males were the same age or a year older than their girlfriends. A few said that their girlfriends initiated intercourse at their sexual debuts either by suggesting sex or physically initiating the sexual contact. A few recounted being forced at their sexual debuts, and others said they were pressured (see discussion below on sexual coercion). A number of males also discussed pressuring the female. Most young men said they had to convince their partner to allow them to use a condom at sexual debut, while in a few cases, the males related that the females convinced them to use a condom. Relationships usually ended because the males or both partners left the location where the relationship was taking place or because the female married someone else.

Sexual coercion at debut

Most young women said they were deceived, forced or coerced at sexual debut. Examples of forced sex include the following:

> *He deceived me to have sex with him and that is how our relationship started. . . . [She laughs] You know, that boy forced me into having sex, he played about with my head. He told me to go to his home for exam papers; by then we had started our exams. So I went. He forced me into sex. I tried to fight but he overpowered me. He kissed then he had sex with me. [She shakes her head.] I felt so bad, but I forgot all about it.*
> *—Rural, out-of-school 19-year-old female*

> *One day I was waiting for a friend of mine and was seated along the path. He grabbed my shoes and took them. He told me I will never see them if I don't go to his place. I feared to go home without the shoes. So I followed him.…When I reached in his house, he closed the door and forced me into sex. I could not scream because I was in his house and dreaded the embarrassment it would cause.… I felt bad and regretted why I had gone there but I did not tell anyone. I kept it a secret. It was very painful. I cried a lot but dried the tears. I went back home and pretended as if nothing happened.*
> *—Rural, out-of-school 16-year-old female*

> *My friend is the one who took me. She told me, "You escort me," and we went to the house of her friend. When we were there we saw that boy also coming. Then she told me that, "You be talking with that boy. I am also talking with this one outside here and there is nothing he will do to you." I also started talking with him knowing that she was outside. But she had gone and the boy forced me into sex.*
> *—Rural, in-school 19-year-old female*

> *R: There was one day I went to his home with my friend who is related to him. Later he gave me money for transport and told me that if I got somewhere in the middle of the journey back, I should call him. When I called, he told me to go back and meet him at a pub. So I went back alone and from there he forced me to have sex with him.*
> *I: How did you feel about it?*
> *R: I felt bad because he just forced me.*
> *—Urban, out-of-school 19-year-old female*

> *The first time he asked to have sex and I refused, we spent about a week when we were not talking. It was like our relationship had ended. But he would send his friend to tell me not to end the relationship. He was annoyed and angry with me. After that week, we went to his place and this time he forced himself on me and we had sex.…I was hurt, every part of my body was hurting. I got flu. I was very disappointed. I did not even want to see anyone of them, the boy and his friend. That day he forced me, I abused him, and because of anger he slapped me twice.…He started sending my friend, a girl, because he knew I was mad at him and did not want to see him again. My friend convinced me that such things happen to every girl so I should get used to it. So I forgave the boy and went back.*
> *—Urban, out-of-school 15-year-old female*

The last respondent's quote demonstrates how coercion becomes, at least among some respondents, normalized.

Coercion not only happened around penetration. There was also coercion not to use contraceptives and around getting pregnant. Males convinced their partners that condoms could slip off and stay inside the vagina, and could only be removed by an operation. Some males told their partners that it was embarrassing for them not to have a child at their age, stating that they wanted their partners to provide them with a child.

There were a few stories of male being sexual coerced by force and pressure, yet the situations were qualitatively different than the females' experiences. Among the males who said they were coerced, one was mentioned earlier under the "Sexually Active Adolescents" heading. He had been raped at age five or six while living on the street. A few young men said that they had felt pressured by their girlfriends to have sexual intercourse.

> *R: I will not lie to you—we were together, she asked me to have sex. Then we went to a classroom and then had sexual intercourse. It was at night.…She would ask me to have sex but for me I did not want.…When I was refusing to have sex, I was fearing that she would get pregnant.…For me, I never wanted to have sex. She forced me into it.*
> *I: What caused that?*
> *R: I feared someone would find us. If we were found, they would beat us. We could even be suspended.*
> *—Urban, in-school 13-year-old male street youth*

I always talked about studies when I was with her, but she always talked about sex.…She is the one who told me that I should prove if I am a man since I act like I am a boy. She then took me to their home when her mother had gone to the garden and I played sex with her for my first time. Then I did it again with her and this time I felt good [shyly smiling].…At first, I was so scared, but when we did it again I felt so good but I can't do it again.…I feared getting sick and making her pregnant. I also feared being caught playing sex with her because if I was caught I would be taken to prison.…I told her we should not play sex without a condom then she agreed.…I would decide for her to come and visit me.…Yes, she wanted me to have sex with her just to prove that I am a man.…I feared because I felt it was not the right thing.
—Rural, in-school 17-year-old male

Fellow students used to make noise for us saying "so and so likes that girl"—that is for the boys. Also the girls were saying "she likes that boy," meaning me.…She told me that people are always talking about us, that I am your wife but we have never even done anything. Why don't we do it so that when they talk indeed we have done what they think we are doing?…[She said:] "They talk, but you do not show that you love me. I would like them to talk when we have indeed been in love, when we have had sex together."…According to her, my failure to have sex with her was a sign that I did not like her…She was asking me whether I had other girls if my love is not for her.…She insisted that I do not like her and I enjoy seeing her being embarrassed by boys and girls in school. I told her I fear playing sex because I had never done it. She told me that she had also never had sex but let's go and start together. She insisted and I felt she was forcing me into having sex. She wanted to know whether I really liked her. She gave me an ultimatum saying that I should tell her so that she makes a decision because there are a lot of other boys who would like her to be their girlfriend.…We went in the truck talking with her and when we reached Masaka where our school was to play a football match, I asked her to take a walk with me so we walked around looking for a nearly bush where we could go.…She was not a virgin. She just lied to me so that I could have sex with her.…My heart was beating terribly about the idea of having sex. I feared a lot wondering how I was going to play sex. The first time scared me.
—Urban, out-of-school 19-year-old male

Even though these boys said they had been pressured to have sex, they described situations in which they took initiative to have sexual intercourse. The type of pressure meted out by young women in these situations is different in tone and manner than the pressure described in young women's accounts of being coerced by males. Females challenged males' masculinity when the males were not as sexually aggressive as the young women wanted them to be, whereas females were much more likely than males to relate being pressured, paid or deceived not just to have sex but also to expose themselves to the risk of unintended pregnancy.

Most recent sexual partners

Approximately half of the sexually active respondents had only had one sexual partner. Among the other half, a small proportion were married. When the respondents were asked what they did together with their last sexual partner, the majority said they talked about marriage and, if in school, encouraged each other to study. Sexual and reproductive health–related decisions that the adolescents talked about in their relationship covered having sex, protecting themselves against HIV and other STIs, guarding against pregnancy, using contraception, being faithful and going for blood tests together. "We talk about going for blood test but we fear to test for HIV/AIDS. What if the results come out when we are positive? What do we do? We might even end up separating," (urban, out-of-school 18-year-old female). "We are reading the Straight Talk paper and they were encouraging people to go for blood check, and we decided based on that to make the decision to have a blood test," (urban, in-school 17-year-old male). A number of young women said that young men unilaterally made decisions in the relationship including deciding to get her pregnant or the number of children they would have. The respondents with children talked with their partner about how to raise their child.

There were a number of topics that respondents said they could not talk about with their partners. One urban, out-of-school 17-year-old male said, "We never talked about sex" because "it could make her upset." Sexual betrayal, on the part of either partner, was another taboo topic.

But the bad thing is my husband has started coming back late in the night, at around twelve, midnight. At first when I had just come here, let me say

the first one and a half months, he used to come back in the evening at around six or seven P.M. But now I don't know why he has changed. I am worried he might be having another woman outside there and he might end up bringing AIDS to me. I cannot talk to him about it because he is so quiet. Okay, he cannot beat me, but I just don't want to ask him. I just leave him to do what he wants. He tells me that these days money is scarce, yet he comes back at night. Those days when he used to come back early, he did not complain about money which means he has somewhere he is spending the money.
—Urban, out-of-school 18-year-old female

I: What were the things that you could not talk about?
R: I cannot tell him that I cheated on him and went out with another man. . . . I fear he would refer to me as a rumor monger if I told him things said by neighbors [about him]. And he would chase me away from his house if he hears that I am cheating.
—Urban, out-of-school 18-year-old female

Pressure to Have Sexual Intercourse

Of the entire sample, including adolescents who were sexually active and adolescents who were not yet sexually active, most adolescents said they had not been pressured to have sex. A few females reported having been pressured by their boyfriends and male friends, while a few others said that they had been pressured by strangers. Sometimes the pressure led to engaging in intercourse, while in other situations, it did not. A rural, out-of-school 19-year-old female said, "You see for boys, you can't befriend them most of the time without him telling you such things [that he wants to have sex]. But he finds that you are not interested, he leaves you alone."

Among young men, it was more common to have been pressured by their friends than their girlfriends to engage in sex. An urban, in-school 19-year-old male related that his friends called him impotent: "It's not true, yet my friends are insisting on it as if it's true. So they want to force me to do something which I don't want." Some of the pressure came in the form of false information: "[A friend] told me to play sex because [he said] when the sperms remain inside your body they can spoil your penis" (urban, in-school 19-year-old male). A few related being pressured by their girlfriends:

Whenever we are together she tells me to organize and have sex with her. At one time we had sports at school and I was participating. She timed when I was coming out of the hall. [She caught me and] she told me that we shall go for sex. I refused.
—Urban, in-school 14-year-old male

A few boys talked about how they pressured their girlfriend to have sex:

She never pressured me. It was I pressuring her all the time.
—Rural, in-school 13-year-old male

She was our neighbor, so at one time she came to our place and there was nobody home, so I caught her and had sex with her.
—Rural, out-of-school 18-year-old male

I asked her to give me sex and she gave in and that's what I wanted.
—Urban, out-of-school 17-year-old male

Adolescents were pressured not to have sex by mothers/parents and friends. A rural, in-school 15–year-old disabled female said, "My mother said that if I ever play sex she would kill me," and "[Mother] demanded that I stop going to men because they will bring disease to me" (rural, in-school 14-year-old female). An urban, in-school 13-year-old orphan related what she had been told: "My parents, they told me not to have a boyfriend because he can make you pregnant and he can destroy my private parts."

My father is ever telling me not to have sex before marriage because it might lead to impregnating a girl, which is a big problem, and impregnating a girl means being imprisoned and dropping out of school.
—Rural, in-school 17-year-old male

Mummy called me when I was nine years old. She told me, "When you grow up, never have sex before you have finished your education." . . . She never told me the reason why I should not have sex. She just told me not to have sex before I have finished my education.
—Urban, in-school 12-year-old male

A rural, in-school 15-year-old male orphan related, "My mother tells me that when you play sex that you will get AIDS and you will die. And I am the one who will look after her when she is old in future." Pressure from friends included being told by one "not to have sex and said this could lead to pregnancy, yet I am still very small to have a baby" (urban, in-school 17-year-old female). Another female recounted: "That one time a certain man pressured her [respondent's friend] and caught her by force. Through that experience she could tell me that I could resist when he [respondent's boyfriend] pressured me" (urban, in-school 19-year-old female).

Reactions to Hypothetical Pressure to Have Sex

The most common reaction to a hypothetical scenario in which the respondents is being pressured to engage in sexual intercourse was for the respondent to say that they would refuse to have sex. The second most common reaction was to attempt to refuse and "tell [him or her] I do not want to" but consent if the partner insisted. The third most common reaction was to leave the partner (which either meant physically removing oneself or breaking up). Males were more likely to say they would employ excuses to reject sexual intercourse, while females were more likely to say they would break up with the partner.

Females said they would refuse by "seriously" telling him "no" and giving him reasons such as disease and pregnancy or being young and still in school as reasons why they could not engage in sexual intercourse. A few said that they would alert elders (e.g., headmasters, parents) who could remove and punish the boy, and others said they would shout for help. Males said they would refuse to have sex if a female pressured them. One said it is because he does not know what her intentions would be. An urban, in-school 18-year-old male said, "She will not force me because it is the male to determine." Two married males interpreted the question to mean someone other than their wife. Both used the reason that they had a wife to refuse sex with someone else.

A minority of young women said that if the male insisted, they would accept, telling him that he must use a condom or resigning themselves to the fact that they would get AIDS. An urban, out-of-school 19-year-old female explained: "I would refuse, but if he insists, I give him what he wants. After all, it doesn't depreciate." An urban, in-school 17-year-old female said, "If you refuse he will not feel good.…You might find yourself having sex in case you do not want to embarrass him. Boys turn it into war if the girl refuses to have sex with him."

Likewise, some males said that they would try to refuse to have sex if they did not want to, but if she insisted, they would have sex. They spoke about using a condom in this type of situation to protect themselves and that they would give in out of love. A rural, out-of-school 18-year-old male said, "Because if I refuse she will also refuse when I need and she doesn't need." An urban, in-school 13-year-old street youth explained, "You see, young women are tricky. If she really wants to have sex with you, she will lure you into having sex with her." A minority of males also said that they would use excuses to avoid sex by deceiving the girl and putting sex off or feigning illness (including having STIs).

A few females said that they would leave a boy who demanded sex. An urban, in-school 19-year-old female explained, "I cannot just give in to him because he wants to play sex. I also first consider my feelings. I cannot do something I don't want just to please him." Others who took this tact said they would remove themselves from the situation by leaving him, but if he insisted, they could resort to leaving him and alerting elders who might be around. Males said they would leave a girl who pressures them to have sex, because, as an urban, in-school 17-year-old put it, "such a person can bring you problems." A couple of males said that they would beat a female who pressures them to have sex.

> *If she wants to play sex when I do not want, I refuse and even beat her because a woman is not supposed to ask for sex. [If she insisted], I would beat her more.*
> *—Rural, out-of-school 13-year-old male*

> *I can refuse or even move away and leave her. [If she insists], I tell her to leave me alone. If not, beat her.*
> *—Urban, out-of-school 15-year-old male*

Transactional sex

A number of young women related being pressured with money or gifts to engage in sexual intercourse at debut. A rural, out–of-school 15-year-old female related how her debut happened: "The man told me that 'If I have sex with you I will use a condom and nothing will happen to you, I will also give you 2000 shillings,' so I accepted because I needed the money." A rural, out-of-school 17-year-old female related: "At the end of it all he asked me to show him that I loved him by having sex with him and I complied. I could not refuse because I was ashamed of all the things he had done for

PROFILE OF A COERCIVE TRANSACTIONAL RELATIONSHIP

A rural, out-of-school 17-year-old female related how the financial dependency that she had on her partner, who was 15 years older than she, trapped her in a physically dangerous and emotionally damaging relationship.

He would pick me from home secretly and take me for film shows in town. I would always lie to my mother that I had gone to my aunt's place and would spend nights with him. I eventually got pregnant. He has a wife and three children. When we had just met, we would talk about love. He would tell me how he was going to pay my fees, buy for me good clothes and uniform and how he would marry me. I thought he cared so much and would look after me and did not know he had a wife. But now there is nothing good that we talk about. The times he comes, he wants food or he comes to quarrel and fight. Marriage is not good at all and he doesn't care for his son or me. I am just in sorrow, yet I cannot go back home. My parents were so disappointed in me since I am the first-born. . . . When we had just met we could talk about everything with love. But he could not tell me he had a wife and also me. I would not tell him things happening at home, like if they abused me or beat me.…He refused me to take any precautions against pregnancy; he refused and said that he wanted a child. He said that he had no children and my child would be his first-born and that he was looking forward to that. It was much later when I was already pregnant that I discovered he was a liar who had a wife and three children already.…Of course every time I have sex with him I fear HIV/AIDS because he has another wife who I cannot trust. He also moves around with other girls, so my health is at stake but I have no option since I am solely dependent on him so I just brush my fears off.…Yes, at first I had insisted that we use condoms. But as time went on he started complaining that condoms react on him badly, that they itch. He insisted and since I was in love, I accepted, I got pregnant and I am not sure of my status with regard to AIDS or STIs.

The complex role that money plays in a relationship is brought out in this young woman's story. Money encouraged the young woman to take greater risks in the sexual relationship and fosters a cycle of financial dependency that leaves her less able to avoid unwanted sex and protect herself from STIs.

me." A rural, out-of-school 16-year-old female said: "He approached me tactfully and he promised some dresses and some sun glasses and I gave in."

Transactional sex, however, is not necessarily coercive and may in fact be a normal aspect of romantic relationships, as can be seen from how this type of exchange was discussed by the young women: "We were friends, he would give me money and we also had sex" (rural, out-of-school 18-year-old female), and "When we reached his place, he told me he was going to have sex with me but he would not tear me [damage my private parts] and that he's not a bad person. So I believed him and had sex with him, then he gave me 300 shillings" (rural, out-of-school 15-year-old female).

Perceptions of Being at Risk of Pregnancy, STIs And HIV

When asked if they felt at risk of getting pregnant or getting their partner pregnant, or contracting HIV/AIDS or another STI in their last or current sexual relationship, half of the respondents said they felt at risk. Pregnancy was a more common fear than contracting an STI, including AIDS. Some respondents were afraid because they did not use condoms; in some of these cases, the partner was reluctant to use condoms or prohibited the use of contraceptives altogether.

It was not only the males who were reluctant to use contraceptives. A number of males said that their partner refused condoms because they caused her pain. Condoms were also seen by females as a barrier to emotional intimacy.

> *We talk about it and she always tells me that I will make her pregnant. She very much loves sex, yet we are not using any protective measures. She doesn't want me to use a condom because she loves me very much. I have always told her that I will make her pregnant but she does not listen. . . .*

Me, I want to use a condom but she tells me that just because I don't love her that is why I am proposing to use a condom.
—Rural, out-of-school 18-year-old male

One of the respondents described having been forbidden by her partner from using contraceptives, and she became pregnant. This made her financially dependent on the father of her child, and she was therefore unable to avoid subsequent unprotected sex with him, even once she became aware that he had other sex partners (see text box, page 46). One urban, out-of-school 19-year-old female whose partner did not want to have a child explained, "He had the condoms but would put it on and then remove it before we play [sex]." Some of the respondents who felt at risk had become pregnant. Regarding STI risk, a rural, out-of-school 19-year-old female said, "I don't know what he does out there. You know, men are very difficult. A man can't be trusted." A rural, out-of-school 19-year-old male explained

I fear to get AIDS . . . you may think you have agreed not to have other sexual partners but she may decide to go and infect me. . . . I take precautions that whenever I sleep with her I put on a condom and at times I dodge her.

Those who did not feel at risk for pregnancy or STIs said they trusted their partners or they were using condoms, hormonal contraceptives or both. Motivations to use condoms included having seen people suffer with STIs and not wanting to suffer like them and fearing AIDS because it kills. A young woman who used condoms said she and her partner had chosen that method because "they guard against STDs and pregnancy." One male who used condoms had already made his girlfriend pregnant and she had had an abortion. That experience motivated him to be a consistent condom user. One of the respondents who felt safe using condoms explained that she and her boyfriend did not use them on "safe" days.

A rural, out-of-school 16-year-old male described how he and his partner prevented pregnancy:

R: We decided not to see each other during periods that were not safe, so she would not come home.
I: How did you tell which periods are safe?
R: She calculated them herself.
I: How about the condom?
R: I did not know how to use a condom.

An urban, out-of-school 19-year-old female related surreptitiously using the pill:

I: What about decisions to prevent pregnancy?
R: He is the one who decided on that issue by use of a condom, but before I started having sex with him I already knew how to use pills. And I did it without him knowing. Otherwise, if he got to know he would leave me.
I: Did you both agree?
R: No, we did not make these decisions both of us, so we did not both agree.

Regarding STI prevention, she continued,

R: We decided that we should stick on each other so he did not have to get other women and I had to love him alone. It's the only way we decided as regards sexually transmitted infections.
I: How did you reach that decision?
R: We sat and talked about it and concluded by deciding to stick to each other. And since we had a blood check-up, both of us found we were okay. We only had to be faithful to each other.

Some respondents who had not felt at risk came to find out that they, in fact, had been at risk. An urban, out-of-school 18-year-old female had thought that she was protecting herself from pregnancy because she was getting a hormonal injection, paid for by her boyfriend, but while on the injection, she became pregnant. She suspected the boyfriend had bribed the nurse to inject her with an expired drug, so she talked to the nurse. "When I got pregnant, I went back to that woman for an explanation and that is what she told me." Therefore, in spite of this respondent's best intentions and forethought, her partner—in collaboration with the health care provider—deceived her. Regarding whether she felt at risk of STIs, this respondent said that she and her partner do not discuss how to protect themselves from STIs but that they did talk about AIDS. She said, "Me, I told him that in case he gets another woman, he should use a condom."

One respondent had been advised to use drugs by a friend to avoid pregnancy but the drugs she was recommended to use were not contraceptives.

My friends told me to always take aspirins: You take four of them with two Panadols when you are going to have sex, and you will not get pregnant. I did that but it did not work . . . That is the time I got

pregnant and produced a baby girl.
—Rural, in-school 19-year-old female

Overall, communication within the relationship about sexual matters seemed to be common with decisions related to sexual and reproductive health generally being made together. Approximately half of the respondents felt that they were putting themselves at risk of an unintended pregnancy or STIs, including HIV/AIDS, in the course of their last or current relationship. Some of this fear was based on suspicion about their partners' fidelity. While it is perhaps understandable that betrayal and other romantic interests are not discussed in the relationship, these behaviors place young people at great risk for negative sexual and reproductive health outcomes. Trust of one's partner was a reason cited for not using contraception, yet partner betrayal, which only sometimes aroused suspicion in the other member of the couple, came up with relative frequency.

Knowledge of contraception is not universal, nor is use 100% effective. Birth control sabotage is part of the reason why some of the respondents were at risk of HIV/AIDS and pregnancy. Examples of this include the male putting the condom on and taking it off before penetration and the male paying someone to inject his partner with expired hormones. Perhaps even more surprising are the arguments females use to discourage condom use, since conventional wisdom is that women would like to use condoms with greater frequency than their male partners allow. Partner resistance, on the part of both males and females, either led to surreptitious use or foregoing contraceptives altogether.

Discussion

Never having had a relationship or sexual intercourse was primarily because of a fear of HIV/AIDS: Being in a relationship is equated with sexual intercourse and sexual intercourse is equated with AIDS. While it is true that a high national rate of HIV places Ugandans at great risk of contracting HIV through one act of intercourse, compared with the risk in a low-HIV prevalence setting, the assumption that intercourse equals HIV ignores the role of condoms in preventing transmission of the virus. The use of condoms is hampered by prevalent assumptions that condoms are not effective and, worse, dangerous because they can get stuck in the woman's vagina and require surgery to be removed.

While the high number of young women who described their sexual debut as coerced is alarming, another possible interpretation of this high prevalence is that it may be a product of cultural norms. That is, it may be much more socially acceptable for a female to name her sexual debut as coerced than for her to claim agency and sexual desire. Because of that possibility, we have presented as much of the females' actual words as possible to allow the reader to make up their own minds about females' accounts of their experiences at sexual debut.

While most adolescents said they could turn down unwanted sex in the face of pressure, a minority of both sexes believed that they would give in to sex under such circumstances to please their partner, avoid a fight or bank sexual goodwill with their partner so that their partner would be more inclined to not turn them down the next time they wanted sex. Of particular note is females' discussion of going along with sex to protect the male ego and that some males said they would react violently to pressure.

A variety of attitudes toward condoms and fidelity put adolescents at risk for unintended pregnancy and STIs. Some of the respondents performed or experienced birth control sabotage. Partner resistance, on the part of both males and females, also led to either surreptitious contraceptive use or foregoing contraception. Trust of one's partner was another reason cited for foregoing contraceptive use yet partner betrayal came up with relative frequency. This suggests a potential inconsistency between the perceived level of safety that respondents felt in relationships and their actual level of risk.

Chapter 9

Implications for Policy and Programming

These findings from the 103 in-depth interviews with adolescents highlight their knowledge, experiences and perceptions about important sexual and reproductive health issues such as pubertal body changes; HIV and AIDS; sexual and reproductive health problems and care-seeking behavior; nonmarital pregnancies and childbearing; adolescent romantic relationships, including experiences with and reactions to their first sexual experience; and the sources of influence on adolescents' ability to protect their own sexual and reproductive health. Policy and programmatic initiatives can help support young people to take better care of their sexual and reproductive health.

Sexual and Reproductive Health Information

There is a need to adequately equip adolescents, particularly young women, with knowledge about body changes and how to manage them before the onset of puberty—beginning when the adolescent is around 10 years old. This can be achieved through the introduction or enhancement of school counseling and guidance sessions for all girls and young women, since the majority in this age cohort are going to school. Senior women teachers also need to be well-equipped with necessary materials and information to assist young women undergoing body changes. Whenever possible, adolescents' preference for information from health care providers should be respected. In light of current time constraints of the medical profession, one way of doing this would be for health care providers to be brought into schools and other venues where adolescents congregate to impart sexual and reproductive health information to youth. Improved parent-child communication should be encouraged so that parents can either preemptively teach young people about the body changes they can expect to experience, or they can, at the very least, respond to young people's concerns with accurate and complete information. If religious institutions are discouraging traditional pathways of information transmission about puberty, it would be helpful if they introduced other ways of imparting intergenerational transmission of knowledge about these matters.

It is generally expected that males are the ones to reject condom use, but males in this sample related that some of their female partners, in fact, rejected condom use because the young women said that condoms caused them pain and that they were a barrier to sexual intimacy. These are both subjective experiences of condoms that can possibly be addressed by talking with young women about the benefits of using condoms with the hopes that they will determine that the benefits outweigh the costs. A further justification that should be used to encourage young women to use condoms is that unfaithfulness, including adultery, is more prevalent than either member of the couple acknowledges. Unfaithfulness was a topic that youth said they could not talk about and we know from quantitative data with young people that a primary reason they do not use condoms is because they trust their partner.[37] Therefore, adolescents should be encouraged to protect their own reproductive health because they do not know what their sexual partner may be doing when the two of them are not together.

As evidenced by what young people know about modern contraceptives, contraceptive information being imparted to young people is frequently incomplete and incorrect. One of the topics that young women wanted to know more about was how to avoid pregnancy after having unprotected sex. While emergency contraception is not generally available in Uganda, teaching young women about the birth control regime they can use to prevent ovum implantation would fill this information gap and help young women avoid unwanted pregnancies, and, at least for some, the dangers of unsafe abortion. Most of the adolescents did not perceive there to be barriers to their ability to access information on nonmarital pregnancy yet they have far from complete information. This suggests that

adolescents are unaware of how incomplete their information is. As a consequence, there is more of a burden on educators (be they teachers, health care providers or others) to reach out to adolescents with information because the adolescents may not be coming to them proactively with questions.

Efforts to combat stigma against the HIV-positive population has the potential to increase tolerance and possibly support for this vulnerable segment of the population. While only a few respondents expressed stigma against HIV-positive individuals, it is disturbing that some respondents perceived HIV-positive individuals to rape young women because they do not want to die alone. This perception should be forthrightly addressed.

Sexual and Reproductive Health Services

The stigma attached to adolescent nonmarital relationships hampers young people's ability to seek health care if they need contraception or treatment for a sexual health problem. Parents and guardians should be encouraged to understand the reality of adolescent transitions to adulthood in contemporary Uganda so that they are more capable of dealing with young peoples' sexual and reproductive health needs. This requires adults accepting first and foremost the importance of helping young people protect their health and communicating this belief to young people to minimize adolescents' fear in speaking to their parents about such matters.

Home remedies were used with some frequency to treat sexual and reproductive health–related problems due to financial constraints or adolescents being too shy to reveal their condition to a formal provider. While it is true that bacterial infections such as gonorrhea and syphilis can clear up on their own in some cases, simply treating the symptoms of bacterial infections does not clear the adolescent of the infection and therefore even if the symptoms go away, the infection can remain communicable and put the adolescent's partners at risk of exposure. Therefore, for STIs in particular, efforts must be made to educate young people about the proper treatment of sexual health problems and to reduce the barriers (embarrassment and cost) to accessing modern medical care and medication for these health problems that cannot be effectively treated with home remedies. Reducing stock-outs of medication at public facilities would be one way to improve treatment compliance. Furthermore, having more providers on staff to reduce the long lines would address another barrier and lastly, if the medical providers were trained to give injections in the least painful way possible, that might further reduce the barrier of adolescents' fears of injections. There is a need to increase access to treatment services for sexual and reproductive health conditions through ensuring availability of free services and drugs, while at the same time increasing awareness among young people about the availability of these free services.

Gender Roles that Impact Sexual and Reproductive Health Behavior

The shame young women felt at the onset of puberty—from having difficulty managing their menstruation to disliking the male sexual attention that comes with the pubertal changes of maturation—may be indicative of their difficulties in managing their sexuality in a way that they feel comfortable in Ugandan society. The fact that dressing in a sexually suggestive way was named as an HIV risk factor by males who saw it as something that would motivate them to want to have sex is an example of how men blame women's sexual expression for their own sexual behavior. Young women's chastity was expected, as demonstrated by males' understanding of the term abstinence as applying only to females. Males were the most common perpetrators of pressure to have sex—either pressuring their girlfriends or pressuring their other male friends to have sex. Girls had difficulty avoiding unwanted sexual intercourse and negotiating contraceptive use if they chose to be sexually active. The stigma attached to an unmarried female who was sexually active or pregnant serves as a mechanism of social control that does not affect males as severely. Being kicked out of school for being pregnant curtails young women's future life opportunities much more directly than those of the male involved in the pregnancy.

Males' general lack of interest and their exhibited lack of knowledge about female-controlled contraceptive methods, as well as their resistance to learning about such subjects, may be a product of the fact that avoiding pregnancy is largely seen as women's responsibility. The consequences for men who cause a pregnancy are likely to be much less severe than they will be for the woman: Men have the option of denying their involvement and are rarely brought up on defilement charges; thus, they have little incentive to assume greater responsibility for contributing to young women's ability to avoid an unintended pregnancy. If males were more informed about all modern contraceptives, they could play a more active role in preventing unintended pregnancy and thereby protect the

health of their sexual partners who may be too young to carry and deliver a healthy pregnancy or who may be tempted to seek an unsafe abortion. Educating males about respecting the reproductive health of their partners and other ways of encouraging gender equality are needed.

Another gender dynamic that makes young women particularly vulnerable to sexual and reproductive health risk is that money and gifts are frequently offered to them in exchange for sex. The power dynamic that this establishes can make it more difficult for young women to demand that a condom be used. Some young women related that peer pressure influenced them to accept gifts from men for sex. While transactional sex within this population has been treated in depth elsewhere,[38] these data suggest that minimizing young women' motivations to engage in transactional sex, possibly through encouraging parents to speak candidly with their daughters about their financial needs and increasing opportunities for young women to earn disposable income, may act as protective behaviors that could be promoted more widely.

In sum, in spite of the fact that sexual intercourse is common among adolescents within this sample, young people do not receive the education they need to be able to have sex in a protected and safe manner, so they are placing themselves at risk of HIV and unintended pregnancy. Health services are not yet accessible to adolescents and there remain significant barriers that prevent them from accessing needed services, be that contraceptives or STI treatment. It is imperative that parents acknowledge the contemporary sexual and reproductive health needs of their young people and support them in protecting their sexual and reproductive health so that they can become sexually healthy adults.

Appendix A
Adolescent Interview Guide

1. Brief background information

a. Family

- Who do you live with here?
- How long have you been living in this community?
- Are you married?
- Have you ever had/fathered a child?

b. Individual characteristics

- What is your age (at last birthday)?
- Are you a student in school?
- What do you usually do during the day?

2. Puberty and socialization

a. Body changes

- When a young person is growing into an adult, what are some of the changes in the body that happen?
- Have you experienced any changes in your body (pubic hair, voice breaking, menstruation, wet dreams, rapid growth, beards or breasts)?
  - o When did you first start experiencing body changes?
  - o How did you feel about these changes happening to you?

b. Information about puberty

- Has anyone ever talked to you about body changes that happen when a young person becomes an adult?
  - o Can you tell me about who talked to you and what you talked about?
  - o When were you first told about these changes?
  - o In what ways, if any, did you find these talks useful or not?

c. Initiation ceremonies

- Have you had an initiation ceremony?
  - o Can you tell me about your experience? (When? Where? What happened?) Who performed the ceremony? Why do you think the ceremony was done?
  - o What did you think about it? Would you recommend it for a younger family member or friend who has yet to go through it? Why or why not?
  - o In what ways, if any, did this change how you act towards (the opposite sex)? How about with (the same sex)?

3. Relationships

a. First boyfriend/girlfriend

- When did you have your first boyfriend/girlfriend, if ever?
  - o What is/was he/she like? (age, schooling).
  - o How did you come to know each other?
  - o Did anybody know about your relationship (Who? Who else? What were their reactions?)?
    - What about your parents/guardians?
  - o What were the (sexual) things you did together?
  - o How did you feel about this relationship?
  - o What happened to this relationship?
  - o RELATIONSHIP ENDED: How long did this relationship last? What happened after that? Did you have other boyfriends/girlfriends?
- NEVER HAD A BOYFRIEND/GIRLFRIEND: [Optional question?] What are some of the reasons why you have never had a boyfriend/girlfriend?
- Have you ever wanted to have a boyfriend/girlfriend?
  - o What have you done, if anything, to try and get one? What was the outcome?
  - o When do you expect to have your first girlfriend/boyfriend?

b. First sexual experience

- When was the first time you had sexual intercourse (if ever)?
  - o How did this come to happen?
  - o How did you feel about it then (happy, curious, regrets)? How about now?
- NEVER HAD SEX: What are the reasons why you have not had sexual intercourse?
  - o Probe for fear of pregnancy, fear of sexually-transmitted diseases (like HIV/AIDS), religious reasons, no boyfriend/girlfriend, aspirations like staying in school.
  - o Has anyone pressured you to have sexual intercourse? Who? In what ways?
  - o Has anyone pressured you to not have sexual intercourse? Who? In what ways?
  - o How do you feel about not having had sexual intercourse? (happy, curious, regrets?)
  - o When do you expect/plan/anticipate to have sexual intercourse for the first time? Why then?

c. EVER HAD SEX: Current or last sexual relationship

- Let's talk about your relationship with the person you last had sexual intercourse with. What was he/she like? (age, schooling).
  - o What were the things you could talk about together?
  - o What were the things you could not talk about? Why couldn't you talk about these things?
- What kind of decisions did you make? What kinds of decisions were made by him/her?
  - o How about decisions to prevent pregnancy? What did you decide to do? How did you reach that decision? Did you both agree/disagree?
  - o How about protecting against sexually-transmitted infections? What did you decide to do? How did you reach that decision?
- When you had sex with him/her, did you ever think you were at risk of pregnancy, HIV/AIDS or any other kind of sexually-transmitted infection? (It is important to note that each of these conditions should be probed on separately because they mean different things to different adolescents)
  - o IF YES: What happened? How did you feel about it?
  - o IF NO: Why not?
- Did you ever feel pressured by him/her to do something that you thought would put you at risk for pregnancy, HIV/AIDS or any other kind of sexually-transmitted infection?
  - o IF YES: What happened? How did you feel about it?

4. Health care seeking

a. Health problems and steps in getting help

- Let's talk about the last time you needed care for a health problem. What was the problem? What did you do? Where did you go?
- Have you ever experienced a health problem such as pains or sores on your private parts? [IF NONE, ASK: Have you had any kind of reproductive health problem—anything sex or pregnancy-related?]
  - o When did this last happen?
  - o What was the matter the last time this happened? What do you think was the cause?
  - o Who did you first talk to about it? Why? Were there others? Who? Why?
  - o What did you do first? (Who did you go to? Why? What happened?)
  - o What did you do next? (How long was it before you did this? Who did you go to? Why? What happened?) GO THROUGH ALL THE STEPS TO GET CARE.
  - o Was there something you thought about doing but you could not? (What was that? What were the reasons you could not do it?)
  - o What could you have done to prevent this problem, if anything?

b. IF NO CARE SOUGHT

- What were the reasons you didn't seek care at all?
- What were the problems you had in trying to get care?
- What would have made things easier for you?

c. IF NO REPRODUCTIVE HEALTH PROBLEMS: Hypothetical health care situation

- If you had a problem with your private parts, how would you deal with the situation? [If too sensitive a reaction from young girls, consider "If you had a menstrual problem"]
- How confident/sure are you that you could do that?
- What would make it easier for you to deal with such a problem?

5. Risk Assessment and Perceptions

a. *Risk assessment*

- What are some of the major problems facing you now?
  - o Which one of these is the most critical? Why?
  - o How much of a problem do you think AIDS is for you compared to (most critical problem named above, if not HIV)? What makes you feel this way?
- What things do you think are "risky sexual behaviors"? (probe on having sexual intercourse without a condom; having more than one sexual partner)
  - o Why do you think these are risky?
  - o What do you think may happen to someone who does these kinds of things?
- What kinds of sexual behaviors do you think are not risky?
  - o Why do you think these are not risky?

b. *Hypothetical risk situations*

- Let's talk about some of the situations young people your age find themselves in. Suppose your closest friend wanted you to use alcohol and you did not want to: How would you deal with that situation? What if your friend insisted, what would you do?
- Suppose you had a boyfriend/girlfriend who wanted to have sex with you when you did not want to: How would you deal with that situation? What if he/she insisted, what would you do?

c. *Perceptions*

- HIV/AIDS: What comes to your mind when you hear about AIDS?
  - o What makes you think that way?
  - o What do you think about people who have HIV/AIDS?
  - o Do you personally know someone who has HIV/AIDS?
  - o What do you think you can do to prevent HIV/AIDS?
- Premarital pregnancies: What comes to your mind when you hear about someone having a baby before marriage?
  - o What makes you think that way?
  - o What do you think a person can do to prevent having a baby before marriage?

6. Information and communication

a. *HIV/AIDS*

- Has anyone ever talked with you about HIV/AIDS?
  - o Can you tell me about who talked to you and what you talked about? (when first happened, when last happened, what talked about, with whom)
  - o In what ways, if any, did you find these talks useful or not?
  - o IF EVER IN SCHOOL: Have you gotten any information about HIV/AIDS at school? (What was talked about? Condom? Delaying sexual intercourse? Staying a virgin until marriage? The importance of being faithful?) Who talked about these issues (guest speakers, head teachers, guidance and counseling teachers, class teachers, etc).
- Are there people you feel you can go to for information about HIV/AIDS?
- Whose information do you trust about HIV/AIDS and how to prevent it? Why? Have you talked with (this person/these people)?
- Are there times when you tried to get information and could not do so? What kind of information were you trying to get?
- What type of information do you really want about HIV/AIDS?

c. *Pregnancy*

- Has anyone ever talked with you about preventing pregnancy?
  - o Can you tell me about who talked to you and what you talked about? (when first happened, when last happened, what talked about, with whom)
  - o In what ways, if any, did you finds these talks useful or not?
  - o IF EVER IN SCHOOL: Have you gotten any information about preventing pregnancy at school? (What was talked about? Contraceptive methods? Delaying sexual intercourse? Staying a virgin until marriage?) Who talked about these issues (guest speakers, head teachers, guidance and counseling teachers, class teachers, etc).
- Are there people you feel you can go to for talk about preventing pregnancy?
- Whose information do you trust about preventing pregnancy? Why? Have you talked

with (this person/these people)?
- What type of information do you really want about preventing pregnancy? Why?

d. Other information
- What other things do you want to know more about? (probe on relationships)

7. Religious groups
- Do you belong to a religious group?
  - o What group?
  - o How does this group help you make decisions in your everyday life?
  - o Has this group talked about or done any activities that have to do with HIV/AIDS or preventing pregnancy (or anything else health-related)? What did they do?
  - o What do you agree with from what your religious group teaches about these things? What do you disagree with?
  - o If not in a group – why not?

8. Perceptions of Self and Aspirations

a. Perceptions of Self
- How do other people think about you?
  - o What do your peers think?
  - o Your family?
  - o Other people in your community?

b. Aspirations
- What do you want your life to be like in the next five years? (What about your education or work?)
  - o What could make these things more or less likely to happen?
  - o How do you think you can overcome the obstacles?
- What things do you hold most dear in your life?
- Who do you most want to be like? What things make you want to be like this person?
- What are the things in your life that you feel happy about?
- What are some things that you hope to achieve in your life?

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