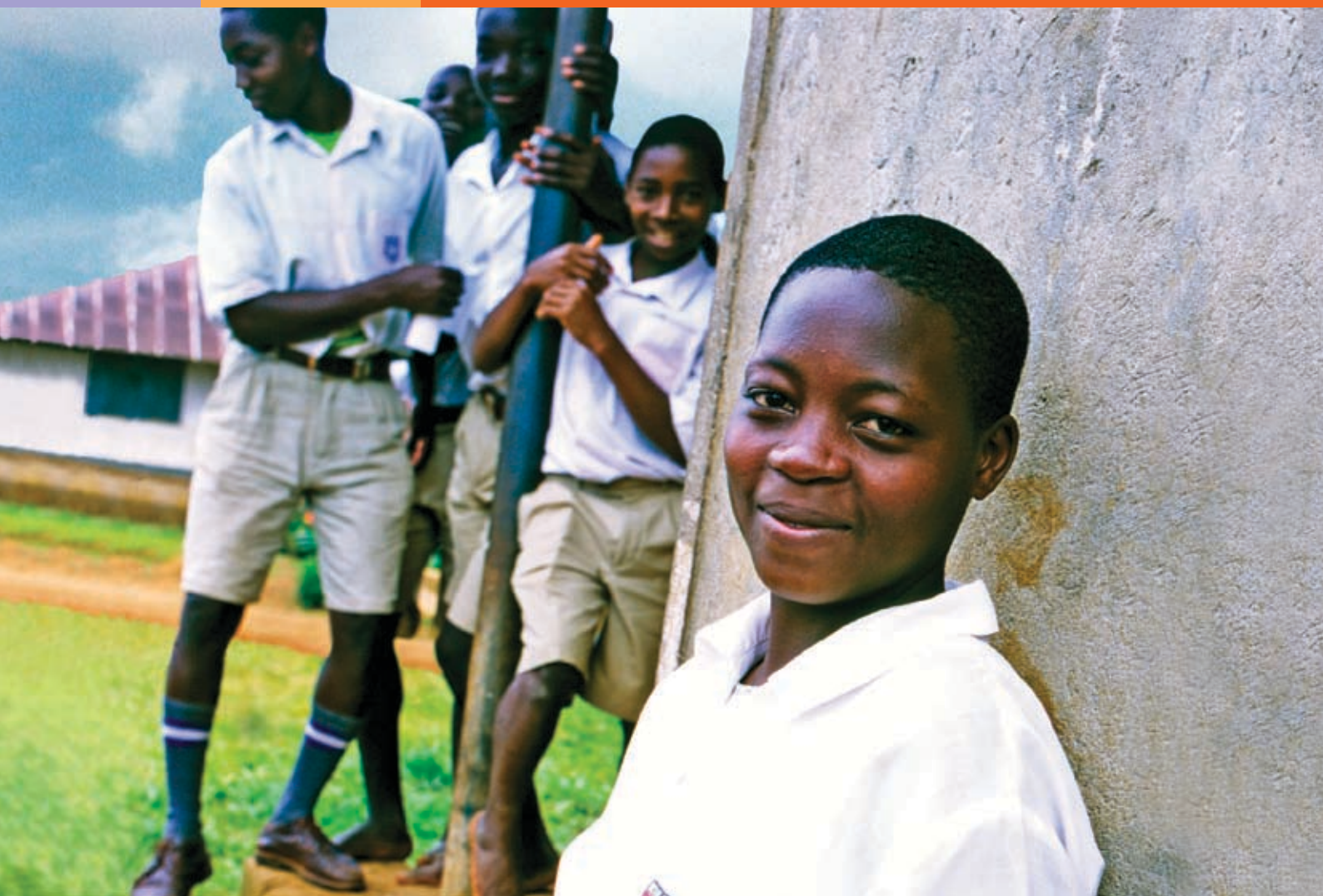
PROTECTING THE NEXT GENERATION

Protecting the Next Generation in Uganda

NEW EVIDENCE ON ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH NEEDS



Protecting the Next Generation in Uganda:

New Evidence on Adolescent Sexual and Reproductive Health Needs

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This report is part of a larger project, conducted in Burkina Faso, Ghana, Malawi and Uganda, titled Protecting the Next Generation: Understanding HIV Risk Among Youth. The project was designed to contribute to the global fight against the growing HIV/AIDS epidemic among adolescents by documenting and analyzing young people's sexual and reproductive health needs; communicating the new research findings to a broad audience to raise awareness; and stimulating the development of improved youth-serving policies and programs.

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Executive Summary

As young people grow into adolescence and young adulthood, most will become sexually active and thus be exposed to the dual risks of unintended pregnancy and sexually transmitted infections (STIs), most importantly HIV. Although Uganda's multipronged HIV prevention program—consisting of direct programmatic efforts to promote abstinence, monogamy and condom use, as well as a wide range of other strategies to fight stigma, such as outreach to religious leaders—successfully contributed to a drop in HIV prevalence in the 1990s, that decline may have reached a plateau. Key to Uganda's continued success in reducing HIV/AIDS, as well as unwanted pregnancy and unsafe abortion, is a commitment to focusing on young people, who dominate the country's population. This, however, is no simple task. Those committed to protecting the next generation of Ugandans must recognize the diversity and varying needs of adolescents. For all adolescents, one thing is certain: Any program or policy aimed at protecting the sexual and reproductive health of youth will be more successful if it reaches them at the appropriate time, in some cases before they become sexually active.

What adolescents tell us about their sexual behavior

- In Uganda, women initiate sex early: Twenty percent of women aged 20–24 and 10% of men that age have had sexual intercourse by age 15; by age 18, 64% of young women and 50% of young men have become sexually experienced.
- Twenty-three percent of females aged 15–19 have ever been in a union, and 26% have never been married but have had sex; by contrast, only 4% of males aged 15–19 have ever been in a union, and 45% have never been married but have had sex.
- Young women—who marry and become sexually active at a young age, often with older and more sexually experienced partners—have a greater risk of HIV/AIDS than their male counterparts. In fact, young women in Uganda are nine times more likely than young men to contract HIV.
- Among unmarried adolescents, sex is sporadic. A considerable proportion of 15–19-year-olds (11% of females and 17% of males) are sexually experienced, but have not had sex in the past year.
- Gifts and money are an intrinsic and pervasive part of adolescent sexual relationships. The fact that three-quarters of unmarried, sexually experienced women aged 15–19 report having received gifts or money in exchange for sex suggests that the practice may be largely part of normal dating behavior, as opposed to transactional sex.
- Forced sex, although less common than exchanging gifts or money for sex, still exists: Seven percent of sexually experienced 15–19-year-old females cite force as the main reason they first had sex.
- Young men and women who are in school are less likely than their out-of-school counterparts to have had sex, reinforcing the protective role of schools and education.

Adolescents' contraceptive use needs improvement

- Contraceptive use is fairly widespread among adolescents in Uganda: Thirty-five percent of females aged 15–19 and 55% of males that age used a method at last sex. About six in 10 sexually experienced adolescents (62% of females and 57% of males) have ever used a method.

- The most commonly used contraceptive method among Ugandan adolescents is the condom, which 15–19-year-olds use 5–10 times more than any other modern method.
- To be most effective, condoms need to be used correctly; however, only 42% of females aged 15–19 and 48% of males that age have seen a demonstration of how to put on a male condom.
- Young women are more likely than their male counterparts to report using condoms to prevent unwanted pregnancy, rather than to prevent HIV or STIs. Feeling safe with their partners and not having a condom are common reasons adolescents give for not using condoms.

Adolescents get information from a variety of sources

- Knowledge of HIV/AIDS is widespread among Ugandan adolescents: Virtually all 15–19-year-olds have heard of HIV, and nine in 10 know someone who has died of AIDS. Awareness of contraceptives is also very high: More than nine in 10 have heard of the condom and eight in 10 have heard of the pill.
- However, detailed knowledge of HIV/AIDS and pregnancy prevention remains low and misperceptions abound. Only 28% of young women and 37% of young men can name two methods of HIV prevention, such as using a condom, and reject three common misperceptions, such as believing that HIV can be transmitted by a mosquito bite. A similar proportion of adolescents know basic facts about pregnancy prevention.
- Young people obtain information about sexual and reproductive health from a variety of sources and cite teachers, health care providers and the mass media as their preferred sources.
- School is an important source of early and reliable information; however, Uganda's sex education policy is ambiguous, and the quality of available information is unknown. Only about half of sexually experienced 15–19-year-olds (49% of females and 47% of males) have ever received sex education in school.

The public health care sector can do more for adolescents

- Fourteen percent of sexually experienced women aged 15–19 who know of at least one STI and 34% of comparable adolescent men do not know where they would go for treatment; only 2% of young women and 7% of young men believe that there would be no obstacles to obtaining treatment.
- Adolescents who do know where to go overwhelmingly prefer government clinics or hospitals; however, fear, shame and embarrassment are their main reasons for not seeking contraceptive and STI care.
- Despite these obstacles, more than half of young people who have experienced an STI have sought treatment.
- Overall, youth know that clinics and drug shops provide and sell condoms, although recent reports reveal that running out of stock is a problem.
- Of 15–19-year-olds who know of HIV, 75% of females and 80% of males know of a place to get tested, primarily government clinics.

Policy implications and recommendations

The evidence clearly suggests a number of ways to build on Uganda's existing response to HIV/AIDS and the fight against unintended pregnancy and unsafe abortion.

- It is important to acknowledge that adolescence is a time when most people become sexually active and that meeting the needs of young people is integral to an effective national prevention strategy.
- Greater educational opportunities are needed, especially for young women. The low level of detailed knowledge about HIV/AIDS and pregnancy prevention shows that there is a great need for comprehensive sex education, including information on abstinence and contraceptive methods, particularly condoms. Comprehensive sex education should be taught to youth in and out of school. Pregnant adolescents should be given a chance to return to school.
- There is a need to make formal health care services more welcoming and accessible to young people. Also, young people's access to contraceptives should be improved by providing better information about methods and their availability, improving the types of methods available and making contraceptive services low cost or free.
- Special attention should be directed at the most vulnerable youth, including those not in school and young married women.
- Condom supply and the availability of counseling and testing for HIV and STIs should be scaled up. Young people should have access to screening and treatment for STIs without fear of embarrassment or judgmental attitudes from caregivers.
- Young men should be targeted to address their particular vulnerabilities, as well as behaviors that contribute to their own health risk and that of their partners.
- There is a need to systematize Uganda's existing policies aimed at helping youth. More than a dozen such national plans and laws exist—including national policies on health, youth, adolescent health, affirmative action and sexual offenses—but not enough is being done to systematically implement these policies and unify their goals. We have reached a crucial point in the history of the AIDS epidemic in Uganda, and now the future of the country is in our hands. We can and must do all we can to protect the next generation.

Chapter 1

Introduction

Young people dominate the population in Uganda today. In fact, according to a 2006 report released by the United Nations Population Division, Uganda has "the youngest population in the world."[1] In 2006, the median age of the country's estimated 30 million people was 15. Furthermore, within 10 years, Uganda's children—all 10.4 million of them—will become adolescents, while the country's 3.1 million adolescents will become young adults.

As these millions of young people grow into adolescence and young adulthood, most will become sexually active and thus exposed to unintended pregnancy and sexually transmitted infections (STIs), most importantly HIV. Providing young people with the information and services they need to protect themselves and their partners is key to the country's success in reducing HIV/AIDS, as well as unintended pregnancy and unsafe abortion. This, however, will be no simple task. Those committed to protecting the next generation of Ugandans must recognize that young people vary with respect to family structure, school status, marital status and other characteristics (Table 1.1).[2] And because adolescents are different, their sexual and reproductive health service needs and the obstacles to meeting those needs often differ. Young women—especially the 19% of 15–19-year-old women who are already married—have different needs and face different obstacles than young men; similarly, the needs and obstacles differ for orphans compared with young people living with their parents; and for those who are not in school compared with those who are. For all adolescents, however, one thing is certain: Any program or policy aimed at protecting the sexual and reproductive health of youth will be more successful if it reaches young people at the appropriate time, in some cases before they become sexually active.

After some past success, recent progress in the fight against HIV/AIDS has slowed

In Uganda and throughout the world, AIDS began as an epidemic primarily spread by adults to adults through sexual activity; however, the disease did not remain among adults for long. Children and youth soon began to contract HIV through mother-to-child transmission or through sexual contact. In 2004–2005, 3% of young Ugandan women and about 1% of their male counterparts were HIV positive.[3] In addition, a whole generation of youth was economically, emotionally and socially devastated in a very short time by the death from AIDS of many of their parents, caregivers and elders, and eventually their peers as well. More than one-quarter (28%) of 15–17-year-olds in Uganda have lost one or both of their parents to AIDS.[4] Losing a parent can have long-term consequences for young people: For example, Ugandan women aged 15–18 who have lost both parents or have lost one parent but do not live with their surviving parent are more likely than others to not attend school,[5] which in turn is associated with adverse sexual and reproductive health outcomes.[6]

In 2007, after two and a half decades of the epidemic, AIDS still has no cure. Thus, we must strive to develop more effective ways of preventing transmission of HIV. This includes rethinking the way in which we understand the sexual and reproductive health and behavior of youth. And although the problems facing Uganda include unwanted pregnancy, other STIs and sexual exploitation, HIV/AIDS remains critical. And the key to stopping the spread of HIV is changing social behavior and societal attitudes, and eliminating social stigma. HIV/AIDS is not simply a medical problem—it is a social problem as well.

Uganda's ABC (Abstain, Be faithful to a single partner and use Condoms) approach to fighting HIV/AIDS of the late 1980s and early 1990s was carried out by a broad range of governmental and nongovernmental organizations, and has been widely touted as a model for combating the epidemic. Adopted by the Ministry of Health in 1987, the ABC strategy focused on prevention among heterosexual couples through community mobilization and education. The government implemented programs designed to combat stigma and taboos associated with discussion of sexuality and to promote abstinence, monogamy and condom use as tools to protect oneself from contracting HIV.[7] Most observers agree that behavioral changes resulting from this strategy played an important role in battling the epidemic and reducing HIV infection rates in Uganda.[8–11] However, as noted above, the effort aimed to do more than change behaviors. Edward Green, a medical anthropologist at Harvard University, observes the following:

> *ABC is far from all that Uganda has done. In fact, the country pioneered approaches toward reducing stigma, bringing discussion of sexual behavior out into the open, involving HIV-infected people in public education, persuading individuals and couples to be tested and counseled, improving the status of women, involving religious organizations, enlisting traditional healers and much more.*[12]

Uganda is now in the middle of the third decade of the HIV/AIDS epidemic. HIV prevalence peaked in 1992 at an average rate of 18%,[13] and then declined steadily to 6% among men and women aged 15–49 by 2005.[3] There are signs, however, that the pace of the decline has stalled and that the infection rate might even be rising again.[14] According to the 2003 midterm review of the Uganda AIDS Commission's National Strategic Framework for HIV/AIDS:

> *The situation since about 2000 shows that the expected change in HIV prevalence has occurred only too slowly. Overall, the current HIV prevalence of 6.4% in the general population is unacceptably high. Compared with the past, no more clear declining trend in ANC HIV prevalence is being seen. Instead, a stabilization pattern is becoming more apparent.*[15]

Although causes of this "stabilization pattern" are not easy to pinpoint, evidence suggests that a shortage of condoms may be playing a role.[16] A crisis in condom supplies, which began in late 2004 with a recall of all government-manufactured Engabu condoms, has dragged on, as the government and the foreign donors on which the nation depends for medical supplies have failed to sufficiently replenish the stock. A lack of confidence in government-brand condoms since the recall coupled with U.S. funding restrictions and a drop in World Bank funding have all contributed to the condom shortage.[17]

Sex exposes adolescents to adverse outcomes other than HIV/AIDS

The impact of unintended pregnancy among youth can be every bit as tragic as that of HIV/AIDS. An unintended pregnancy may compel a young woman to obtain an abortion; however, because of legal restrictions and limited access to proper medical facilities in Uganda, these procedures are often unsafe and can result in life-threatening complications. If a young woman instead chooses to continue with the pregnancy, she still risks injury and death by putting her immature body through the rigors of childbirth. And even if she survives the risks associated with unsafe abortion or childbirth, her pregnancy may result in her dropping out of school, ending her education and limiting her chances of advancement and economic independence. Furthermore, poverty can become an unwanted inheritance of children born to young mothers, as women living in poverty are more likely to raise children in conditions of vulnerability, with less access to regular health care and education.[18]

About three in 10 young Ugandan women aged 12–19 have ever had sexual intercourse.[4(p.56)] Many of these young women desire smaller families and greater spacing between children than did women of previous generations.[19] But despite these aspirations, almost half of married women aged 15–19 who have had at least one child, and seven in 10 of their unmarried counterparts, report that they would have preferred their last birth to have occurred later or not at all.[4(p.81)] Clearly, not everyone

TABLE 1.1

Percentage distribution of 15–19-year-olds, by family structure, marital status, school attendance and orphan status, according to sex

Characteristics	Females	Males
CORESIDENCE WITH BIOLOGICAL PARENTS		
Both parents	31.8	40.6
One parent	21.6	27.7
Spouse	17.9	0.8
None of above	27.7	30.9
UNION STATUS		
Married	18.8	1.6
Not married	81.2	98.4
SCHOOLING STATUS		
In school	50.6	67.2
Not in school	49.4	32.8
ORPHAN STATUS*		
Both biological parents alive	71.3	68.7
Mother died, father alive	6.2	6.2
Father died, mother alive	15.7	17.6
Both biological parents died	6.8	7.5
Total	100.0	100.0

Note *Data only available for 15–17-year-olds.
Source Reference 2.

experiencing an unwanted or mistimed pregnancy will carry it to term. In fact, one in six pregnancies in Uganda today ends in abortion, despite legal restrictions.[20]

As will be discussed later in this report, young people lack knowledge about how pregnancy occurs. Not surprisingly, older and better educated adolescents are better able to cite ways to protect themselves from HIV and unintended pregnancy, and to reject common misconceptions about how the virus is spread and how a young woman becomes pregnant. But even the most privileged adolescents hold misconceptions about how to prevent unintended pregnancy and HIV/AIDS.

New evidence can help show the way forward

The future of Uganda's youth is the future of the country; to shape and protect the former is to shape and guarantee the latter. Arming young people with the information and skills they need to prevent unintended pregnancy and disease is a matter of simple equity for some of the more vulnerable and powerless people in an already poor and relatively difficult environment.

Protecting Ugandan youth from unintended pregnancy and HIV infection is, in fact, an issue of promoting human rights among a substantial proportion of the country's population. This report is offered as a discussion point and a resource for all who are concerned with Uganda's society, its children and its youth—now and in the future. It is aimed at policymakers, program managers, advocates and others who would like to stop the HIV/AIDS epidemic from being passed on to yet another generation with the devastating results that we unfortunately have come to know all too well.

In Uganda, there is political willingness at the highest levels to protect youth from the risks associated with sexual activity. President Yoweri Museveni has noted the potential of this age-group:

> *Young people present an opportunity for a sustained effort to reduce HIV infections and to sustain a national response to HIV/AIDS, because young people are not yet fixed in attitudes and behaviors that perpetuate vulnerability.... They therefore represent a generation that can create new and safer norms with respect to sexual practices.*[21]

The question that remains is how can this be done? Currently, Uganda's civil society, policymakers and religious leadership are engaged in an extensive debate about how to move forward; however, such key decision makers need accurate and detailed information about sexual attitudes and behavior among young people—specifically, the circumstances or environment within which adolescents are exposed to sexual activity. This report presents key findings from a new body of research describing the sexual and reproductive behaviors, attitudes and risks of 12–19-year-olds in Uganda. The research on which the report is based draws on information gathered directly from young people through in-depth interviews, focus group discussions and a nationally representative survey around issues of sex, relationships, marriage, HIV/AIDS and pregnancy among young women and men (for more details on data sources, see box on page 9).

A guide to this report

This report discusses in detail the sexual and reproductive lives of Uganda's youth, focusing on 15–19-year-olds. Chapter 2 provides an overview of the patterns of sexual behavior among adolescents. Chapter 3 explores adolescents' contraceptive use for protection from unwanted pregnancy and STIs, including HIV. Adolescents' knowledge of sexual and reproductive health—including reproduction, contraception and STIs, particularly HIV/AIDS—is examined in Chapter 4. Chapter 5 explores the variety of sources from which adolescents obtain sexual and reproductive health services, and describes the context of adolescents' lives that influences their sexual and reproductive health risk, their need for information and services, and their chances of obtaining those services. Finally, Chapter 6 suggests ways in which the deepened knowledge of young people's lives provided in this report can be used to shape policies and programs that will reduce their risk of HIV infection and unintended pregnancy.

A Note on the Conflict in the North

Because of the ongoing war in northern Uganda, this report does not have information about the actual conditions for adolescents living in that region of the country. Young people living in camps for the internally displaced have a particularly high risk of unintended pregnancy, abortion and STIs, including HIV; however, the unrest precluded researchers from conducting fieldwork for the 2004 survey in Uganda's four northern districts: Kitgum, Gulu, Pader and Lira. Interviews with young people in refugee camps conducted by a human rights group reveal that the conflict has kept many young people out of school and that the lack and distance of youth-friendly clinics is of particular concern.[1]

According to the Uganda AIDS Commission:

> *The civil conflict in Uganda has been a contributing factor to the spread of HIV in the northern region (UNAIDS, 2005). The national Sero-Behavioural Survey indicates the central northern region as being among those with the highest prevalence.*[2]

In addition, women in areas of conflict are often widowed, which increases their risk of being raped or physically abused, and forces some to resort to commercial sex work to support their children—situations that may result in unintended pregnancies.[3]

Once the war comes to a definite end and the camps are completely dispersed, it is possible that this increased prevalence of negative sexual and reproductive health outcomes in the North will spread to other parts of Uganda. In any event, it is clear—as the Uganda AIDS Commission has also stated—that specialized attention will have to be paid to internally displaced Ugandans.

Data Sources

QUANTITATIVE DATA

This report is based largely on data from two large national surveys. The first survey, the 2004 Uganda National Survey of Adolescents, was designed to investigate a wide range of issues related to sexual and reproductive health—especially the prevention of HIV infection—among adolescents aged 12–19. This nationally representative household survey was organized by the Uganda Bureau of Statistics, in collaboration with ORC Macro, Makerere Institute of Social Research and the Guttmacher Institute; it was conducted between January and July 2004. The survey used a two-stage, self-weighting, national sample design based on the frame used by the 2002 Uganda census. The first stage involved a systematic selection of 202 enumeration areas from urban and rural regions of the country with probability proportional to size. In the second stage, 38 households were systematically selected per enumeration area. During fieldwork, four districts in the Northern Region (Kitgum, Gulu, Pader and Lira) had to be dropped from the sample because of security concerns. Fourteen enumeration areas were part of the four districts dropped from the sample. Thus, the survey sample for Uganda is representative of the whole country, excluding four districts in the Northern Region. All adolescents aged 12–19 who had spent the night before the survey in the household (de facto residents) were eligible to be interviewed. A total of 5,112 adolescents aged 12–19 were interviewed (2,602 females and 2,510 males); the overall response rate among eligible adolescents was 87%. Further details about the study design and findings are available elsewhere.[1]

The second survey, the 2006 Uganda Demographic and Health Survey, was a nationally representative survey of 8,531 women aged 15–49 and 2,503 men aged 15–54. More than one-fifth of respondents (1,948 females and 582 males) were aged 15–19. The survey, which was fielded by the Uganda Bureau of Statistics, was designed to gather information on a wide range of demographic, health and nutritional issues. The data cited in this report have been published previously.[2]

QUALITATIVE DATA

This report also draws on qualitative data collected by the Guttmacher Institute and Makerere Institute of Social Research. Twelve focus group discussions with 14–19-year-olds were conducted in 2003 to explore in depth adolescents' views on sexual and reproductive health issues—including abstinence, condom use and STIs—and to determine their preferred and actual sources of sexual and reproductive health information and services. Participants were selected from both urban and rural areas, and comprised a mixture of male and female, and in-school and out-of-school adolescents. Urban focus group discussions were conducted in urban areas of Kampala and Mbarara; rural focus groups took place in the rural areas in Mbarara district. Each discussion group had 8–12 participants and lasted an average of 2–2.5 hours. The discussions were recorded, transcribed and translated from local languages into English. Results from these discussions, along with findings from similar focus groups conducted in Burkina Faso, Malawi and Ghana, have been published.[3]

In addition, 103 in-depth interviews were conducted in 2003 with male and female adolescents aged 12–19 to examine the context of and motivations behind the sexual and reproductive health behaviors of adolescents, and to explore issues that are difficult to assess in large-scale quantitative surveys that rely on closed-ended questions. Thirty-five of the interviews were conducted in Mbale district, Eastern Uganda; 34 in Mbarara district, Western Uganda; and 34 in Kampala, Central Uganda. The total includes 17 interviews with adolescents from high-risk groups: orphans, disabled youth, young people who worked or lived on the streets, and those who resided in institutions, facilities for juvenile offenders or refugee camps. The discussions were recorded, transcribed and translated from local languages into English. Further details about the methodology and findings are available elsewhere.[4]

Finally, to provide a better understanding of how adults perceive their roles and responsibilities regarding adolescent sexual and reproductive health, 60 in-depth interviews were conducted in 2005 with adults who were important in the lives of adolescents. These adults included parents, community leaders, teachers and health care providers. Results from this component of the study will be published in a forthcoming report.[5]

Chapter 2

What Adolescents Tell Us About Their Sexual Behavior

Protecting young Ugandans from HIV infection and unintended pregnancy first requires an understanding of their sexual behavior. For example, at what age do young people in Uganda begin having sexual relationships? Who are their sexual partners? Is sexual behavior different for young men than for young women? If so, in what ways and why? And why do young people become sexually active in the first place? In addition, it is essential to know not just about adolescents' sexual behavior, but also about how their attitudes and perceptions influence this behavior. Answers to these questions will help inform successful policies and programs that address the sexual and reproductive health needs of youth. And although reaching youth of all ages will be important, reaching younger adolescents—who have not yet initiated sexual activity—will be especially so (see box, page 16).

Youth want to wait until marriage, but often sex "just happens"

The vast majority of 12–19-year-olds in Uganda think that young women and men should delay sex until marriage;[4(p.59)] even among those who have already had sex, this belief remains strong. However, young people usually do not plan their first sexual experience—it just happens. When asked about the main reason for their first sexual intercourse, half of women aged 15–19 and about eight in 10 of same-aged men who had had sex said they just "felt like it."[4(p.60)] Thus, simple, straightforward desire motivates most sexual initiation. These findings have implications for programs and policies aimed at reducing premarital sex and preventing HIV and unintended pregnancy, such as the need to talk to adolescents earlier—before they have sex—and to acknowledge that the desire to become sexually active is both natural and universal.

Sexual experience is different for female and male adolescents

A gradual increase in sexual experience with age is a natural progression familiar to every culture around the world; however, in Uganda, this progression to sexual activity follows different patterns for women and men. For example, young women initiate sex earlier than their male counterparts. According to the 2006 Uganda Demographic and Health Survey (DHS), 20% of women aged 20–24 and 10% of men that age had had sexual intercourse by age 15 (Figure 2.1).[22] By their 18th birthday, 64% of women and 50% of men had had sex, and by age 20, the proportions were 85% and 74%, respectively. In addition, young women are more likely than their male counterparts to have sex within marriage: Twenty-three percent of 15–19-year-old women have ever been married or have had a cohabiting partner, whereas 26% have never been in a union but have had sex with a boyfriend or a casual acquaintance.[4(p.56)] By contrast, only 4% of adolescent men have ever been married or have had a cohabiting partner, and 45% have never been in a union but have been sexually involved with a girlfriend or casual acquaintance.

With such a dramatic difference in the proportions of young women and men who are married or cohabiting, it is clear that young Ugandan women are often involved with older men, which may lead to adverse outcomes. For example, rates of HIV infection are nine times higher among adolescent women than among adolescent men,[3(p.101)] at least in part because some married adolescent women are infected by their older husbands—who are likely to have had multiple sexual partners before the marriage.[23] Equally important, married adolescents have sex more frequently than unmarried sexually active youth. Thus, if a young woman's husband is HIV positive or has extramarital partners, she would have an elevated risk of

becoming infected. In addition, a large age difference between partners could result in an uneven power dynamic between the adolescent and her older, more experienced partner, which in turn could have serious implications for her ability to refuse intercourse or to insist on use of a condom.

Adolescent sexual relationships are unstable

Overall, fewer than half of 15–19-year-olds (47% of females and 48% of males) have ever had sex (Figure 2.2).[2] Many who have had sex have been in short-term relationships: Eleven percent of females and 17% of males aged 15–19 who are sexually experienced have not had sex in the past year. In addition, 10% of 12–19-year-old females who had sex in the past year did so only once with their last partner, and for another 27%, their last relationship lasted less than a year.[4(p.63)] Among males aged 12–19, one-time and short-lived sexual relationships are even more common, accounting for 67% of the last relationships reported by adolescent men who had sex in the past year.

Among adolescents, men are more likely than women to have multiple sexual partners. Eleven percent of sexually experienced men aged 15–19 report that they have had two or more sexual partners in the past year, compared with only 5% of sexually experienced adolescent women.[4(p.62)] This difference is partly explained by the fact that a greater proportion of adolescent women than of men have been in a union;[4(p.56)] however, it also reflects widespread sexual double standards. The Uganda AIDS Commission concludes that "it is not uncommon for 'manliness' to be equated with the number of women one has conquered."[13]

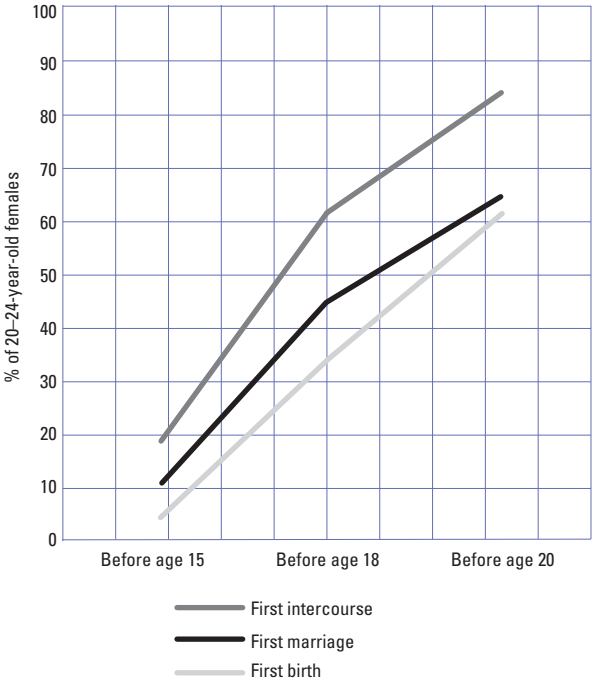
Gifts and money play a part in many sexual relationships

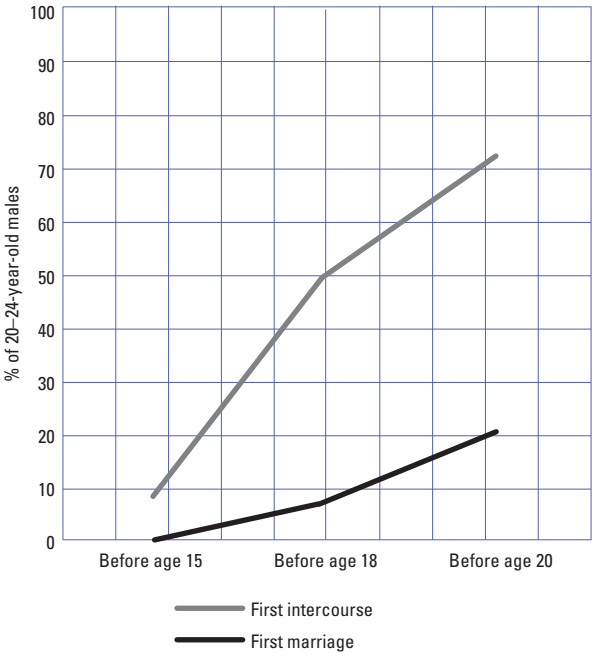
In Uganda, gifts and money tend to be an intrinsic part of many sexual relationships. Three-quarters of unmarried women aged 15–19 who have ever had sex report that they have received gifts or money from their boyfriends in exchange for sex in the past year.[4(p.63)] The proportions of young women who have accepted gifts or money for sex do not seem to vary by the women's area of residence (i.e., urban or rural), level of wealth or school attendance status.[24] Among 15–19-year-old men who have ever had sex, three in 10 have received gifts or money from their girlfriends in exchange for sex in the past year.[4(p.63)] These findings are consistent with previous research.[25,26]

The exchange of gifts and money between boyfriends and girlfriends, however, is not necessarily what Ugandans view as transactional sex—a term typically signifying a situation in which an older man gives money or gifts to a younger woman who makes it clear that she engages in sex in exchange for payment. According to qualitative research, the exchange of gifts and money has become more common among age-mates in Uganda than among

FIGURE 2.1

Sexual initiation and marriage occur earlier among females than among males.

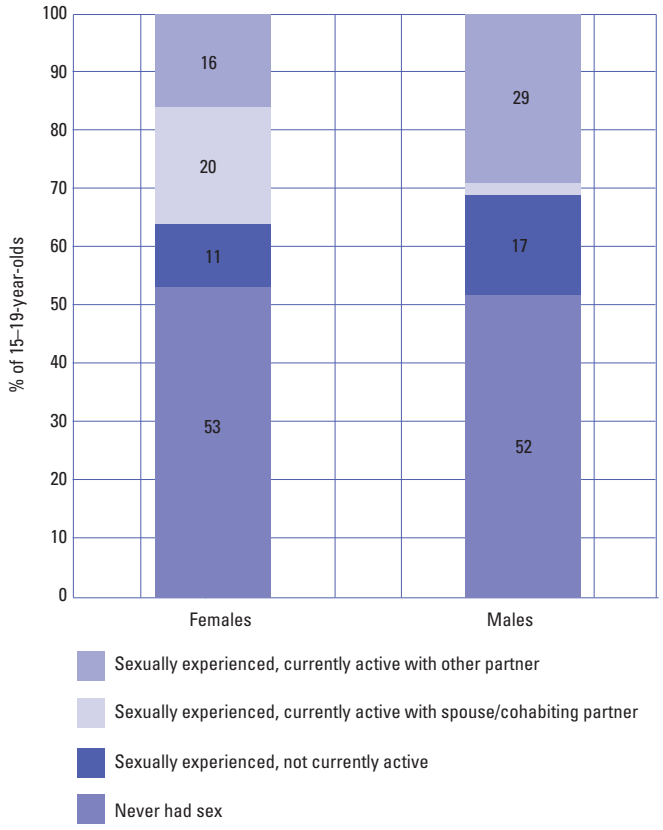




Source Reference 22.

FIGURE 2.2

Most adolescents have never had sex or are not currently sexually active.



Source Reference 2.

cross-generational couples.[27] But transactional sex, as it is traditionally defined, is also practiced. Young women exchange sex for rides in men's cars, marks in school, employment and gifts. The Ministry of Gender, Labour, and Social Development estimates that as many as 30% of 15–24-years-old females are involved in transactional relationships with men at least 10 years their senior.[28] Reports of young people having "sugar daddies" or "sugar mummies," who help pay for schooling, clothes and occasional luxuries, are familiar in most Ugandan communities.[25,29] In a focus group discussion, one young man explained:

> *If you have been financially assisted by a sugar mummy or sugar daddy, he or she makes you pay in kind.*[30]
>
> *—Male, urban, in school*

Whether sex is clearly part of the exchange or not, it can be a risky proposition for youth, as one young woman described during an in-depth interview:

> *Interviewer (I): What things do you think are risky sexual behaviors?*
>
> *Respondent (R): Getting gifts from boys; ignoring the advice of parents or any other person.*
>
> *I: Okay. How would gifts from boys be of danger? How would they be risky?*
>
> *R: It is very risky because a boy can't give you a gift without anything you could give him, which can lead you to sex.*[31]
>
> *—Female, aged 16, rural, in school*

Another young woman in a focus group discussion described similar dangers:

> *Girls, let me say they want to impress boys or attract boys, yet it will not help them because they get those boys for money. They call it "detoothing," but the end result is bad. They can get raped, or they [the boys] ask them to return the money in another way which may not help them.*[30]
>
> *—Female, urban, in school*

More research is needed to determine the extent to which the giving of gifts, clothing or money reflects traditional courting patterns in Uganda (or at least an attempt to hold on to them) or whether it is just an indication of purely transactional and intergenerational sex (i.e., sex with older men), in which a needy female partner is probably less than willing to engage in sex but, by accepting the exchange, is no longer able to independently decide if and how she needs to protect herself from infection and pregnancy by demanding condom use, for example.

Not all adolescent sex is consensual

Seven percent of sexually experienced 15–19-year-old women report that the main reason they first had sexual intercourse was that they were forced to do so.[4(p.60)] Additionally, 23% of sexually experienced females that age report that they were not at all willing participants in their first sexual experience, compared with only 3% of their male counterparts (Figure 2.3).[2] These findings are consistent with those from a study in Rakai District, in which 14% of adolescent females reported their first sexual experience had resulted from physical coercion.[32]

One young woman described her experience:

> *He deceived me to have sex with him and that is how our relationship started. 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.*[27]
>
> *—Female, aged 19, rural, out of school*

The theme of sexual coercion reemerges when adolescents are asked if they have ever been touched, kissed or grabbed in an unwanted sexual way, or whether they have ever been physically forced, hurt or threatened into having sexual intercourse. Almost half of women 15–19 say that they have experienced unwelcome fondling or touching, compared with one-fifth of same-aged men;[4(p.65)] one in four women have had intercourse because of coercion

or injury. The level of reported unwelcome sexual overtures varies very little by urban-rural residence, school attendance status or income,[24] which suggests that this kind of behavior occurs in all walks of Ugandan life.

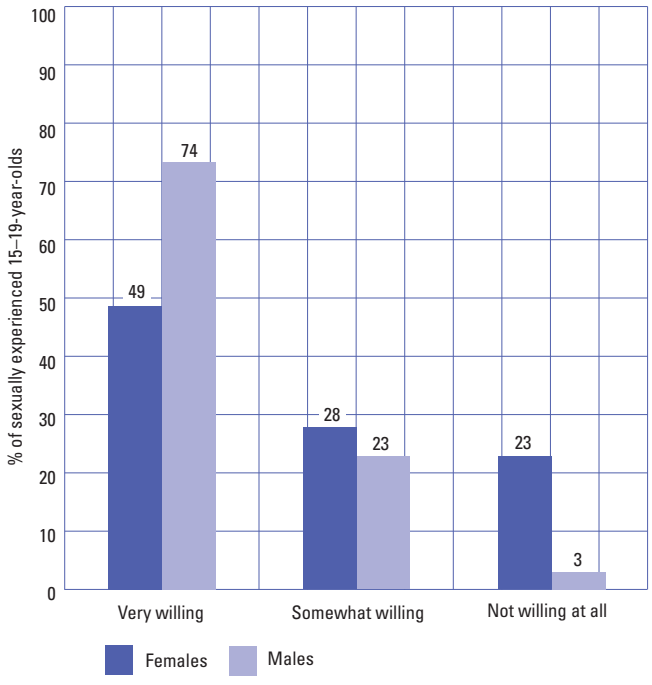
Women aged 15–19 who have experienced sexual violence report that the perpetrators were most commonly strangers (34%), although schoolmates (31%), boyfriends (29%) and acquaintances (23%) are also commonly named culprits (Figure 2.4, page 14).[2] Their male counterparts who have experienced sexual violence tend to report the same groups of perpetrators, although schoolmates and friends are the most commonly named (50%).

STIs and unintended pregnancy are all too common among adolescents

The incidence of HIV among young people is relatively low in Uganda: Three percent of women aged 15–19 and fewer than 1% of men that age are HIV positive.[3] However, the incidence of other STIs is considerably higher. According to the Uganda Adolescent Survey, 20% of sexually experienced adolescent women have ever had an STI.[4,24] And, according to Uganda's 2004–2005 Sero-Behavioral Survey, a similar proportion of 15–19-year-olds have genital herpes (herpes simplex type 2).[3(p.135)] The high rates of genital herpes and other STIs among adolescents are troubling in their own right, but are additionally worrisome because infection with another STI can facilitate the transmission of HIV: Worldwide evidence indicates that the risk of sexual transmission of HIV is substantially increased (3–5 times or more) by the presence of another STI.[33]

FIGURE 2.3

Female adolescents were more likely than their male peers to report not having been willing participants the first time they had sex.



Source Reference 2.

Pregnancy among adolescents is common. More than half (55%) of all women aged 15–19 who have ever had sex have been pregnant; however, this proportion differs by marital and school attendance status.[24] Thirty-five percent of those who are unmarried have ever been pregnant, compared with 88% of those who are married. And only 6% of young women in school have ever had a pregnancy, compared with 73% of those out of school. In addition, nearly three in 10 adolescent women in a union are currently pregnant.[4(p.81)]

Unfortunately, a large proportion of pregnancies and births among adolescent women are not welcomed. Six in 10 pregnant 15–19-year-old women in a union report that they would have preferred to be pregnant later (41%) or not at all (19%).[4(p.81)] And among women this age who have had a child, nearly half would have preferred that the birth had occurred later (23%) or not at all (22%).

Interviews with Ugandan adults reveal that parents, teachers and health care providers think unintended pregnancy among adolescents is common and problematic. One health care provider reported that more than half of mothers seeking antenatal care are between the ages of 13 and 18.[34] Many adults view unintended pregnancy as a major problem because of how it affects the lives of young people—especially young women, who may be forced to drop out of school. In fact, 10% of women aged 15–19 not currently attending school say that pregnancy was the reason they dropped out.[4(p.35)] One community leader commented:

> *Unwanted pregnancy among young girls, this happens after you have counseled them about avoiding unprotected sexual intercourse. You give them examples of girls who have persisted and finished schooling, who are living a meaningful life, but they don't pay attention.*[34]
>
> *—Female community leader, aged 54, rural*

Moreover, adults say that young men often deny responsibility when a young woman becomes pregnant, as exemplified by the comments of one urban community leader:

> *Girls are impregnated by fellow adolescents and they deny responsibility. The boys deny responsibility, and it becomes the duty of the parents to fend for both the daughter and her child when the situation is bad.*[34]
>
> *—Female community leader, aged 50, urban*

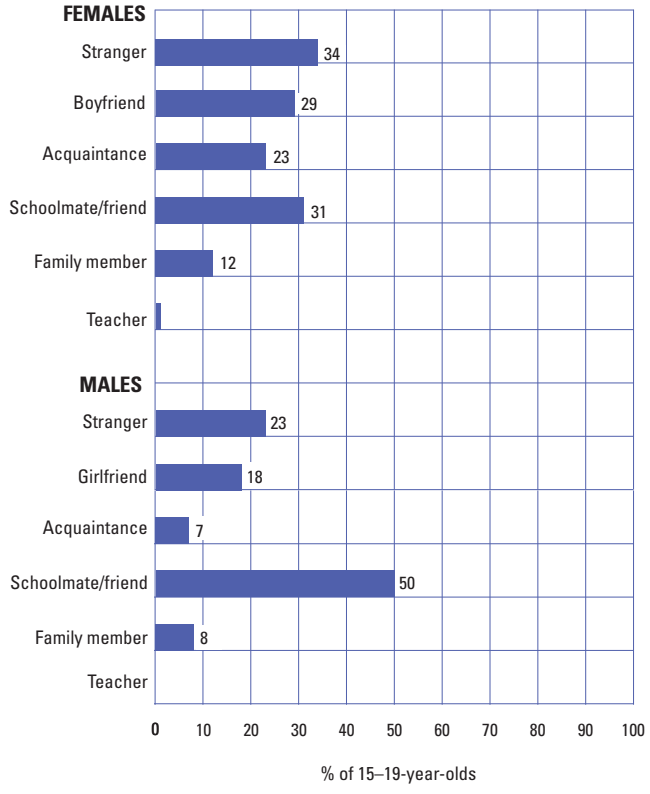
Adolescents delay sex out of fear of the consequences

Many adolescents, especially young women, have anxiety about contracting HIV. Some 80% of females and 69% of males aged 15–19 are somewhat or very worried about getting HIV and AIDS.[4(p.43)] Given that young women are more susceptible to infection, and do indeed have higher HIV rates than young men, their greater fear appears realistic. Anxiety about AIDS varies little by urban-rural residence or by poverty status, which suggests that it is a widely held fear among all adolescents.[35,36] In addition, youth are afraid of pregnancy: Two-thirds of females aged 15–19 are very or somewhat worried about becoming pregnant, and more than half (57%) of males that age are worried about getting someone pregnant.[4(p.43)]

Concerns about HIV and pregnancy loom large among 15–19-year-olds who have not had sex. Nearly three-quarters of such females report wanting to avoid HIV or other STIs (73%) and being afraid of becoming pregnant (71%) as the main reason for delaying sex (Figure 2.5);[2] 21% want to wait until marriage. More than three-fourths (77%) of males aged 15–19 report that they have not had sex because they want to avoid HIV or other STIs, whereas fewer than half (48%) say they are waiting because they do not want to get anyone pregnant. Few adolescent women or men report abstaining from sex because of their religious beliefs or because they think they are too young.[4(p.57)] About half of sexually inexperienced young women and one-third of sexually inexperienced young men say that strong pressure—mainly from parents, but also from other relatives or friends—has influenced them not to have intercourse.[4(p.57)] Among adolescents who have ever had sex but have not done so in the past year, fear of HIV or other STIs is the most common reason for recent abstention.[4(p.58)]

FIGURE 2.4

Young women and men who have experienced forced sex tend to report the same groups of perpetrators.



Source Reference 2.

Adolescents who are still in school are less likely to have had sex

The proportion of youth who are sexually inexperienced varies among different groups of adolescents. For example, all married 15–19-year-old females have had sex, compared with 64% of their unmarried counterparts.[24,37] On the other hand, 75% of adolescent women who are in school have never had sex, compared with 29% of those who are not in school. The differential is somewhat narrower among adolescent men: Fifty-eight percent of those in school have never had sex, compared with 38% of those not in school.

There seem to be bidirectional links between schooling and sexual experience for young women. Some adolescent women drop out of school because they marry, become pregnant or both. Thus, sexual activity can lead to young women's leaving school.[38] One parent explained the situation as follows:

> *When they get pregnant, they drop out of school; in the end they suffer in future.*[34]
>
> *—Male parent, aged 37, rural*

At the same time, being in school delays sexual initiation. Some young women remain abstinent so that they can continue their education without fear of pregnancy.

Poverty and orphanhood may lead youth to drop out of school. About 30% of young people aged 15–17 have lost one or both parents.[4(p.33)] A recent study found that Ugandan women aged 15–18 who have lost both of their parents or who have lost one parent but do not live with their remaining parent are significantly less likely than their nonorphaned peers to attend school.[5] As one young woman pointed out:

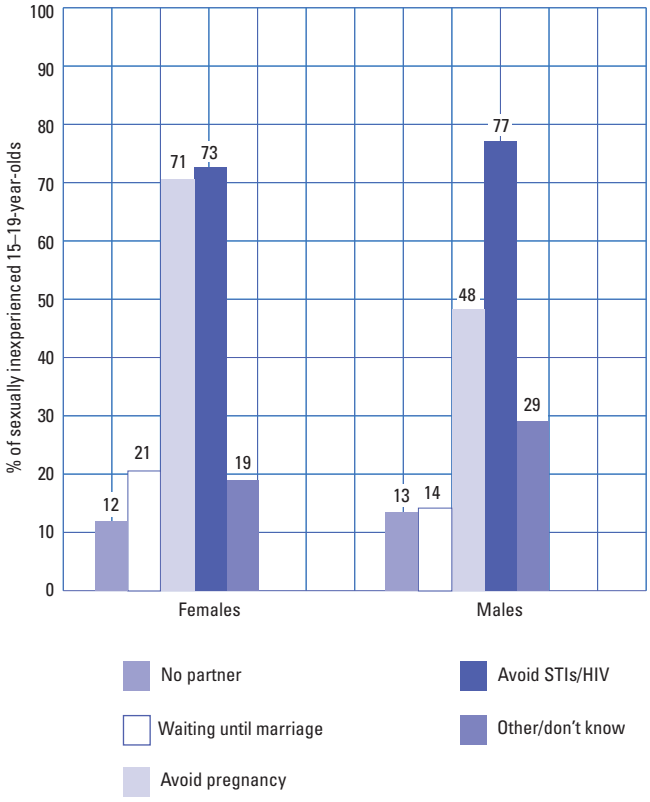
> *I don't have a mother. I don't have anyone to help me pay my school fees. My father got another women, and they mistreated me so much that I decided to leave home. Even before leaving home, my father wasn't paying my school fees.*[27]
>
> *—Female, aged 18, urban, out of school*

Similarly, a teacher stated the following:

> *Many parents are unable to enable their children to continue with education. They stop them at P.7. When a girl or boy leaves school when she or he is young, there is a possibility of being idle and engaging in sexual activi-*

FIGURE 2.5

Most adolescents who delay sexual activity do so to avoid STIs/HIV and pregnancy.



Notes Totals may exceed 100 because multiple responses are possible. Other reasons include school, religion, parents, not interested, sex is bad/shameful, fear of arrest/jail, no reason.

Source Reference 2.

ties. The girls get pregnant when they are very young....We have many dropouts who leave school because their parents are poor.[34]

—Female teacher, aged 42, rural

Sexual activity is less common among youth who have parental supervision

One-third of 15–19-year-old females live with both biological parents, 22% with one parent, 18% with their husband or cohabiting partner and the remaining 27% with neither a parent nor a husband (Table 1.1, page 7);[2] among same-aged men, 41% live with both biological parents, 28% with one parent, 1% with their wife or cohabiting partner and the remaining 31% with neither a parent nor a wife. A greater proportion of adolescents in urban areas than of those in rural areas do not live with either biological parent: Among young men, 59% in urban areas do not live with either parent, compared with 28% in rural areas; the proportions among young women are 63% and 43%, respectively.[35,36]

In Uganda, parents want to know where their children are when they go out and who they are with, especially at night; however parents and guardians appear to be much more vigilant about keeping an eye on their daughters than on their sons. Two-thirds of adolescent women say that their parents always know where they go at night, compared with fewer than half of adolescent men.[35,36] Among those not living with a parent, 74% of women aged 15–19 and 30% of men that age report that their guardians always know where they go at night. Young women who live with two parents and those whose parents always know where they are at night are less likely than others to be sexually active (Table 2.1).[2] In addition, a smaller proportion of young women who have lost one or both parents than of those with two parents have remained sexually abstinent (46% vs. 56%); by contrast, being an orphan seems not to be associated with sexual status among men.[2]

TABLE 2.1

Percentage of unmarried 15–19-year-olds who had sexual intercourse in the last 12 months, by level of parental monitoring

Parental monitoring	Females	Males
LIVING ARRANGEMENT		
Both parents/guardians	16.7	28.5
Only mother	27.9	31.6
Only father	27.2	30.3
No parents/guardians	29.3	32.2
PARENTS/GUARDIANS KNOW WHERE ADOLESCENT GOES OUT AT NIGHT		
No	44.3	49.4
Sometimes	42.4	33.1
Always	15.9	18.4
PARENTS/GUARDIANS KNOW WHAT ADOLESCENT DOES WITH FREE TIME		
No	40.3	50.0
Sometimes	38.0	33.0
Always	15.3	19.4
PARENTS/GUARDIANS KNOW WHO ADOLESCENT'S FRIENDS ARE		
No	39.2	39.3
Sometimes	31.4	31.7
Always	16.5	25.1

Source Reference 2.

Younger Adolescents Are Prime Targets for Prevention Efforts

If adolescents are the best hope for stemming the HIV epidemic in Uganda, then the younger group—those between the ages of 12 and 14—should engender the greatest optimism. In many ways, these younger adolescents resemble their older counterparts: They live predominantly in rural areas, they are of diverse religious affiliations, they are poor and many are orphans or live with only one parent.[1] However, they are different in several very significant ways. First, the majority of 12–14-year-olds have not yet reached puberty (74% of females and 68% of males).[1] Second, almost all are still in school (93% of females and 96% of males). Third, they are far more likely than their older counterparts to be closely monitored by parents or guardians. Fourth, the vast majority have never had sex (92% of females and 85% of males). And finally, none are married.

Together, these differences mean that 12–14-year-olds have very low risk of HIV infection and unintended pregnancy. In addition, the opportunities for encouraging younger adolescents to delay sexual activity and to avoid unsafe sex are greater than those for older adolescents—half of whom are already sexually active. But even though relatively few young teenagers have had sex and most are closely supervised, they are not necessarily sexually naive. In fact, four in 10 say they have a close friend who has had intercourse (Table 2.2);[2] of course, some of these close friends may be older adolescents. Even so, it is only a matter of time before younger adolescents become older and become sexually active.

YOUNGER ADOLESCENTS NEED SEX EDUCATION

To be able to protect themselves from HIV and unintended pregnancy when they become sexually active, younger adolescents must first be taught which sexual behaviors can put them at risk. Younger adolescents, however, are less likely than their older counterparts to have talked to a family member about sex: Thirty-nine percent of 12–14-year-old females and 25% of same-aged males have ever had such a discussion, compared with 52% of 15–19-year-old females and 31% of same-aged males.[3,4]

One woman in her early teens stated:

> *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."*
>
> *—Female, aged 13, rural, in school*

And although almost all younger adolescents are still in school, few have attended sex education classes: Among 12–14-year-olds, 34% of females and 22% of males have received sex education in school (Table 2.2).[2] These are discouraging findings, given President Museveni's personal interest in communicating directly with young people about HIV prevention.

Lack of sex education classes is at least part of the reason for younger adolescents' poor HIV knowledge. Only 21% of 12–14-year-old females and 17% of males that age know that HIV transmission can be reduced by having sex with only one faithful and uninfected partner, and by correct and consistent condom use; that a healthy-looking person can have HIV; and that a person cannot get HIV from mosquito bites or from sharing food with an infected person (Table 2.2).[2] However, almost nine in 10 young adolescents know at least two of the three ABC strategies for avoiding infection.

TABLE 2.2

Percentage of 12–14-year-olds who had knowledge of HIV and other STIs, percentage who had had sex and percentage who had been exposed to sex education in school, by gender

Characteristics	Females	Males
KNOWLEDGE OF ABC PREVENTION OF HIV		
Not having sex at all	88.6	88.3
Having just one partner who is not infected and who has no other partners	82.9	84.5
Using a condom correctly at every sexual intercourse	78.6	85.1
≥2 aspects of ABC	86.8	88.1
A STI other than HIV	37.5	37.7
Composite measure of HIV prevention*	20.8	16.8
SEXUAL ACTIVITY		
Has close friends who have had sexual intercourse†	41.9	42.3
Ever had sexual intercourse	7.6	14.9
Ever been physically forced, hurt or threatened into having sexual intercourse‡	9.3	4.2
EXPOSURE TO SEX EDUCATION IN SCHOOL		
Never attended school	2.1	1.5
Attended school; sex education not offered	52.0	62.3
Attended school; sex education offered but not attended	12.1	14.2
Attended school; had sex education	33.8	22.0
EVER COUNSELLED, TESTED FOR HIV AND RECEIVED RESULTS	0.5	0.2

*Correctly replied to direct questions that HIV transmission can be reduced by having sex with only one, faithful, uninfected partner, and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites and that a person cannot get HIV from sharing food with someone who is infected. †Only unmarried 12–14-year-olds were asked this question. Only one case was excluded in Uganda. ‡Question was asked of only one eligible adolescent per household, and only if no one older than three was present or within hearing range.

Notes: ABC=Abstain, Be faithful and use Condoms.

Source: Reference 2.

YOUNGER WOMEN MAY BE EASIER TO REACH THAN OLDER ONES

Sixty-three percent of 12–14-year-old females are in school and are not working, compared with 33% of their 15–19-year-old peers.[5] Such differences suggest that younger adolescent women would be easier to reach with special sexual and reproductive health information and services than their older counterparts, one-fifth of whom are married and probably limited in their ability to take time away from their domestic responsibilities. However, because of sensitivity surrounding the discussion of sex, interventions aimed at 12–14-year-old females may not be welcome in some communities.

Chapter 3

Adolescents' Contraceptive Use Needs Improvement

For two decades, Ugandans have debated how best to deal with the fact that as adolescents mature, they inevitably will become more aware of sex and most likely will engage in intercourse—at a time when sex, if unprotected, can have tragic or even lethal consequences. Yet, there is still no consensus on the way forward. The center of disagreement revolves around abstinence versus condom use. On one side, conservatives and religious leaders argue that condoms are simply an escape route for immoral behavior; on the other side, secular and progressive leaders argue that to oppose condom use is to ignore the realities of human behavior in Uganda today. Both sides of the debate have produced loud and outspoken voices that run the risk of creating a situation so polarized that there would be little chance of agreement. Nevertheless, these debates are important, as they delineate the boundaries within which these issues will be analyzed and ultimately resolved.

In Uganda, public life is dominated by religion and is greatly dependent on the input from Catholic, Protestant and Islamic leaders. Religious belief plays a large part in the way many Ugandans, including youth, form opinions—or even learn how to have an opinion in the first place. When 12–19-year-olds are asked about their religious affiliation, about four in 10 say they are Catholics; about four in 10 Protestant, Pentecostal or other Christian; and more than one in 10 Muslim.[4(p.38)] Whatever their faith, however, the vast majority (86–92%) say that religion is very important in their lives and that they attend a religious service at least once a week.

In personal interviews, most young people report that during religious sermons and discussion groups, religious leaders express strong disapproval of sexual activity outside of marriage.[27] This has implications for any intervention that appears to accept that young people have sex or that promotes anything other than abstinence as a way to protect young people from the consequences of uninformed and unprotected sexual activity.

This chapter examines contraceptive use and nonuse among sexually active adolescents to better understand the possible consequences of policies that disapprove of contraception—particularly condom use among youth—in favor of sexual abstinence until marriage.

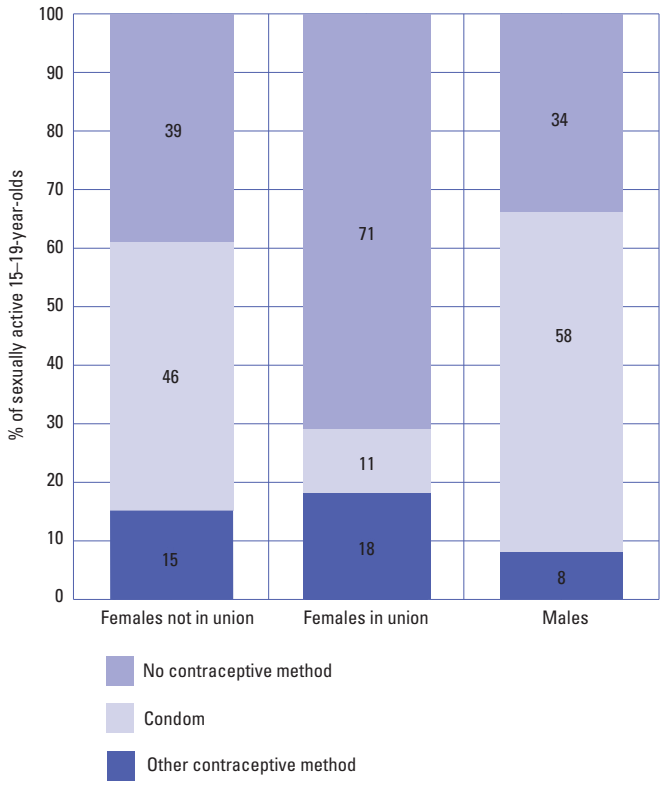
Most youth have heard of contraceptives, but use is less widespread

Adolescents in Uganda have a generally high level of awareness of contraception: Among 15–19-year-olds, 95% of women and 98% of men have heard of condoms, and 83% of women and 77% of men have heard of the pill.[4(p.70)] Unfortunately, that high level of awareness does not translate into an equally high level of use. Among 15–19-year-olds who have ever had sex, 62% of women and 57% of men have ever used a method, mostly condoms.[4(p.73)]

Two-thirds of all sexually active males aged 15–19 and 61% of same-aged sexually active females not currently in a union used any contraceptive method the last time they had sex (Figure 3.1, page 18);[2] among both groups, the condom is the most commonly used method (58% and 46%, respectively). Nearly one in five women aged 15–19, however are married or cohabiting,[4(p.32)] and only 29% of that group used a method at last sex (11% used a condom and 18% used another method). This difference in contraceptive use between adolescent women by union status reflects the fact that a greater proportion of the in-union group either want to have children or are already pregnant.[4(pp.74 & 81)]

FIGURE 3.1

Female adolescents who are in a union are less likely than their unmarried counterparts and males to have used a contraceptive method at last sex.



Source Reference 2.

Among sexually active 15–19-year-olds, contraceptives were used at last sex by greater proportions of women living in urban areas than of those in rural areas (61% vs. 31%), of women still in school than of those out of school (55% vs. 29%) and of women from the wealthiest families than of those from families of lower wealth status (55% vs. 21–30%).[24] Urban women, women in school and women of higher wealth status are less likely to be married, to be pregnant or to want to conceive.[2] Sexually active adolescent men living in urban areas were more likely than their rural counterparts to have used a method at last sex (78% vs. 51%), and men from the wealthiest families were more likely than those from families of lower wealth status to have done so (76% vs. 37–52%).[37] The longer adolescent men have been in a relationship, the more likely they are to have used a contraceptive method at last sex: Thirty-nine percent of males aged 15–19 used a method with partners with whom they had had sex only once, compared with 49% of those in a relationship of three months or less and 60% of those in a relationship of 4–6 months.[4(p.75)]

Condom use is common among adolescents

Women and men aged 15–19 tend to use condoms 5–10 times more often than other modern contraceptive methods.[4(p.73)] This is good news, in that the condom is the only contraceptive method that prevents STIs and unintended pregnancy. It is less good news in light of the fact that men, not women, control the use of this method. In fact, only 41% of 15–19-year-old women feel very confident that they could get their partners to wear a condom.[4(p.102)]

Overall, about half of sexually experienced women aged 15–19 have ever had intercourse with a man who was using a condom.[4(p.73)] Most sexually active adolescents (nine in 10 women and eight in 10 men) report having only one sexual partner in the past year (Figure 3.2).[2] Among men with one recent partner, half used a condom with that partner; among women with a single recent partner, about one-quarter were protected by condom use. Adolescent males—regardless of whether they report having one or two or more recent partners—are more likely than their female counterparts to have used condoms in the last year.

Married adolescent women are the least protected against STIs

According to the 2004 National Survey of Adolescents, 26% of sexually experienced 15–19-year-old women who had heard of STIs had had an infection or symptoms, compared with only 6% of their male counterparts.[4(p.90)] This discrepancy may in part reflect the fact that adolescent women are less likely than adolescent men to be protected by condoms during sex. Married adolescent women may have an even higher risk of STIs, including HIV, than their unmarried counterparts, given that only 8% of sexually active married women and 11% of those with a live-in partner were protected by a condom the last time they had sex, compared with half of their unmarried, sexually active counterparts.[4(p.98)]

Adolescents often use condoms incorrectly or inconsistently

Although condoms may be the contraceptive method most used by adolescents, not all young people know how to use them correctly. Seventy-seven percent of 15–19-year-old women and 84% of men that age know that a condom needs to be put on before beginning to have sex; about as many know that a condom cannot be used more than once (64% of women and 76% of men) and that a condom should only be put on the penis when it is erect (72% of women and 91% of men).[4(p.101)] However, fewer than half (42% of women and 48% of men) have seen a demonstration of how to put on a male condom. Thus, many adolescent couples who may be anxious to avoid pregnancy or STIs may not know how to do so effectively, as exemplified by the comments of one young man:

Respondent (R): We decided not to see each other during periods that were not safe, so she would not come home.

Interviewer (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.[27]

—Male, aged 16, rural, out of school

Furthermore, to be most effective, condoms must not only be used correctly, but also consistently. According to one study, 64% of sexually active males who had sex at least twice during the three months preceding the survey used a condom during that period; of those, only 56% used a condom every time they had sex.[39]

Young people give various reasons for using or not using condoms

Adolescents choose to use or not use condoms for many reasons. When 15–19-year-olds who had had sex in the past year but had not used a condom were asked why they were not using a condom, the most common reasons given by married females were that they felt safe (36%), they did not have a condom (21%) and they wanted to become pregnant (15%).[4(p.99)] Among females not in a union, the main reasons were that they did not have a condom (30%), they felt safe (25%) and their partner refused to use one (20%); among males, the major reasons were that they felt safe (40%) and they did not have a condom (31%).

In addition, some adolescents may choose not to use condoms because they equate use with mistrust within a relationship. Fifty-five percent of women aged 15–19 and 59% of men that age believe that using a condom shows lack of trust in one's partner.[4(p.102)] Similarly, some young people may believe that using a condom means that you do not love your partner. One focus group participant explained:

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.[40]

—Male, aged 18, rural, out of school

Furthermore, some young people may not have a positive attitude toward condoms. Almost four in 10 women aged 15–19 and half of same-aged men agree with the idea that condoms reduce sexual pleasure.[4(p.102)] And other adolescents distrust condoms:

[My aunt] recommends me to keep myself holy until the end because if I start to use condoms or pills, these are not safe.[27]

—Female, aged 18, rural, in school

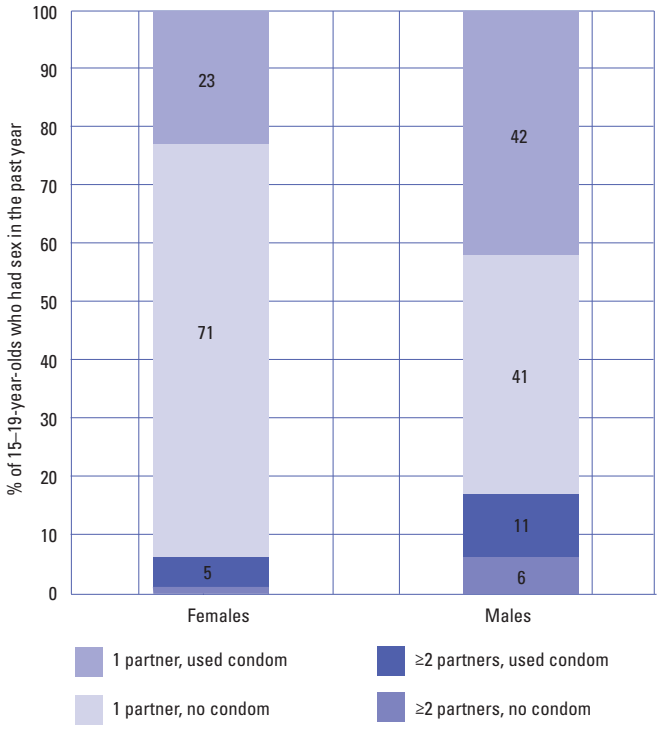
You can also get AIDS when the condom slips off and they also say that a condom is not 100% safe, that it has small holes we cannot see but the virus can pass through and you get infected, and even some condoms are expired.[27]

—Male, aged 15, urban, in school

Fortunately, some adolescents do choose to use condoms, for reasons that vary by gender. Forty-two percent of unmarried females aged 15–19 who used a condom at last sex did so only to prevent pregnancy, and a similar proportion (41%) used the method to prevent both pregnancy and STIs, including HIV (Figure 3.3, page 20).[2] Among their married counterparts, 57% used condoms at last sex for pregnancy prevention, and another 5% used the method for dual protection. However, females—whether in a union or not—were more likely than males to have used condoms for pregnancy prevention. Among males aged 15–19 who used a condom at last sex, 39% did so only to prevent pregnancy, 37% only to prevent STIs, including HIV, and 23% to prevent both outcomes.

FIGURE 3.2

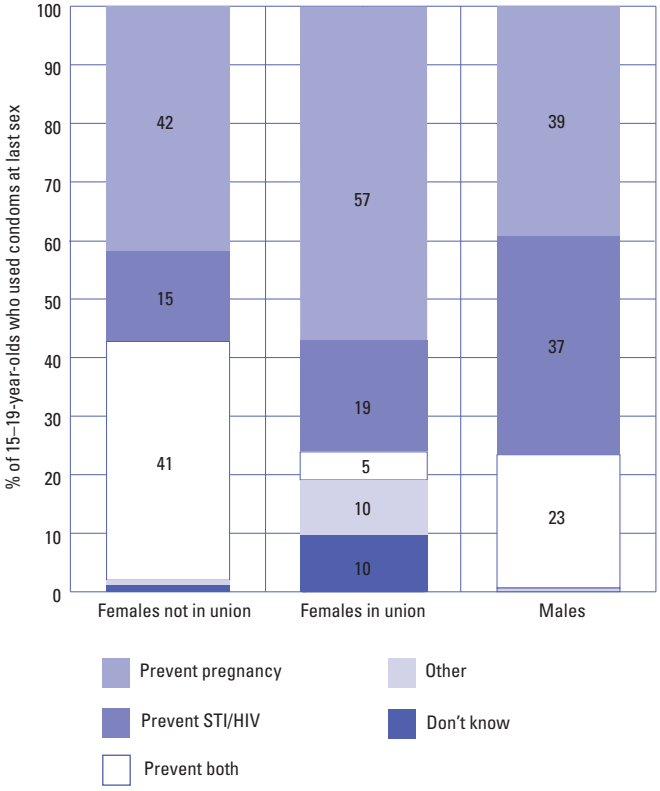
Most sexually active adolescent females had one partner in the last year, with whom they did not use a condom.



Source Reference 2.

FIGURE 3.3

Pregnancy prevention is the most common reason adolescents used condoms at last intercourse.



Note Ns are weighted.
Source Reference 2.

Excessive drinking can impede youth from protecting themselves during sex

Thirty-one percent of women aged 15–19 and 43% of men that age have tried alcohol.[4(p.42)] Most teenagers are very young when they have their first drink of alcohol—about half are younger than 15. Among adolescents who have ever consumed alcohol, one-third of females and one-half of males admit they have been drunk in the past year. Studies have shown a relationship between alcohol use and increased likelihood of being HIV positive.[41,42] Thirteen percent of 15–19-year-old women in a union said their male partners had drunk alcohol at last sex in the past year.[4(p.63)] Studies carried out in the districts of Mbale, Rukungiri and Kabale revealed that lack of sexual control due to drinking was a problem among young people.[43]

The link between excessive drinking, unprotected intercourse and the risk of HIV infection has already drawn some attention. According to a study by Asiimwe and colleagues, "Alcohol is strongly embedded in the cultural and social set-up of many communities in Uganda and is used to promote unity and togetherness. [In] focus group discussions…alcohol drinking and alcoholism were reported to be the major social factors influencing the spread of HIV/AIDS."[44] As noted by the study participants, when people consume alcohol, their judgment can be impaired, increasing their risk of unprotected sex and thus their risk of acquiring HIV/AIDS.

Chapter 4

Adolescents Get Information from a Variety of Sources

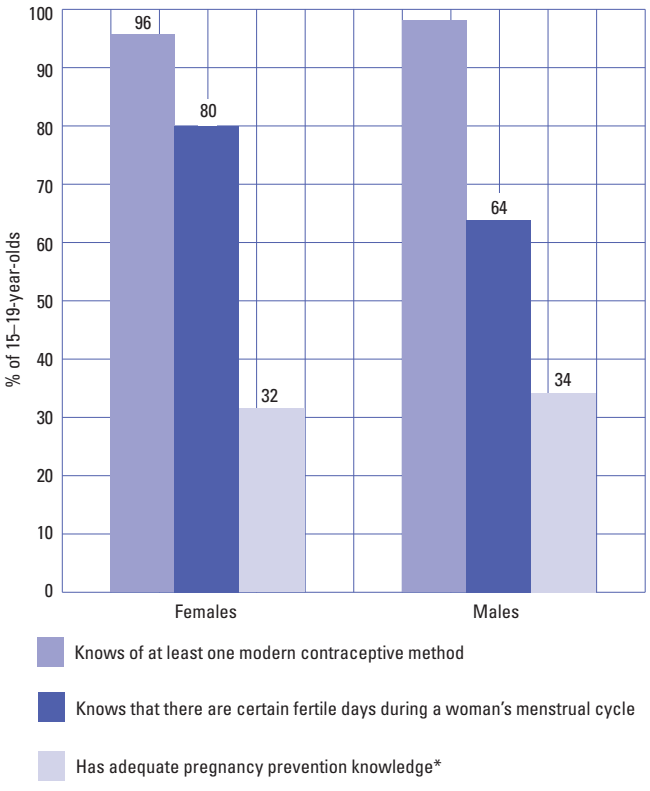
Knowledge is power, as the saying goes. And if young people are to have the power to avoid adverse sexual and reproductive health outcomes, such as HIV and unintended pregnancy, they must possess good knowledge of their bodies, of behaviors that can put them at risk and of the ways in which they can protect themselves. Therefore, adolescents must have access to reliable sexual and reproductive health information; however, although there are many sources from which adolescents can and do obtain information, not all of the information they receive is trustworthy. This chapter examines the level of Ugandan adolescents' sexual and reproductive health knowledge, the sources from which they obtain information and their perceived needs in these areas.

Lack of knowledge about contraception and reproduction is common

Almost all 15–19-year-olds (96% of females and 99% of males) know of at least one modern contraceptive method (mainly the condom, the pill or the injectable); however, fewer (80% of females and 64% of males) know that there are certain days during the menstrual cycle when a woman is more likely to get pregnant (Figure 4.1).[2] And only one-third (32% of females and 34% of males) have detailed knowledge about pregnancy prevention (i.e., they can name at least one modern method and know that there are certain days when a woman is more likely to conceive and that a woman can get pregnant the very first time she has sex or if she has sex standing up). Urban teenagers and those from the wealthiest families have the highest level of knowledge about pregnancy prevention.[45,46] Furthermore, substantial proportions of young women and men believe that a woman cannot get pregnant if her partner withdraws before ejaculating or if she washes thoroughly after sex (Table 4.1, page 22).[2]

FIGURE 4.1

Virtually all adolescents know at least one modern contraceptive method, but other knowledge is less universal.



Note *Respondent knew that there are certain days when a woman is more likely to get pregnant; that a woman can get pregnant the very first time she has sexual intercourse; that a woman can get pregnant if she has sex standing up; and knew of at least one modern method of contraception.

Source Reference 2.

Knowledge of HIV/AIDS is wide, but not deep

AIDS is very real in the consciousness of young Ugandans today. Only 1% of 15–19-year-old females and males have not heard of the disease.[4(p.88)] Moreover, most have personal experience with HIV and AIDS: Seven in 10 young women and men know someone who is infected, and nine in 10 adolescents know somebody who died of AIDS.[4(p.89)]

Overall, adolescents seem well informed about how HIV can be transmitted. More than 93% of women and men aged 15–19 know that the virus can be acquired by having sex with an infected person, by sharing razors or other sharp objects with an infected person or by receiving injections with a contaminated needle.[4(p.88)] In addition, three-quarters know that a pregnant woman who is HIV positive can transmit the virus to her child during delivery. A greater proportion of young women than of young men, however, know that infants can acquire the virus from their mothers through breastfeeding (68% vs. 57%).

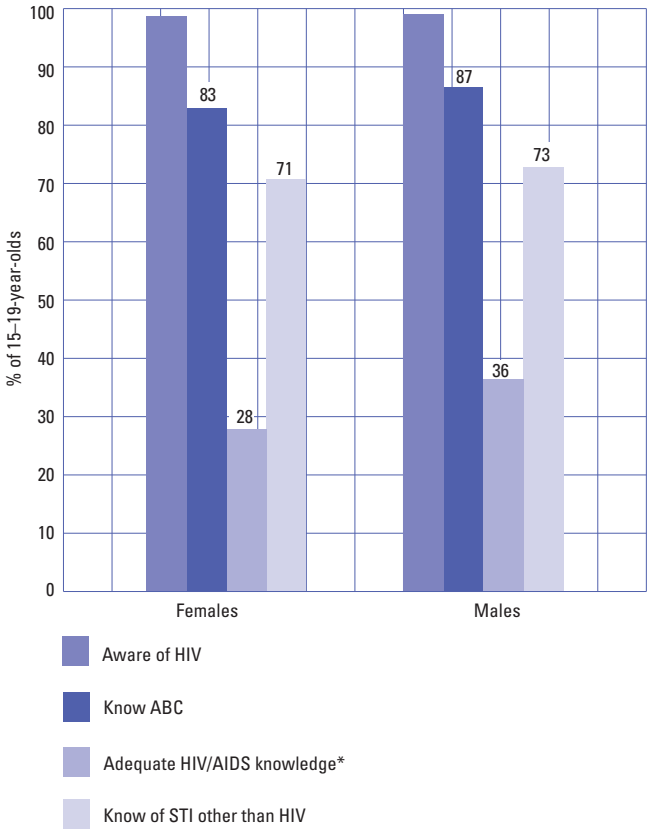
Nevertheless, many adolescents in Uganda have incorrect and potentially dangerous ideas about transmission of HIV. About four in 10 females and males aged 15–19 believe that the virus can be acquired through a mosquito bite, and 17% of females and 11% of males that age believe that it can be acquired by sharing food with an HIV-positive person.[4(p.88)] In addition, one in 10 young women believe that HIV can be transmitted through witchcraft or supernatural means. Even more alarming, one in 10 adolescent women and men believe that an HIV-positive man can be cured of AIDS by having sex with a virgin.

As a result of this uneven level of knowledge, only 28% of 15–19-year-old women who have heard of HIV/AIDS, and 36% of comparable young men, know all of the following facts about the disease: the risk of HIV transmission can be reduced by having only one, faithful, uninfected partner and by using condoms; a healthy-looking person can have HIV; and a person cannot get HIV from a mosquito bite or by sharing food with someone who is infected (Figure 4.2).[2] As with pregnancy prevention, urban teenagers and those from the wealthiest families have the highest level of HIV knowledge.[45,46]

Although nearly all youth have heard about HIV, only 71% of women aged 15–19 and 73% of their male counterparts have heard of any other STIs or their symptoms (Figure 4.2);[2] urban adolescents and those from the wealthiest families are the most likely to be able to name an STI other than HIV.[45,46] And even among those who have heard of other STIs, 16% of adolescent women and 19% of adolescent men are unable to name any possible symptoms of an STI.[4(p.90)] These findings suggest that programs and policies may be focusing their messages primarily on HIV, without informing youth enough about other STIs.

FIGURE 4.2

Virtually all adolescents have heard of HIV/AIDS, but fewer have in-depth knowledge of HIV/AIDS or know of other STIs.



Notes *Respondent knew that HIV transmission can be reduced by having sex with only one, faithful, uninfected partner and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites and that a person cannot get HIV from sharing food with someone who is infected. ABC=Abstain, Be faithful and use Condoms.

Source Reference 2.

TABLE 4.1

Percentage of 15–19-year olds, by beliefs about how pregnancy can occur

Can a woman get pregnant if:	% who answered no or don't know	
	Females	Males
It is her first intercourse	39	31
She has sex standing up	57	45
She washes thoroughly after sex	48	37
Her partner withdraws before ejaculation	76	84
She has sex half way between menstrual periods.	22	18

Source Reference 2.

Many youth do not receive sex education in school

The vast majority of 15–19-year-olds who have ever had sex have attended school (93% of females and 98% of males); however, only about half of sexually experienced adolescents (49% of females and 47% of males) have received sex education in that setting (Figure 4.3).[2] Thirty-nine percent of young women and 38% of young men attended schools that did not offer sex education; 5% of young women and 13% of young men went to schools that offered sex education but never attended such classes. The group least likely to have received sex education in school is married adolescent women (37%).[45,46]

Uganda's official position on sex education in schools remains undefined, and there is no official estimate of the number of schools in the country that provide sex education courses. When sex education is offered, it generally covers how pregnancy happens, contraception or pregnancy prevention, abstinence and STIs.[4(p.120)]

Among adolescents who have attended school, slightly more than half last attended a government-aided religious school, and about one-quarter a government-aided secular school; the remainder last attended a private school, most of which were religious.[4(p.36)] The fact that about two-thirds of adolescents attend some type of religious school suggests that implementing a uniform national sex education curriculum uninfluenced by religious concerns would be very difficult.

In March 2003, President Museveni introduced a set of teachers' manuals for distribution to all of the nation's primary schools. The manuals contained chapters on how HIV is transmitted and how to prevent infection, as well as basic information on the importance of safer sex, condom use, being faithful and getting tested for HIV. These manuals, however, were strongly criticized by conservative and religious advocacy groups in the country because of the sections on condoms and on the concept of safe sex, and at the end of 2003, they were withdrawn from circulation.[47]

Youth obtain reproductive health information from a variety of sources

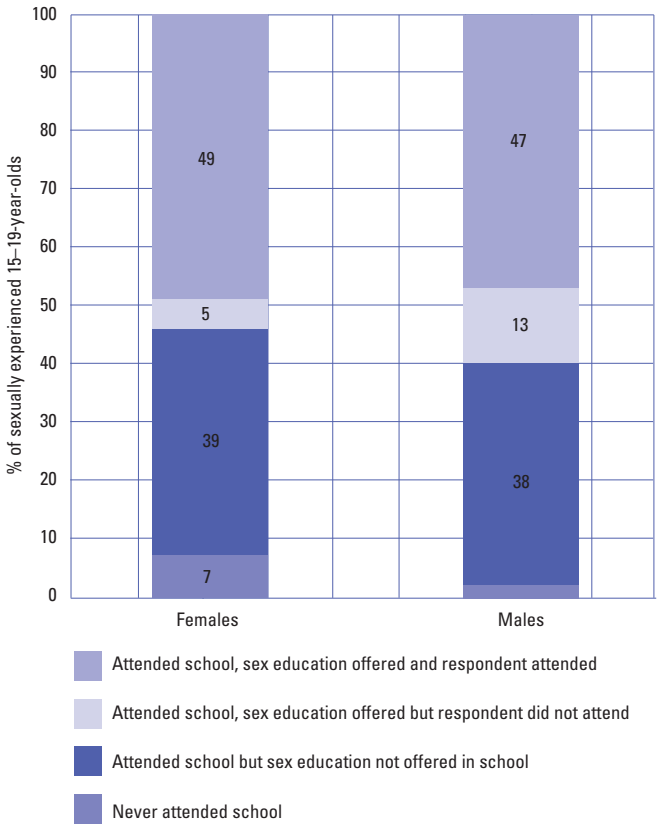
Adolescents receive information about contraception and HIV from various sources. Between one-half and two-thirds of 15–19-year-olds who know of at least one contraceptive method report that they have received information about contraceptives from the mass media, mainly radio, or from a teacher or health care provider.[4(p.122)] Young males are more likely than females to report obtaining information on contraceptives from friends (50% vs. 45%) and the mass media (66% vs. 54%), whereas females are more likely than males to get their information from family members (46% vs. 23%). Two-thirds of 15–19-year-old females who have heard of HIV/AIDS report getting information about the disease from mass media, teachers or health care providers and family members—and four in 10 mention friends.[4(p.136)] The responses are somewhat different for men aged 15–19: Nearly eight in 10 say that they get information from the mass media, and seven in 10 from teachers or health care providers; smaller proportions mention family members (36%) or friends (47%).

Adolescents rely on the mass media for much of their information

Young people in Uganda have frequent access to the mass media. High proportions of all adolescents say they have heard public information messages about family planning in the past few months.[4(p.128)] Some adolescents have read about family planning in a newspaper or magazine. Furthermore, nine in 10 of all 15–19-year-olds say they have heard the message, "Produce only children you can look after."

FIGURE 4.3

Fewer than half of sexually experienced adolescents have ever had sex education in school.



Source Reference 2.

The radio is the most common mass media outlet among youth. Almost one-half of women and two-thirds of men aged 15–19 listen to the radio almost every day; by contrast, only 8% of both sexes watch television on a daily basis.[4(p.119)] Radio listening is especially high in the capital city of Kampala, where about 50 FM stations serve an urban population of less than 1.5 million. Radio stations in Uganda often carry health information programs and talk shows giving advice about people's family and love lives, and about seven in 10 adolescents have heard radio programs broadcasting family planning messages to young people.[4(p.128)]

Specialized nongovernmental organizations have emerged to produce such material. One example is the Straight Talk Foundation, whose programs are directed specifically at keeping its target audience of adolescents aged 10–19 and young adults aged 20–24 safe from early pregnancy and STIs, including HIV. This foundation runs a broad range of information programs that give adolescents accurate information about their health and bodies, child and human rights, and HIV and other STIs, as well as information to help young people develop life skills, such as assertiveness, confidence building and decision-making.

Certain groups of youth, however, are especially hard to reach. These include adolescents who are out of school, those who cannot read and those living in remote rural areas. Some of these youth live in an information vacuum and are very disadvantaged.[40] Even so, radio programs directed at young people have obviously been key in educating youth. Findings from one study suggest that radio played a major role in disseminating HIV/AIDS information and in slowing down the epidemic during the 1990s.[48]

Youth also rely on teachers and health professionals

As noted above, substantial proportions of adolescents obtain sexual and reproductive health information from teachers. For example, two-thirds of 15–19-year-olds who know of at least one contraceptive method report obtaining information about contraception from a teacher or health care providers.[4(p.122)] One participant in the in-depth interviews recalled that she learned about the risk of AIDS from a teacher:

Interviewer (I): Has anyone ever talked with you about HIV/AIDS?

Respondent (R): Yes, at school.

I: Who talked to you?

R: The senior woman teacher is the one who told us about AIDS. She said if you do not use protection.

I: What form of protection?

R: Condoms. You risk contracting AIDS. She told us that if you find abstinence hard, then you must use protection.[27]

—Female, aged 16, urban, in school

Some young people get information from family members

Family members do not seem to play the major role in youth's sex education. Only about half (52%) of 15–19-year-old women report that any family member has ever talked to them about sex-related matters;[45] young women from the wealthiest families are slightly more likely than average to have talked to a family member about sex. Some adolescent women obtain information about contraceptives from their family; women who recall such conversations most commonly say that the family member was their mother or another female relative.[4(p.122)] When parents do talk to their children about sex, it is often to scare rather than instruct them about the consequences of sexual activity:

I: Has anyone ever talked with you about HIV/AIDS?

R: No one has ever talked to me about AIDS apart from my mother, when she warned me about not loving boys. She said they can impregnate me or give me AIDS.[27]

—Female, aged 14, urban, out of school

Only one-third (31%) of adolescent men report that any family member has ever talked to them about sex-related matters;[46] urban males and those from the wealthiest families are slightly more likely than average to have had such conversations. Furthermore, only 14% of adolescent men said their father has ever discussed any sex-related matters with them.[4(p.41)] These findings echo the general lack of communication about sex between young men and their family.[4(p.122)]

Youth prefer to receive information from formal sources

The mass media, health professionals and teachers are adolescents' preferred sources of sexual and reproductive health information (Figure 4.4).[2] Only about one-quarter of males and females aged 15–19 prefer to rely on friends for this information. There are differences by gender, however: A greater proportion of men than of women prefer to obtain information from teachers (56% vs. 43%), whereas a greater proportion of women than of men prefer to obtain information from family members (47% vs. 23%).

In in-depth interviews, adolescents expressed a preference for receiving information from doctors, nurses and clinics:

I: Are there people you feel you can go to for information about HIV/AIDS?

R: Yes.

I: Who are those?

R: The doctors and nurses.

I: Whose information do you trust about HIV/AIDS and how to prevent it?

R: The information from doctors.

I: Why?

R: They know the problems faced by that person having AIDS.[27]

—Male, aged 12, urban, in school

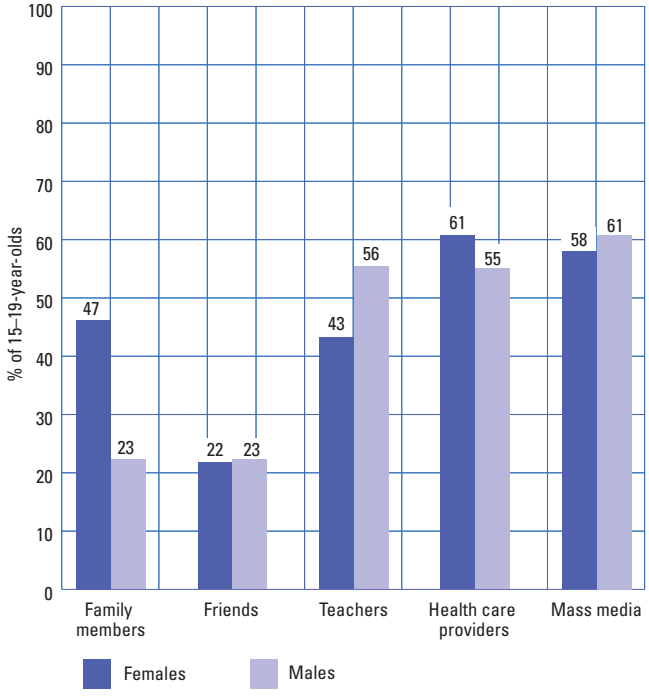
The vast majority (85–86%) of 15–19-year-olds who have attended school believe that sex education should be taught in schools.[4(p.121)] In addition, half reject the notion that teaching sex education to young people encourages them to have sex. Furthermore, most of those who have heard of HIV/AIDS (88% of women and 94% of men) believe that 12–14-year-olds should be taught how to avoid the disease; about eight in 10 adolescents go even further, saying that they believe 12–14-year-olds should be taught how to use condoms to avoid AIDS. Importantly, the findings of a recent review of 83 studies that examined the impact of curriculum-based sex and HIV education on sexual behavior of young people in countries throughout the world confirm that such education does not motivate young people to have sex earlier.[49]

What do youth want to know?

Young people continue to have many unanswered questions about HIV/AIDS and prevention of unwanted pregnancies, as exemplified by the following comments from focus group discussions:

FIGURE 4.4

Adolescents prefer to receive sexual and reproductive health information from the mass media, teachers and health care providers.



Source Reference 2.

I: What type of information do you really want about HIV/AIDS?

R1: Where did AIDS come from? How did it start affecting people? Is there hope to find its cure?

R2: I want to have information about treatment of AIDS patients.

R3: I need information that can tell me how a person who has been infected looks like, and how one can live longer with the disease.

R4: Such information like if one got AIDS, or if I am worried that I have got it, where can I go to prove?[50]

—Males, aged 13–16, urban, in and out of school

I: Is there any information that you want to know?

R: I need to know about pills, because they say when a girl misses to swallow, she gets pregnant.[27]

—Male, aged 18, urban, in school

I: Are there people you feel you can go to for talk about preventing pregnancy?

R: My teacher, because he gets it from a book.

I: What other things do you want to know about preventing pregnancy?

R: How can I use a condom.[27]

—Male, aged 17, rural, in school

To be effective, information interventions need to be shaped around the concerns and perceptions of young people themselves. Although adolescents are currently receiving information from a variety of sources, it is evident from this study that there is sometimes a difference between where these youth prefer to get their information and where they actually get it. Fortunately, young people tend to prefer more reliable sources—teachers and health care providers. Removing barriers and granting young people better access to these sources will help to equip them with the information they need to protect themselves against STIs and unintended pregnancy.

Chapter 5

The Public Health Care Sector Can Do More for Adolescents

The threats to the younger generation from HIV and unintended pregnancy begin to become clear the more that is known about adolescents' sexual behavior and knowledge; however, they become even more apparent when put in the context of the challenges young people face in accessing sexual and reproductive services. As the situation becomes clearer, better and more effective sexual and reproductive health policies and programs can be developed and implemented to help protect young people from the adverse outcomes of sexual activity. Yet, even the best and most effective programs and policies will not help adolescents if they do not know that there are sexual and reproductive health services available to help them protect themselves or if those adolescents who do know that such services exist do not use them because they do not know where to go or perceive barriers preventing their access.

Thus, it is important to understand what adolescents already know about available sexual and reproductive health services. Do young people know that such services exist and where they can be found? Do they use them? If not, why not? If so, what do adolescents think about the quality and availability of services offered, and do adolescents feel that such services are effective at addressing their problems?

Adolescents perceive barriers to accessing contraceptive services

Adolescents who are sexually active but do not want a child need contraceptive services. Although condoms are the contraceptive method most commonly used by adolescents, especially those not in a union, discussion around contraception needs to be much broader than just about condoms. It must include consideration of the full array of contraceptive options that exist to prevent unwanted pregnancy, as well as of young people's access to them.

Among sexually experienced 15–19-year-olds who know of at least one contraceptive method, only 6% of women and 12% of men perceive no barriers to obtaining a method.[4(p.123)] The most commonly perceived barriers to procuring contraceptives are fear (43% of females and 36% of males) and embarrassment or shyness (32% of females and 38% of males—Figure 5.1).[2] Rather remarkably, similar proportions of married and unmarried adolescent women report that feeling shy, embarrassed or fearful is a barrier to obtaining contraceptives.[45] This suggests that young married women perceive some pressure to begin childbearing right after marriage. In addition, they may reflect the low level of acceptance of family planning among many Ugandans, even those who are married.

Not knowing where to go to obtain contraceptives and cost are also perceived barriers frequently reported by adolescents. Fifty-eight percent of 15–19-year-old women and 63% of men that age know a source for contraceptives.[45,46] However, a greater proportion of young men than of young women cite not knowing where to get contraceptives as a barrier (28% vs. 16%—Figure 5.1).[2] This difference may be due to the fact that one in five adolescent women have started childbearing,[4(p.81)] and of those who have ever been pregnant, more than nine in 10 have received antenatal care.[51(p.11)] Thus, young women are more integrated into the health care system and are probably better acquainted with local clinics and hospitals. A greater proportion of young women than of young men, however, see cost as a deterrent to obtaining contraceptives (35% vs. 23%). Some less commonly cited obstacles to accessing contraceptive services include inconvenient hours in clinics, disrespectful treatment by health care

workers and, for women, not being allowed to go to clinics on their own and the fact that some clinics have only male health providers.

The large majority of 15–19-year-olds (78% of females and 74% of males) who know of a source for contraceptives say that they would rather go to a government health clinic or hospital than to a private health facility or a drug shop.[4(p.124)] Some 72–85% of adolescent women and 63–86% of adolescent men perceive government health facilities as offering confidentiality, accessibility, respectful treatment and affordability, although roughly half of each group thought that at least one of these characteristics was lacking in these facilities.[4(p.125)] Nevertheless, it is important to bear in mind that fewer than one in five sexually experienced adolescent women and only one in four sexually experienced adolescent men have ever obtained a contraceptive method; of those, six in 10 have gone to a government facility for their supplies.[4(p.127)]

Many of the adults interviewed about adolescent sexual and reproductive health conditions in their communities believe that the health centers in their area provide condoms, and that young people can also buy them from drug shops and pharmacies in cities and from rural trading centers.[34] Although this is true, adolescents still experience barriers to obtaining condoms. In 2005, a package of three condoms purchased in the private sector cost 330–1,000 Ugandan Shillings (less than US$1);[52] today, a package can cost 500–5,000 Ugandan Shillings (less than US$1–US$3). On the other hand, health clinics do sometimes offer condoms for free, although there is evidence that in public health facilities throughout Uganda, running out of contraceptive supplies is a widespread problem.[53,54]

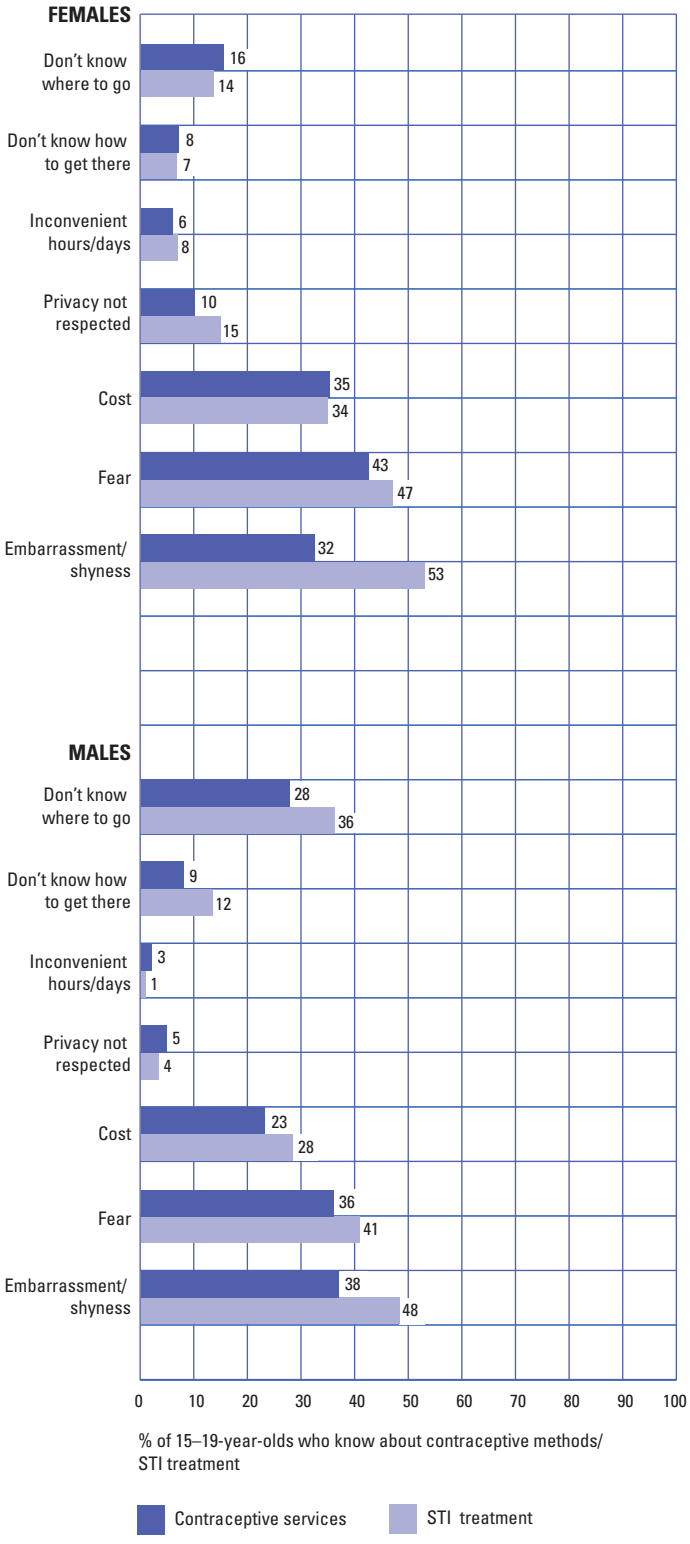
Embarrassment, shyness and fear keep many adolescents from STI treatment

Among sexually experienced 15–19-year-olds who know of at least one STI, 18% of women and 6% of men report ever having had an STI or experiencing a specific STI symptom.[4(p.90)] Fourteen percent of sexually experienced adolescent women who know of at least one STI and 34% of comparable adolescent men do not know where they would go for treatment;[4(p.131)] only 2% of young women and 7% of young men believe that there would be no obstacles to obtaining treatment.[4(p.131)] Embarrassment and shyness and fear are the barriers most commonly reported by both females and males (41–53%); a substantial proportion of adolescents (34% of females and 28% of males) cite cost as a barrier (Figure 5.1).[2] In addition, 36% of males report that not knowing where to go is an obstacle to their seeking STI services.

Perceived barriers such as cost, fear or embarrassment may discourage many adolescents from seeking treatment and may cause them instead to use home remedies to treat sexual and reproductive health-related problems.

FIGURE 5.1

Perceived barriers to contraceptive services/STI treatment among ever sexually active 15–19-year-olds who know at least one method/STI.



Source Reference 2.

Although some symptoms of bacterial infections can sometimes clear up on their own, resolution of symptoms does not necessarily mean that the infection is gone. Adolescents without symptoms may still be infected and can put their partners at risk of exposure.[27]

Among young people who know where STI services are offered, both sexes overwhelmingly prefer to go to government clinics or hospitals, because they believe these facilities are likely to provide accessible and affordable services in a respectful and confidential way.[4(pp.131 & 135)] Of the more than half of 15–19-year-olds (55% of women and 53% of men) who have ever had an STI and have gone for treatment, six in 10 went to a government clinic or hospital. Among those with an infection who did not seek treatment, eight in 10 women and seven in 10 men would prefer to go to a government clinic or hospital rather than any other facility; embarrassment and cost were by far the major reasons cited for not seeking treatment.[4(p.135)]

Assurance of confidentiality may lead young people to seek treatment from formal health care providers, as is exemplified in one adolescent's description of her experience:

> *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.*[27]
>
> *—Female, aged 15, urban, out of school*

Very few young people have been tested for HIV

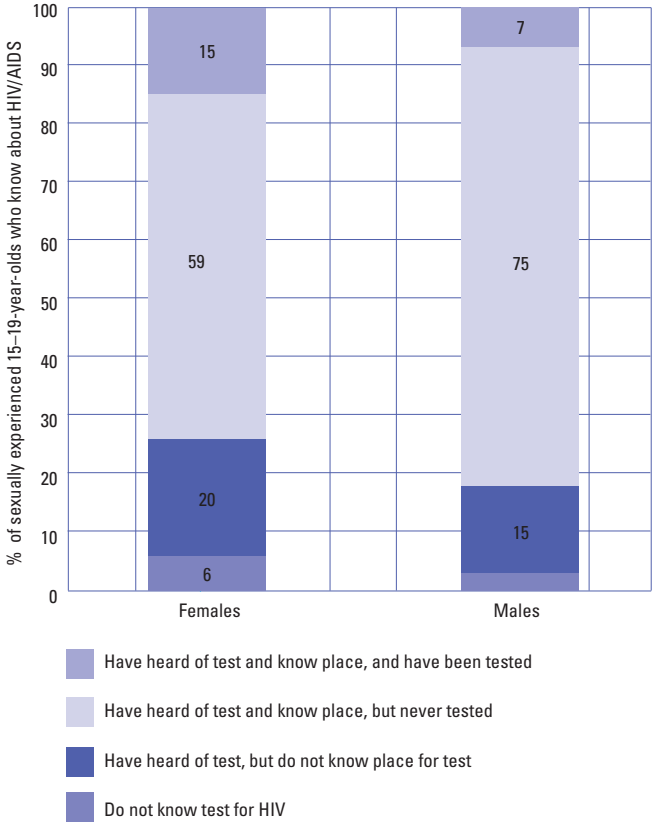
Ideally, all sexually active adolescents, whether married or unmarried, would learn their HIV status through voluntary counseling and testing (VCT) at an accredited public facility. The vast majority (93–94%) of 15–19-year-olds who know about HIV/AIDS also know that a test exists to determine whether a person is infected.[4(p.138)] And most (75% of females and 80% of males) know of a source for testing—usually a government facility. Twenty-nine percent of females and 37% of males are aware that private clinics, hospitals and doctors offer VCT, and 17% of females and 15% of males know that nongovernmental clinics do so. Young people differ in their knowledge of whether VCT costs money: About one-third believe that testing is free, one-third think that a person has to pay to get tested and one-third do not know whether the service is free or not. (In fact, VCT services are free in government-run facilities.[55])

Despite high levels of awareness of VCT and good general knowledge of the facilities likely to offer testing, only 15% of sexually experienced women aged 15–19 who know about HIV/AIDS and 7% of their male counterparts have ever been tested (Figure 5.2).[2] A greater proportion of adolescents living in urban areas (27% of females and 10% of males) than of those living in rural areas (13% of females and 7% of males) have ever been tested.[45,46] Testing also varies by adolescents' household wealth status, with the wealthiest females and males being the most likely to have been tested. It is probable that most of the young women who have been tested did so as a part of routine antenatal care; urban adolescents are more likely than those in rural areas to have received antenatal care.[2]

Most sexually experienced adolescents—59% of females aged 15–19 and 75% of males that age—know of VCT and know where to receive it, but have not been tested (Figure 5.2).[2] Thus, knowledge and access do not seem to be the most pressing problems facing young people in search of testing. In fact, the major barriers seem instead to be cost and distance. When adolescents who want to be tested for HIV are asked why they have not yet had the test, 30% of young women and 19% of young men say the major reason is that the cost is too high (Table 5.1).[2] In addition, anecdotal evidence suggests that many young people without a source of income simply cannot afford to travel to a health facility—especially if the test is offered at an inconvenient location, or if it the patient has to return to learn the results.[56]

FIGURE 5.2

Most sexually experienced adolescent have heard of HIV testing, but have not been tested themselves.



Source Reference 2.

Adolescent reproductive health services are seriously lacking

There have been a number of assessments of the availability of adolescent-friendly reproductive health programs in Uganda, and all have concluded that such programs are seriously lacking.[40,43,57] For example, according to a 1999 UNICEF-sponsored examination of the sexual and reproductive health needs of adolescents in five districts of Uganda:

> *Despite the presence of various health care programmes managed by government and NGOs in the five districts, there are no specific adolescent friendly health services (AFHS) apart from a few efforts by programmes and NGOs....Findings clearly indicate that several gaps exist in the available services that could have been utilized by adolescents for their health and development needs in the districts. Gaps in services mainly relate to service content, quality of service e.g., negative attitudes of providers, and inadequate coverage. Coordination is weak at both national and district levels.*[43]

Yet, youth tested for HIV in two clinics reported in their exit interviews that providers' knowledge and friendliness were what they liked most about the VCT service.[58] Furthermore, a 2000 evaluation of reproductive health service programs for adolescents concludes:

> *[C]overage is still limited...The programmes reach less than half of Uganda's districts. That means few adolescents are currently reached. Most projects/programmes on adolescents reviewed have targeted few districts, and if they have gone any deeper, they have reached a few selected sub-county levels. Others are based in urban areas, and the deep rural areas where the majority of adolescents who need...services live are left out....[T]he northern and northeastern part of Uganda has been scantly covered.*[57]

In general, ongoing activities seem to be fragmented and uncoordinated; coordination and sharing of information and strategies among stakeholders is still limited; most services are not friendly to adolescents in terms of services, environment, personnel and hours of service; and information, education and communication materials for adolescents have not been adequate in terms of choices, quantity and quality.[57]

TABLE 5.1

Percentage of 15–19-year-olds who want to be tested for HIV, by reasons why they have not been tested, according to gender

Reason	Females	Males
Costs too much	30	19
Not currently sexually active	21	20
Not at risk for other reasons	14	27
Don't know where to go	12	10
Don't want to know status	10	8

Source Reference 2.

Chapter 6

Policy Implications and Recommendations

Adolescents are the key to halting the spread of HIV/AIDS in Uganda, in Sub-Saharan Africa and around the world. Even though Uganda has been successful in the past in fighting the AIDS epidemic, it is the sexual and reproductive behavior of young Ugandans today that will determine the future course of the country's epidemic. Unless young people are supported in their strong desire to avoid HIV/AIDS, hundreds of thousands will join the ranks of Ugandans who are already afflicted with the disease, with long-term debilitating consequences for children, families and Uganda's productive workforce.

Unintended pregnancy is also a risk of sexual activity that has long-term consequences for Ugandan adolescents and their families. Too many young women and men who would have liked to postpone childbearing have already failed in this regard because of social values that promote marriage and childbearing at an early age, lack of other options and inadequate knowledge about or access to contraceptives. And many more adolescents will follow suit unless urgent steps are taken to help them protect themselves.

Despite overall broad levels of awareness and knowledge about HIV/AIDS and unintended pregnancy, adolescents in Uganda continue to have substantial unmet sexual and reproductive health needs. Half of all 15–19-year-olds in the country are sexually experienced. Most adolescent women who are married or living with a partner have had a child or are currently pregnant. Condom use among married adolescent women is very low, and 3% of women aged 15–19 are infected with HIV. Substantial proportions of Ugandan adolescents worry about getting AIDS or becoming pregnant unintentionally. Many youth have unanswered questions about one or both of these risks; some have not had any sex education in school; and most would prefer to get the information they need from health care professionals rather than from their friends or family, as is often the case. The future of Uganda depends on how the country responds to these needs.

Where to go from here

The findings of the Protecting the Next Generation project discussed in this report suggest that a broad, multifaceted set of initiatives is required to safeguard the future and invest in the development of Uganda's young people. Below, we suggest key measures that need to be put in place—or, where already implemented, properly supported—to ensure that young people are reached.

■ *Increase access to primary health care.* It is important to remain realistic. The provision of even basic health care remains a constant challenge for the Ugandan government and society. Currently, the government allocates 510 billion Ugandan Shillings—13.4% of the annual budget—to the health sector.[59] This is for the society as a whole, however, and does not necessarily target the needs of 12–19-year-olds, whose transition into sexual activity puts them at particular risk of STIs, including HIV, and unintended pregnancy.

The government is proposing some far-reaching reforms to the health sector, at the center of which is the National Health Insurance Scheme. This plan aims to build a fund through deductions from salaried workers' pay that would enable those covered to access health care on demand from private sector providers. There is the risk, however, that such a plan would benefit only those able to make monthly contributions, and then only in the short to medium term. Because the vast majority of Uganda's adolescents live in rural areas, in poverty and outside the formal economy,

only a small proportion of young people would likely benefit from this initiative. In addition, outreach programs tend to use the mass media, or interventions delivered in clinics and schools—all of which encounter significant barriers, such as inadequate coverage. To get information and services to the most marginalized citizens, alternative strategies are needed, including those that draw on and involve local communities.[60] The African Youth Alliance project (AYA), for example, promoted a supportive environment for adolescent sexual and reproductive health issues in several districts around the country via outreach activities targeted at religious leaders. Working with the Inter-Religious Council, AYA was able to integrate and expand youth-friendly services throughout the country at clinics supported by faith-based groups.[61]

Apart from the National Health Insurance Scheme, there are no other proposals being discussed to address the current weaknesses of the health care services at the national level. Uganda faces a choice: Invest in its health system now or spend more later to deal with the consequences of a health care crisis that could have been avoided. We do not believe that Uganda or its young people can afford to wait. According to findings highlighted in this report, young people would prefer to obtain information and services from the formal sector. We need to honor their preferences by investing in the existing infrastructure and working to make it more youth friendly. Efforts should focus on expanding access to the formal health and education sectors, as opposed to creating much more expensive, stand-alone youth clinics.

• *Systematize existing youth and health policies.* There is strong political will to help young people in Uganda help themselves and their society by remaining healthy and free of AIDS. What is more, the road toward meeting targets of "universal access" has been well mapped in United Nations documents and international commitments ratified by the Ugandan government.[13]

It is encouraging that the Ugandan government has a number of initiatives—some set forth as policies, others backed by law—to address some of young people's needs for sexual and reproductive health information and services. These include:

- Uganda's Poverty Reduction Strategy;
- The National Youth Policy;
- The National Health Policy;
- The National Adolescent Health Policy;
- The National Policy on Young People and HIV/AIDS;
- The Sexual and Reproductive Health Minimum Package for Uganda;
- The Affirmative Action Policy;
- The Sexual Offences Act, a policy setting the minimum age for sexual consent at 18;
- Universal Primary Education Policy (UPE); and
- Various laws prohibiting harmful customary practices, such as early marriage.[40]

However, some of these policies need improvement. One clear example of where improvement is needed is the Education Act, which includes a provision on Universal Primary Education, but is silent on allowing teenage mothers to return to school. A specific provision guaranteeing a young mother's right to resume her education would lift a significant barrier facing young Ugandan women.[62]

There are other areas of the law that serve as barriers to young women. Both the Constitution and Penal Code Act include language that prevents a woman younger than 18 from legally consenting to having sex. Although neither forbids contraceptive use, the implications of such laws make it difficult for young women to purchase condoms or to seek other contraceptive methods from clinics. As shown in this study, fear, shame and embarrassment—reinforced by societal stigma and restrictive policies—are the greatest obstacles standing between young people and access to the information and services they need.

Full implementation of any of these laws and policies, however, is hampered by a lack of resources. As a result, the task has often been assigned to externally funded youth programs developed by nongovernmental organizations, which are not sustainable in the long run. Although local pilot projects involved in many of these areas abound, coordination of youth services at the national level is absent. The National AIDS Commission, along with relevant government ministries, should review these often overlapping policies and the methods in place to uphold Uganda's commitment to them.

■ *Increase condom availability and counseling.* Given the high prevalence of HIV in Sub-Saharan Africa and the increasing number of young people who are infected, promoting condom use for sexually active young people remains a key part of the effort to curtail the spread of HIV. Condoms—used correctly and consistently—are the only contraceptive method that can protect sexually active young people from HIV, as well as unintended pregnancy. The Ugandan government must do everything in its power to ensure a sufficient supply of condoms to meet the demand, and it must abandon abstinence-only social marketing campaigns that do not mention condoms as a vital means of prevention. International aid should be increased, and restrictions such as the requirement that two-thirds of the U.S. President's Emergency Plan for HIV/AIDS Relief be spent on abstinence-until-marriage programs should be reevaluated to focus on scaling up access to condoms and condom use.

Exposure to a condom use demonstration is the most important determinant of knowledge of correct condom use,[39] but only one-third of 12–19-year-olds in Uganda have seen a demonstration of how to correctly put on a

Exposure to a condom use demonstration is the most important determinant of knowledge of correct condom use.

male condom.[4(p.101)] In addition, a smaller age difference between partners is associated with an increased likelihood of using the method. In Uganda, young women often have relationships with older men. Policymakers, program managers and those who provide services to adolescents should pay special attention to these findings to improve interventions aimed at increasing young people's knowledge of condoms and their ability to use the method consistently and correctly.

■ *Improve access to contraceptive methods.* In Uganda, adolescents' need for contraception is not being met. Nearly nine in 10 married 15–19-year-old women have ever been pregnant; of those, four in 10 would have preferred that the pregnancy had come at a later time or not at all.[4(p.81)] Moreover, about 13% of unmarried sexually active adolescent females have ever been pregnant, and most of these pregnancies were unwanted. Even among married adolescents who already have a child, almost one-half would have preferred becoming a mother at a later time, or not at all.

Young people are still embarrassed and fearful at the prospect of seeking contraceptive information and supplies. The reproductive health services that do exist are often out of their reach, not just financially, but also psychologically. For that reason, whatever behavioral changes young people have been able to achieve have been largely from their own efforts.

Government clinics—adolescents' preferred source of contraceptive information and supplies—need to make the full range of contraceptive methods accessible to young people. In addition to combating stigma and shame with youth-friendly services, clinics should remove cost barriers by providing free or very low cost services to adolescents.

■ *Scale up and improve sex education.* Although nearly all young Ugandans have heard of HIV and many have good knowledge of proper condom use, they often lack comprehensive knowledge of how to prevent unintended pregnancies and STIs, including HIV. As noted in Chapter 4, only about half of 15–19-year-olds in Uganda have ever received sex education in school. The fact that some young people rely on home remedies rather than seek care for STI symptoms is a real cause for concern and reveals a need for specific actions. Efforts must be made to educate young people about proper treatment of sexual health problems.

As noted in Chapter 2, younger adolescents (12–14-year-olds) are not naïve: Most have heard of sex and many have friends who are already sexually active. At the same time, their detailed knowledge of how to prevent HIV and unintended pregnancy is dangerously superficial. This combination makes a strong argument for improving sex education. To be most effective, however, this education must reach young people earlier, before they have sex. Early and comprehensive sex education will arm young people with the information they need to lead long and healthy lives, and to avoid unintended pregnancy and HIV/AIDS. Although the timing of sexual debut depends on many factors, some adolescents who are not sexually experienced delay their first sex as a means of avoiding STIs and unintended pregnancy. Adolescents who choose to abstain from sex should be encouraged to do so, until they are ready to become sexually active.

■ *Target information toward young men.* One challenge that has become apparent in this report is the gap between what young men think they know and what they need to know to prevent STIs and unintended pregnancy. Primary care services should be expanded to include sex-

ual and reproductive health information tailored for young men, including instruction on correct and consistent use of condoms, as well as on abstinence and monogamy. If properly equipped, young men can do better at protecting not only their own health, but their partners' as well.

■ *Create greater education opportunities, especially for young women.* Limited opportunities, or the perception of such, can lead young people into doing things that they would have otherwise never done, or at least postponed until they were adults. Education, by contrast, can improve young people's awareness of what choices and opportunities exist for them, as well as provide them with the skills to take advantage of those choices. At present, half of all Ugandan women marry before they are 18 years old, and one-quarter of women aged 15–19 have already had a child. According to previous research, improvements in women's education are associated with reduced rates of early marriage and early childbearing, as well as with overall reductions in family size.[63,64] Young women should be supported in their efforts to obtain an education, and women who have had to drop out of school because of a pregnancy should be given the opportunity to return and finish their education.

■ *Reduce poverty and raise living standards among the young, especially women.* Poverty and gender inequity lie at the heart of many of the adverse sexual and reproductive health outcomes faced by adolescents. For example, early marriage and transactional sex are often unacknowledged survival strategies used by young poor women with few choices because of low levels of education, poor employment prospects and generally low access to economic opportunities. However, once in such relationships, women may not have the power to refuse sex or to insist that their partners use condoms, which puts them at risk of STIs, including HIV, and unintended pregnancy. And because young women often have older partners who are more sexually experienced, their risk of STIs is even higher.[65]

Young women who know how to protect their health, who have the education and skills to earn a steady income, and who can manage their resources effectively will be naturally more protected against the risks borne of want, such as forced, coercive or transactional sex. Programs and policies are needed to tackle poverty and improve women's status in society, including reinforcing efforts to help young women to access education and stay in school.

■ *Target especially vulnerable adolescents.* Because of the AIDS epidemic and the ongoing conflict in the North, many families in Uganda have been displaced and many children have lost one or both of their parents. Orphans and adolescents in displaced families and those still living in conflict areas have especially high risk of adverse reproductive health outcomes, and thus warrant special attention.

Protecting the Next Generation is Possible

Uganda has been highly successful in bringing the spread of HIV/AIDS under some level of control, by the effective dissemination of information about the epidemic and how infection can be avoided, and by support for public openness and tolerance around the issue at the very highest levels of government. This knowledge and these attitudes have helped bring about large-scale changes in certain sexual behaviors: a reduction in the number of sexual partners among men, increases in condom use within nonmarital sexual relationships and a decision on the part of a growing number of young people to adopt sexual abstinence. And in addition to fighting HIV, these efforts have created a much more open basis for interventions that address the problem of unwanted pregnancies among adolescents.

However, the country's record in providing sex education for both in-school and out-of-school youth, and accessible and affordable youth-friendly reproductive health services has been less noteworthy. This situation should not be allowed to continue. Now it is adolescents' turn to be heard. Through this report, this highly vulnerable group has made their fears and wishes clear. They are afraid of contracting HIV and AIDS. They feel burdened by their lack of real understanding of the disease, its roots and its progression. They want better information on how to protect themselves. They want to able to go to reproductive health centers and clinics without fear of embarrassment or rejection. And many would like to know for certain whether or not they are HIV positive. We have reached a crucial point in the history of the AIDS epidemic in Uganda, and now the future of the country is in our hands. We can and must do all we can to protect the next generation.

References

1. Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2006 Revision, Highlights,* New York: United Nations, 2007.

2. Guttmacher Institute, special tabulations of the 2004 Uganda National Survey of Adolescents.

3. Ministry of Health (MOH) and ORC Macro, *Uganda HIV/AIDS Sero-Behavioral Survey 2004–2005,* Calverton, MD, USA: MOH and ORC Macro, 2006.

4. Neema S et al., Adolescent sexual and reproductive health in Uganda: results from the 2004 National Survey of Adolescents, *Occasional Report,* New York: Guttmacher Institute, 2006, No. 25.

5. Yamano T, Shimamura Y and Sserunkuumac D, Living arrangements and schooling of orphaned children and adolescents in Uganda, 2005, <http://www.fasid.or.jp/daigakuin/fa_gr/kyojyu/pdf/discussion/2005-02-007.pdf>, accessed Dec. 8, 2006.

6. Ndyanabangi B, Kipp W and Diesfeld HJ, Reproductive health behaviour among in-school and out-of-school youth in Kabarole District, Uganda, *African Journal of Reproductive Health,* 2004, 8(3):55–67.

7. Mpagi SJ, Is the ABC message still relevant in contemporary Uganda? A social-cultural and gender perspective, paper presented at The Third Session of the Uganda Think Tank on AIDS (UTTA), Kampala, Uganda, July 14, 2005.

8. Cohen SA, Beyond slogans: lessons from Uganda's experience with ABC and HIV/AIDS, *The Guttmacher Report on Public Policy,* New York: Alan Guttmacher Institute (AGI), 2003, No. 5.

9. Kirungi WL et al., Trends in antenatal HIV prevalence in urban Uganda associated with uptake of preventive sexual behaviour, *Sexually Transmitted Diseases,* 2006, 82(Suppl. 1):i36–i41.

10. Murphy EM et al., Was the "ABC" approach (abstinence, being faithful, using condoms) responsible for Uganda's decline in HIV, *PLoS Medicine,* 2006, 3(9):e379.

11. Singh S, Darroch JE and Bankole A, A, B and C in Uganda: the roles of abstinence, monogamy and condom use in HIV decline in Uganda, *Occasional Report,* New York: AGI, 2003, No. 9.

12. Green EC, ABC or A through Z 2007, Share the World's Resources, <http://www.stwr.net/content/view/107/37/>, accessed Nov. 27, 2006.

13. Uganda AIDS Commission (UAC), *Accelerating HIV Prevention in Uganda: The Road Towards Universal Access, Drivers of the HIV/AIDS Epidemic and Effectiveness of Prevention Interventions in Uganda, A Synthesis Report,* Kampala, Uganda: UAC, 2006.

14. Kaiser Family Foundation, Number of new HIV cases in Uganda increasing, AIDS commission official says, *Kaiser Network Daily HIV/AIDS Report: Global Challenges, 2007,* <http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=37396>, accessed Dec. 4, 2007.

15. UAC, Mid Term Review of the National Strategic Framework for HIV/AIDS Activities in Uganda (2000/1–2005/6), *Update* 3, 2003, <http://www.aidsuganda.org/pdf/Update_on_MTR_NSF_Nov17.pdf>, accessed Nov. 1, 2007.

16. Altman LK, U.S. blamed for condom shortage in fighting AIDS in Uganda, *New York Times International,* Aug. 25, 2005, p. A4.

17. Center for Health and Gender Equity, Ugandan condom crisis basic facts, 2005, <http://www.genderhealth.org/pubs/ugandabasicfacts.pdf>, accessed Nov. 1, 2007.

18. Fessler KB, Social outcomes of early childbearing: important considerations for the provision of clinical care, *Journal of Midwifery and Women's Health,* 2007, 48(3):178–185.

19. World Bank, 2006 World Development Indicators, 2006, <http://devdata.worldbank.org/wdi2006/contents/Section2_1.htm>, accessed Nov. 26, 2007.

20. Singh S et al., *Unintended Pregnancy and Induced Abortion in Uganda: Causes and Consequences,* New York: Guttmacher Institute, 2006.

21. UAC, Office of the President, Uganda and Uganda Ministry of Gender Labour and Social Development, *Implementing the Presidential Initiative on the AIDS Strategy for Communication to the Youth: Enhancing HIV/AIDS Awareness and Dialogue among Youth Leadership in Uganda,* Kampala, Uganda: UAC, 2003.

22. Uganda Bureau of Statistics (UBOS) and ORC Macro, *Uganda Demographic and Health Survey,* 2006, Calverton, MD, USA: UBOS and ORC Macro, 2007.

23. Berkley S et al., AIDS and HIV infection in Uganda—are more women infected than men *AIDS,* 1990, 4(12):1237–1242.

24. Appendix Table 2a.

25. Bohmer L and Kirumira EK, Socio-economic context and the sexual behavior of Ugandan out of school youth, *Culture, Health & Sexuality,* 2000, 2(3):269–285.

26. Nyanzi S, Pool R and Kinsman J, The negotiation of sexual relationship among school pupils in south-western Uganda, *AIDS Care,* 2001, 13(1):83–98.

27. Neema S, Qualitative evidence of adolescent sexual and reproductive experiences in selected districts of Uganda, *Occasional Report,* Guttmacher Institute, 2007, No. 31.

28. Rukandema T, The Uganda Cross Generational Sex Pilot: a coordinated social movement, paper presented at the Y.E.A.H. Reproductive and Sexual Health Strategy Design Workshop, Kampala, Uganda, Dec. 2005.

29. Konde-Lule JK et al., Adolescents, sexual behaviour and HIV-1 in rural Rakai district, Uganda, *AIDS,* 1997, 11(6):791–799.

30. Amuyunzu-Nyamongo M et al., Qualitative evidence on adolescents' views of sexual and reproductive health in Sub-Saharan Africa, *Occasional Report,* New York: AGI, 2005, No. 16.

31. Unpublished analysis of the 2003 in-depth interviews with adolescents conducted by the Guttmacher Institute.

32. Koenig MA et al., Coerced first intercourse and reproductive health among adolescent women in Rakai, Uganda, *International Family Planning Perspectives,* 2004, 30(4):156–163.

33. Rottingen JA, Cameron DW and Garnett GP, A systematic review of the epidemiologic interactions between classic sexually transmitted diseases and HIV: how much really is known *Sexually Transmitted Diseases,* 2001, 28(10):579–597.

34. Kibombo R et al., Views of adults on adolescents' sexual and reproductive health: qualitative evidence from Uganda, *Occasional Report,* New York: Guttmacher Institute, 2008, No. 35.

35. Appendix Table 1a.

36. Appendix Table 1b.

37. Appendix Table 2b.

38. Biddlecom AE et al., Premarital sex and schooling transitions in four Sub-Saharan African countries, paper presented at IUSSP Seminar on Sexual and Reproductive Transitions of Adolescents in Developing Countries, Cholula, Mexico, Nov. 6–9, 2006.

39. Bankole A et al., Knowledge of correct condom use and consistency of use among adolescents in four Sub-Saharan African countries, *African Journal of Reproductive Health,* 2007 (in press).

40. Neema S, Musisi N and Kibombo R, Adolescent sexual and reproductive health in Uganda: a synthesis of research evidence, *Occasional Report,* New York: AGI, 2004, No. 14.

41. Mbulaiteye SM et al., Alcohol and HIV: a study among sexually active adults in rural southwest Uganda, *International Journal of Epidemiology,* 2000, 29(5):911–915.

42. Yoder PS, Katahoire A and Kyaddondo D, *Offering Counseling and HIV Test Results at Home or in a Survey Context:* The Experience of Uganda, Calverton, MD, USA: ORC Macro, 2006.

43. Arube-Wanii J and Mpabulungi L, *A Needs Assessment for Adolescent-Friendly Health Services in Uganda: A Study of Kabale, Kiboga Mbale, Nebbi and Rukungiri Districts, Summary Report,* Kampala, Uganda: Child Health and Development Centre, Makerere University, 1999.

44. Asiimwe D, Kibombo R and Neema S, *Focus Group Discussions on Social Cultural Factors Impacting on HIV/AIDS in Uganda,* Kampala, Uganda: Makerere Institute of Social Research, 2003.

45. Appendix Table 3a.

46. Appendix Table 3b.

47. Cohen J, A tale of two presidential initiatives: changes in an HIV prevention program in Uganda, Global AIDSLink, 2007, <http://hrw.org/english/docs/2006/02/01/uganda12591_txt.htm>, accessed Sept. 28, 2006.

48. Albright KS and Kawooya D, The role of information in Uganda's reduction of HIV/AIDS: individual perceptions of HIV/AIDS information, *Information Development,* 2005, 21(2):106–112.

49. Kirby D, Laris BA and Rolleri L, *Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics,* Scotts Valley, CA, USA: ETR Associates, 2006.

50. Unpublished analysis of the 2003 focus groups with adolescents conducted by the Guttmacher Institute.

51. Reynolds HW, Wong EL and Tucker H, Adolescents' use of maternal and child health services in developing countries, *International Family Planning Perspectives,* 2006, 32(1):6–16.

52. Health Global Access Project, 10 months and counting: the condom crisis in Uganda, 2005, <http://www.healthgap.org/press_releases/05/082905_HGAP_Uganda_call_transcript.html>, accessed Dec. 8, 2006.

53. Uganda Debt Network, The Poverty Reduction Strategy Papers (PRSP) and Resource Allocation to the Health Sector in Uganda, *Discussion Paper,* 2004, No. 7.

54. Katende C et al., *Uganda Delivery of Improved Services for Health (DISH) Evaluation Surveys 1999,* Chapel Hill, NC, USA: Carolina Population Center, University of North Carolina at Chapel Hill, 1999.

55. Uganda Ministry of Health, Uganda National Policy Guidelines for HIV Voluntary Counselling and Testing, 2003, <http://www.aidsuganda.org/pdf/Final_VCT_Policy.pdf>, accessed Aug. 28, 2007.

56. Boswell D and Baggaley R, *Voluntary Counseling and Testing and Young People: A Summary Overview,* Arlington, VA, USA: Family Health International, 2002.

57. Neema S and Bataringaya D, Adolescent sexual and reproductive health in Uganda: a documents review, unpublished report, Kampala, Uganda: Makerere Institute of Social Science Research, 2000.

58. McCauley AP, Equitable access to HIV counseling and testing for youth in developing countries: a review of current practice, *Horizons Report,* Washington, DC: Population Council, 2004.

59. Suruma E, Budget speech financial year 2005–2006, delivered at the meeting of the fifth session of the seventh parliament of Uganda, Kampala, Uganda, Jun. 8, 2005.

60. Rani M and Lule E, Exploring the socioeconomic dimension of adolescent reproductive health: a multicountry analysis, *International Family Planning Perspectives,* 2004, 30(3):110–117.

61. African Youth Alliance (AYA), *Improving Health, Improving Lives: The End of Programme Report of the African Youth Alliance,* New York: AYA, 2007.

62. AYA, *Review of Laws, Policies, Strategies & Guidelines Relevant to ASRH & HIV/AIDS,* Uganda: AYA, 2001.

63. Castro Martin T and Juarez F, The impact of women's education on fertility in Latin America: searching for explanations, *International Family Planning Perspectives,* 1995, 21(2):52–57, 80.

64. Singh S and Samara R, Early marriage among women in developing countries, *International Family Planning Perspectives,* 1996, 22(4):148–157, 175.

65. World Health Organization (WHO), Protecting Young People from HIV and AIDS: The Role of Health Services, 2004, <http://www.who.int/child-adolescent-health/New_Publications/ADH/ISBN_92_4_159247_8.pdf>, accessed Dec. 5, 2007.

Box: A Note on the Conflict in the North

1. Robinson JP and Young J, *Listening to Youth: The Experience of Young People in Northern Uganda (Summary Report),* Women's Commission for Refugee Women and Children, 2007, <http://www.womenscommission.org/pdf/ug_machel_short.pdf>, accessed Nov. 26, 2007.

2. Uganda AIDS Commission (UAC), *Accelerating HIV Prevention in Uganda: The Road Towards Universal Access, Drivers of the HIV/AIDS Epidemic and Effectiveness of Prevention Interventions in Uganda, A Synthesis Report,* Kampala, Uganda: UAC, 2006.

3. Singh S et al., The incidence of induced abortion in Uganda, *International Family Planning Perspectives,* 2005, 31(4):183–191.

Box: Data Sources

1. Neema S et al., Adolescent sexual and reproductive health in Uganda: results from the 2004 National Survey of Adolescents, *Occasional Report,* New York: Guttmacher Institute, 2006, No. 25.

2. Uganda Bureau of Statistics and ORC Macro, *Uganda Demographic and Health Survey, 2000-2001,* Calverton, MD, USA: ORC Macro, 2001.

3. Amuyunzu-Nyamongo M et al., Qualitative evidence on adolescents' views of sexual and reproductive health in Sub-Saharan Africa, *Occasional Report,* New York: AGI, 2005, No. 16.

4. Singh S, Darroch JE and Bankole A, A, B and C in Uganda: the roles of abstinence, monogamy and condom use in HIV decline in Uganda, *Occasional Report,* New York: AGI, 2003, No. 9.

5. Kibombo R. et al., *Views of Adults on Adolescents' Sexual and Reproductive Health: Qualitative Evidence from Uganda, Occasional Report,* New York: Guttmacher Institute, 2008, No. 35.

Box: Younger Adolescents Are Prime Targets For Prevention Efforts

1. Neema S et al., Adolescent sexual and reproductive health in Uganda: results from the 2004 National Survey of Adolescents, *Occasional Report,* New York: Guttmacher Institute, 2006, No. 25.

2. Guttmacher Institute, special tabulations of the 2004 Uganda National Survey of Adolescents.

3. Appendix Table 3a.

4. Appendix Table 3b.

5. Appendix Table 1a.

APPENDIX TABLE 1A	Selected social and demographic characteristics of 12–19-year-old females, by age-group, Uganda, 2004						
Characteristic	All		% distribution by residence with biological parents				% whose parents/ guardians always know where they are at night*
	N	% distribution (weighted)	Both	Mother	Father	Neither	
FEMALES AGED 12–19	**2,602**	**100.0**	**39.8**	**15.1**	**7.5**	**37.7**	**75.3**
RESIDENCE							
Rural	2,298	88.2	42.8	15.1	7.4	34.7	75.8
Urban	304	11.8	17.4	14.5	7.9	60.2	71.9
ATTENDING SCHOOL							
No	744	28.4	23.0	13.1	3.8	60.1	62.2
Yes	1,858	71.6	46.5	15.9	8.9	28.7	80.5
UNION STATUS							
Not in union	2,354	90.5	43.7	16.4	8.2	31.7	77.2
In union	241	9.5	0.8	2.9	0.0	96.3	57.1
HOUSEHOLD WEALTH							
Lowest quintile	511	19.7	49.4	19.1	5.3	26.2	78.9
Middle quintiles	1,531	58.6	42.8	15.3	7.6	34.3	74.6
Highest quintile	558	21.7	22.9	10.9	9.1	57.1	73.9
FEMALES AGED 12–14	**1,282**	**100.0**	**46.9**	**15.9**	**7.6**	**29.6**	**82.6**
RESIDENCE							
Rural	1,168	91.0	49.4	16.0	7.5	27.1	82.7
Urban	114	9.0	21.7	14.8	8.7	54.8	80.9
ATTENDING SCHOOL							
No	91	6.9	47.2	10.1	4.5	38.2	71.6
Yes	1,191	93.1	46.9	16.3	7.9	28.9	83.4
HOUSEHOLD WEALTH							
Lowest quintile	288	22.4	52.4	17.4	6.3	24.0	85.4
Middle quintiles	761	59.1	50.7	15.9	7.9	25.4	81.7
Highest quintile	233	18.4	27.8	13.7	8.5	50.0	82.2
FEMALES 15–19	**1,320**	**100.0**	**32.8**	**14.3**	**7.3**	**45.6**	**68.3**
RESIDENCE							
Rural	1,130	85.4	35.8	14.3	7.2	42.6	68.7
Urban	190	14.6	14.8	14.3	7.4	63.5	66.5
ATTENDING SCHOOL							
No	653	49.4	19.7	13.5	3.7	63.2	61.1
Yes	667	50.6	45.6	15.1	10.7	28.5	75.5
UNION STATUS							
Not in union	1,075	81.3	40.0	17.0	9.0	34.1	70.9
In union	241	18.7	0.8	2.9	0.0	96.3	57.1
HOUSEHOLD WEALTH							
Lowest quintile	223	17.0	45.2	21.3	4.5	29.0	70.9
Middle quintiles	770	58.1	35.0	14.6	7.2	43.2	67.6
Highest quintile	325	24.9	19.1	8.9	9.5	62.5	68.0

*For married adolescents, the question refers to parental knowledge before respondent got married.

	% who attend religious services ≥weekly	% distribution by school and work status				% who have worked or done something for money in the past year	% who are very worried about:	
		In school, working	In school, not working	Not in school, working	Not in school, not working		Getting pregnant	Getting HIV/AIDS
	91.7	**23.8**	**47.8**	**14.6**	**13.8**	**32.4**	**52.7**	**68.6**
	92.0	25.9	46.6	15.1	12.5	33.8	52.6	69.2
	89.6	7.9	57.0	11.1	23.9	21.8	52.9	64.2
	88.3	0.0	0.0	51.4	48.6	47.0	48.8	72.0
	93.1	33.2	66.8	0.0	0.0	26.6	54.2	67.3
	91.9	26.2	52.7	10.1	11.0	30.8	54.0	67.8
	89.4	0.4	0.4	58.4	40.8	48.2	38.6	75.6
	92.8	28.0	46.4	14.1	11.5	34.8	53.4	69.1
	91.7	26.2	45.8	16.1	11.9	34.5	50.3	66.8
	91.0	13.5	54.2	11.2	21.1	24.5	58.5	73.0
	92.2	**30.4**	**62.7**	**2.2**	**4.7**	**25.1**	**51.3**	**65.2**
	92.6	32.5	61.0	2.0	4.5	25.9	51.1	65.4
	87.8	8.8	80.7	4.4	6.1	15.7	53.0	64.3
	79.8	0.0	0.0	31.8	68.2	29.5	54.5	68.2
	93.1	32.6	67.4	0.0	0.0	24.7	51.0	65.0
	92.4	32.3	58.3	3.5	5.9	28.5	52.8	65.7
	92.1	33.2	61.2	1.6	3.9	25.9	48.9	63.0
	92.4	19.1	72.5	3.0	5.5	18.2	57.2	71.3
	91.3	**17.3**	**33.2**	**26.8**	**22.7**	**39.5**	**54.0**	**71.9**
	91.4	19.0	31.6	28.7	20.8	42.0	54.2	73.2
	90.6	7.3	42.9	15.2	34.6	25.1	52.9	64.4
	89.4	0.0	0.0	54.1	45.9	49.4	48.0	72.5
	93.1	34.3	65.7	0.0	0.0	29.9	59.8	71.3
	91.6	21.1	40.8	19.6	18.5	37.7	57.4	70.9
	89.4	0.4	0.4	58.4	40.8	48.2	38.6	75.6
	93.3	22.3	30.8	28.1	18.8	43.3	54.3	73.5
	91.3	19.2	30.3	30.7	19.8	43.0	51.6	70.6
	89.9	9.5	41.3	16.8	32.4	29.0	59.6	74.3

APPENDIX TABLE 1B	Selected social and demographic characteristics of 12–19-year-old males, by age-group, Uganda, 2004						
Characteristic	All		% distribution by residence with biological parents				% whose parents/ guardians always know where they are at night*
	N	% distribution (weighted)	Both	Mother	Father	Neither	
MALES AGED 12–19	**2,510**	**100.0**	**43.9**	**17.9**	**10.1**	**28.1**	**57.2**
RESIDENCE							
Rural	2,269	90.3	46.2	17.6	9.9	26.3	57.2
Urban	241	9.7	22.6	21.0	11.5	44.9	56.4
ATTENDING SCHOOL							
No	487	19.1	35.5	17.6	8.0	38.9	36.2
Yes	2,023	80.9	45.9	17.9	10.6	25.5	62.1
HOUSEHOLD WEALTH							
Lowest quintile	509	20.6	49.3	23.7	8.3	18.6	59.5
Middle quintiles	1,543	61.4	47.8	15.9	9.7	26.6	55.3
Highest quintile	449	18.0	25.3	18.0	13.8	42.9	60.7
MALES AGED 12–14	**1,198**	**100.0**	**47.4**	**18.0**	**10.4**	**24.2**	**70.4**
RESIDENCE							
Rural	1,100	91.9	49.1	16.7	10.0	24.1	70.2
Urban	98	8.1	28.6	32.7	14.3	24.5	72.4
ATTENDING SCHOOL							
No	53	4.3	38.5	17.3	11.5	32.7	62.7
Yes	1,145	95.7	47.8	18.1	10.3	23.8	70.7
HOUSEHOLD WEALTH							
Lowest quintile	275	23.3	53.2	21.1	7.1	18.6	69.3
Middle quintiles	726	60.8	50.3	15.5	9.7	24.4	69.1
Highest quintile	192	15.9	28.8	23.6	17.8	29.8	76.0
MALES AGED 15–19	**1,312**	**100.0**	**40.6**	**17.8**	**9.9**	**31.7**	**44.9**
RESIDENCE							
Rural	1,169	88.9	43.4	18.4	9.9	28.3	44.8
Urban	143	11.1	18.8	12.5	9.7	59.0	45.5
ATTENDING SCHOOL							
No	434	32.8	35.1	17.9	7.5	39.5	33.0
Yes	878	67.2	43.4	17.7	11.0	27.9	50.7
HOUSEHOLD WEALTH							
Lowest quintile	234	18.1	44.4	26.9	9.8	18.8	48.1
Middle quintiles	817	62.0	45.5	16.3	9.6	28.6	42.7
Highest quintile	257	19.9	22.9	14.0	10.9	52.3	49.2

*For married adolescents, the question refers to parental knowledge before respondent got married.

	% who attend religious services ≥weekly	% distribution by school and work status				% who have worked or done something for money in the past year	% who are very worried about:	
		In school, working	In school, not working	Not in school, working	Not in school, not working		Getting someone pregnant	Getting HIV/AIDS
	88.0	**45.8**	**35.2**	**15.2**	**3.8**	**52.9**	**35.1**	**51.4**
	87.6	48.9	32.1	15.4	3.6	53.8	34.5	50.8
	91.8	16.9	63.4	13.6	6.2	44.4	40.7	57.0
	81.4	0.0	0.0	79.9	20.1	73.7	37.4	55.3
	89.6	56.6	43.4	0.0	0.0	48.0	34.6	50.5
	85.9	50.9	30.9	13.0	5.2	55.5	32.0	47.6
	88.5	49.3	31.1	16.3	3.3	54.7	34.8	50.6
	88.9	28.6	53.4	14.2	3.8	44.1	40.1	58.1
	88.7	**51.0**	**44.7**	**2.7**	**1.5**	**43.1**	**31.3**	**47.1**
	88.4	53.8	41.8	2.9	1.5	44.2	31.1	47.1
	91.8	20.2	77.8	1.0	1.0	30.6	33.7	48.0
	73.1	0.0	0.0	64.7	35.3	57.7	30.8	44.2
	89.4	53.3	46.7	0.0	0.0	42.4	31.4	47.3
	84.3	54.4	39.9	3.6	2.1	47.9	27.8	41.4
	89.3	55.7	40.4	2.2	1.6	44.8	32.4	48.1
	92.2	28.6	67.7	3.1	0.5	29.7	33.3	51.6
	87.4	**41.0**	**26.2**	**26.8**	**6.0**	**62.1**	**38.6**	**55.3**
	86.9	44.3	22.9	27.4	5.5	63.2	37.7	54.4
	91.7	14.6	53.5	22.2	9.7	53.8	45.8	63.2
	82.4	0.0	0.0	81.7	18.3	75.6	38.2	56.7
	89.8	61.0	39.0	0.0	0.0	55.5	38.8	54.7
	87.7	46.2	20.3	24.2	9.3	64.7	37.0	54.9
	87.7	43.3	22.7	29.0	5.0	63.7	37.0	52.9
	86.1	28.6	42.9	22.4	6.2	54.7	45.0	63.3

APPENDIX TABLE 2A **Sexual activity and risk and protective behaviors of 12–19-year-old females, by age-group, Uganda, 2004**

Characteristic	All		% distribution by sexual activity				% who have ever been touched, kissed, grabbed or fondled in an unwanted sexual way*
	N	% distribution (weighted)	Never had sex	Have had sex but not in past 12 months	Have had sex in past 12 months with spouse/ cohabiting partner	Have had sex in past 12 months with noncohabiting partner	
FEMALES AGED 12–19	**2,602**	**100.0**	**72.1**	**7.3**	**10.1**	**10.5**	**33.8**
RESIDENCE							
Rural	2,298	88.2	72.4	7.0	10.4	10.1	34.1
Urban	304	11.8	70.0	9.2	7.6	13.2	32.4
ATTENDING SCHOOL							
No	744	28.4	35.8	10.2	34.8	19.2	48.3
Yes	1,858	71.6	86.5	6.2	0.3	7.1	28.6
UNION STATUS							
Not in union	2,354	90.5	79.6	7.7	1.3	11.4	32.0
In union	241	9.5	0.0	2.9	95.9	1.2	53.2
HOUSEHOLD WEALTH							
Lowest quintile	511	19.7	77.9	5.1	7.8	9.2	28.6
Middle quintiles	1,531	58.6	70.8	7.9	11.3	9.9	36.5
Highest quintile	558	21.7	70.4	7.7	8.9	13.0	31.5
FEMALES AGED 12–14	**1,282**	**100.0**	**92.4**	**3.9**	**0.2**	**3.5**	**18.9**
RESIDENCE							
Rural	1,168	91.0	92.0	4.2	0.2	3.7	18.6
Urban	114	9.0	97.4	0.9	0.0	1.7	21.7
ATTENDING SCHOOL							
No	91	6.9	86.5	2.2	1.1	10.1	15.6
Yes	1,191	93.1	92.9	4.0	0.1	3.0	19.2
HOUSEHOLD WEALTH							
Lowest quintile	288	22.4	93.4	2.8	0.3	3.5	16.5
Middle quintiles	761	59.1	91.3	4.5	0.1	4.1	20.6
Highest quintile	233	18.4	95.3	3.0	0.0	1.7	17.2
FEMALES 15–19	**1,320**	**100.0**	**52.0**	**10.7**	**19.9**	**17.4**	**48.7**
RESIDENCE							
Rural	1,130	85.4	51.9	10.0	21.2	16.9	50.3
Urban	190	14.6	52.9	14.3	12.2	20.6	40.2
ATTENDING SCHOOL							
No	653	49.4	28.9	11.2	39.5	20.4	53.5
Yes	667	50.6	74.6	10.2	0.8	14.4	44.7
UNION STATUS							
Not in union	1,075	81.3	64.0	12.4	2.7	20.9	47.7
In union	241	18.7	0.0	2.9	95.9	1.2	53.2
HOUSEHOLD WEALTH							
Lowest quintile	223	17.0	58.0	8.0	17.4	16.5	43.9
Middle quintiles	770	58.1	50.0	11.3	22.7	16.0	52.3
Highest quintile	325	24.9	52.5	10.8	15.4	21.3	43.2

*Questions asked of only one eligible adolescent per household and only if no one over the age of three was present or within hearing range.
†Among respondents who had ever had sex.
‡Respondent answered "yes" to a direct question about ever having an STI or answered "yes" to having had a specific symptom.
§Among respondents who had had sex in the past year.
**Question not asked if sex partner was a spouse or live-in partner.

	% who have ever been physically forced, hurt or threatened into having sexual intercourse*	% who have ever been pregnant†	% who have ever had an STI†,‡	% who used a contraceptive method at last sex§	% distribution by number of recent sexual partners and condom use§				% whose last sex partner was ≥5 years older§	% who had sex in exchange for money or gifts§,**
					One partner; used condom	One partner; no condom	≥2 partners, used condom	≥2 partners, no condom		
	17.4	**48.6**	**18.5**	**34.1**	**22.6**	**71.4**	**4.5**	**1.5**	**38.6**	**75.6**
	17.5	49.5	18.4	30.6	18.9	74.5	4.8	1.7	37.4	75.8
	16.4	41.9	19.4	60.9	48.4	50.0	1.6	0.0	46.9	74.2
	26.7	71.8	18.9	29.2	16.7	77.8	4.0	1.5	46.0	76.9
	14.0	4.8	17.8	47.8	39.6	53.2	5.8	1.4	17.1	74.0
	16.1	28.8	17.5	46.1	34.4	56.5	7.0	2.0	26.2	75.0
	30.6	87.8	20.4	19.2	7.9	90.0	1.3	0.8	54.6	100.0
	16.5	52.2	16.8	21.8	17.2	79.3	2.3	1.1	33.3	81.1
	17.5	50.6	18.5	30.1	17.7	75.2	5.2	1.8	37.4	72.1
	18.1	41.1	19.6	53.7	38.4	56.8	4.0	0.8	45.6	77.8
	9.3	**6.2**	**12.4**	**26.1**	**21.3**	**72.3**	**2.1**	**4.3**	**10.4**	**66.7**
	9.6	6.4	12.8	25.0	22.2	71.1	2.2	4.4	10.9	67.9
	6.7	0.0	0.0	50.0	0.0	100.0	0.0	0.0	0.0	50.0
	15.6	33.3	0.0	20.0	20.0	80.0	0.0	0.0	10.0	66.7
	8.8	2.4	14.1	27.8	21.6	70.3	2.7	5.4	10.5	66.7
	5.6	5.0	10.5	27.3	27.3	72.7	0.0	0.0	9.1	100.0
	10.5	6.1	12.1	25.8	22.6	67.7	3.2	6.5	12.9	60.9
	9.0	8.3	16.7	25.0	0.0	100.0	0.0	0.0	0.0	66.7
	25.5	**55.1**	**19.5**	**34.8**	**22.8**	**71.3**	**4.7**	**1.2**	**41.3**	**77.0**
	25.9	57.0	19.2	31.1	18.6	74.8	5.1	1.4	40.2	77.2
	23.3	43.3	20.0	61.3	50.0	48.4	1.6	0.0	48.4	75.9
	28.5	72.8	19.4	29.4	16.6	77.7	4.1	1.5	46.9	77.5
	23.0	6.0	19.2	55.4	46.5	46.5	6.9	0.0	19.6	76.3
	24.4	34.6	18.6	50.0	36.9	53.6	7.9	1.6	29.2	76.3
	30.6	87.8	20.4	19.2	7.9	90.0	1.3	0.8	54.6	100.0
	29.6	61.7	18.3	21.1	15.8	80.3	2.6	1.3	36.8	78.8
	24.3	58.3	19.6	30.3	17.2	76.0	5.4	1.4	39.9	75.5
	25.7	43.6	19.9	54.6	40.0	55.0	4.2	0.8	47.5	78.3

APPENDIX TABLE 2B **Sexual activity and risk and protective behaviors of 12–19-year-old males according to age group in Uganda, 2004**

Characteristic	All		% distribution by sexual activity				% who have ever been touched, kissed, grabbed or fondled in an unwanted sexual way*
	N	% distribution (weighted)	Never had sex	Have had sex but not in past 12 months	Have had sex in past 12 months with spouse/ cohabiting partner	Have had sex in past 12 months with noncohabiting partner	
MALES AGED 12–19	**2,510**	**100.0**	**67.8**	**12.3**	**1.0**	**18.9**	**15.3**
RESIDENCE							
Rural	2,269	90.3	67.9	12.5	1.0	18.6	14.4
Urban	241	9.7	67.1	10.4	0.4	22.1	24.3
ATTENDING SCHOOL							
No	487	19.1	42.6	14.8	4.6	38.0	19.3
Yes	2,023	80.9	73.7	11.8	0.1	14.5	14.3
HOUSEHOLD WEALTH							
Lowest quintile	509	20.6	69.7	14.6	1.0	14.6	11.2
Middle quintiles	1,543	61.4	66.9	12.1	1.2	19.8	14.8
Highest quintile	449	18.0	68.8	10.2	0.2	20.7	21.1
MALES AGED 12–14	**1,198**	**100.0**	**85.2**	**7.3**	**0.1**	**7.4**	**10.1**
RESIDENCE							
Rural	1,100	91.9	84.6	7.6	0.1	7.7	9.7
Urban	98	8.1	91.8	4.1	0.0	4.1	14.3
ATTENDING SCHOOL							
No	53	4.3	82.7	9.6	0.0	7.7	9.1
Yes	1,145	95.7	85.3	7.2	0.1	7.4	10.3
HOUSEHOLD WEALTH							
Lowest quintile	275	23.3	85.3	9.3	0.4	5.0	8.4
Middle quintiles	726	60.8	83.5	7.4	0.0	9.1	9.9
Highest quintile	192	15.9	91.1	4.2	0.0	4.7	13.8
MALES AGED 15–19	**1,312**	**100.0**	**51.4**	**17.1**	**1.8**	**29.7**	**19.9**
RESIDENCE							
Rural	1,169	88.9	51.7	17.3	1.9	29.0	18.6
Urban	143	11.1	50.0	14.8	0.7	34.5	32.3
ATTENDING SCHOOL							
No	434	32.8	37.7	15.4	5.2	41.7	20.4
Yes	878	67.2	58.1	17.9	0.1	23.9	19.5
HOUSEHOLD WEALTH							
Lowest quintile	234	18.1	51.1	21.0	1.7	26.2	15.9
Middle quintiles	817	62.0	51.6	16.5	2.4	29.5	19.0
Highest quintile	257	19.9	51.8	14.8	0.4	33.1	26.4

*Questions asked of only one eligible adolescent per household and only if no one over the age of three was present or within hearing range.
†Among respondents who had ever had sex.
‡Respondent answered "yes" to a direct question about ever having an STI or answered "yes" to having had a specific symptom.
§Among respondents who had had sex in the past year.
**Question not asked if sex partner was a spouse or live-in partner.

	% who have ever been physically forced, hurt or threatened into having sexual intercourse*	% who have ever gotten someone pregnant†	% who have ever had an STI†,‡	% who used a contraceptive method at last sex§	% distribution by number of recent sexual partners and condom use§				% whose last sex partner was ≥5 years older§	% who had sex in exchange for money or gifts§,**
					One partner; used condom	One partner; no condom	≥2 partners, used condom	≥2 partners, no condom		
	6.7	**4.2**	**4.2**	**46.9**	**36.1**	**46.7**	**9.4**	**7.8**	**0.2**	**34.3**
	6.6	4.4	4.1	43.3	32.1	49.4	9.9	8.5	0.2	32.7
	6.3	2.5	5.0	74.5	67.3	25.5	5.5	1.8	0.0	45.5
	9.7	10.3	4.0	51.0	38.9	42.4	11.8	6.9	0.0	31.3
	5.9	1.1	4.3	44.1	34.1	50.0	7.8	8.1	0.3	36.3
	5.6	3.8	3.8	30.0	22.2	61.7	4.9	11.1	0.0	31.1
	7.6	4.7	4.3	43.9	32.6	47.8	10.9	8.7	0.3	30.7
	4.9	2.9	4.3	70.2	57.9	31.6	8.4	2.1	0.0	47.5
	4.2	**0.0**	**1.7**	**12.2**	**8.7**	**72.8**	**4.3**	**14.1**	**1.1**	**33.3**
	4.4	0.0	1.7	11.6	8.0	72.7	4.5	14.8	1.1	32.3
	2.0	0.0	0.0	25.0	25.0	75.0	0.0	0.0	0.0	100.0
	4.8	0.0	0.0	25.0	0.0	75.0	25.0	0.0	0.0	33.3
	4.0	0.0	1.8	11.6	9.1	72.7	3.4	14.8	1.1	33.3
	6.3	0.0	0.0	0.0	0.0	82.4	0.0	17.6	0.0	18.2
	4.2	0.0	2.5	14.9	10.4	68.7	6.0	14.9	1.5	34.0
	1.1	0.0	0.0	11.1	11.1	88.9	0.0	0.0	0.0	60.0
	8.9	**5.4**	**4.9**	**54.5**	**42.3**	**40.8**	**10.6**	**6.4**	**0.0**	**34.4**
	8.7	5.8	4.9	51.1	38.2	43.5	11.2	7.0	0.0	32.8
	11.3	2.8	5.6	78.4	70.6	21.6	5.9	2.0	0.0	44.2
	10.2	10.6	4.2	51.5	39.7	41.7	11.6	7.0	0.0	31.3
	8.1	1.7	5.5	57.4	44.7	39.9	9.6	5.8	0.0	37.4
	4.7	5.3	5.3	36.9	27.7	56.9	6.2	9.2	0.0	34.0
	10.5	6.2	4.9	51.6	38.4	42.4	12.2	7.1	0.0	29.9
	7.8	3.3	4.9	75.6	62.8	25.6	9.3	2.3	0.0	46.7

APPENDIX TABLE 3A **Knowledge and use of sexual and reproductive health information and services among 12–19-year-old females, by age-group, Uganda, 2004**

Characteristic	All		% who know there are certain days when a woman is more likely to get pregnant	% with adequate pregnancy prevention knowledge*	% who know three main ways to avoid HIV†	% with adequate HIV/AIDS knowledge‡	% who know someone who has HIV or who has died from AIDS
	N	% distribution (weighted)					
FEMALES AGED 12–19	**2,602**	**100.0**	**62.1**	**25.7**	**76.7**	**24.3**	**89.0**
RESIDENCE							
Rural	2,298	88.2	60.7	24.0	76.2	21.6	88.7
Urban	304	11.8	72.7	38.8	80.7	44.0	91.2
ATTENDING SCHOOL							
No	744	28.4	79.0	28.0	79.7	23.0	89.4
Yes	1,858	71.6	55.4	24.8	75.6	24.8	88.9
UNION STATUS							
Not in union	2,354	90.5	59.1	25.4	76.0	24.1	88.8
In union	241	9.5	90.2	28.2	82.5	25.7	91.8
HOUSEHOLD WEALTH							
Lowest quintile	511	19.7	52.6	19.8	69.7	17.2	84.2
Middle quintiles	1,531	58.6	60.9	23.4	76.4	21.0	89.0
Highest quintile	558	21.7	74.0	37.3	84.0	39.5	93.4
FEMALES AGED 12–14	**1,282**	**100.0**	**43.4**	**19.7**	**70.0**	**20.8**	**85.7**
RESIDENCE							
Rural	1,168	91.0	42.9	18.9	69.7	19.5	85.7
Urban	114	9.0	48.2	27.0	73.0	33.9	86.1
ATTENDING SCHOOL							
No	91	6.9	42.0	18.2	70.5	17.0	70.8
Yes	1,191	93.1	43.4	19.7	70.0	21.0	86.8
HOUSEHOLD WEALTH							
Lowest quintile	288	22.4	37.8	16.3	63.0	15.3	83.0
Middle quintiles	761	59.1	42.0	18.0	70.3	18.7	85.3
Highest quintile	233	18.4	54.7	28.8	77.6	34.3	90.7
FEMALES 15–19	**1,320**	**100.0**	**80.4**	**31.6**	**83.3**	**27.8**	**92.2**
RESIDENCE							
Rural	1,130	85.4	79.2	29.3	82.9	23.9	91.9
Urban	190	14.6	87.4	45.5	85.3	50.3	94.3
ATTENDING SCHOOL							
No	653	49.4	83.8	29.3	80.9	23.8	91.8
Yes	667	50.6	76.8	33.8	85.6	31.6	92.6
UNION STATUS							
Not in union	1,075	81.3	78.2	32.5	83.4	28.2	92.4
In union	241	18.7	90.2	28.2	82.5	25.7	91.8
HOUSEHOLD WEALTH							
Lowest quintile	223	17.0	71.7	24.2	78.0	19.7	86.1
Middle quintiles	770	58.1	79.7	28.7	82.4	23.2	92.7
Highest quintile	325	24.9	87.8	43.4	88.7	43.3	95.4

*Correctly replied to direct questions that there are certain days when a woman is more likely to get pregnant; that a woman can get pregnant the very first time she has sexual intercourse; that a woman can get pregnant if she has sex standing up; and knows of at least one modern method of contraception.
†Abstain, Be faithful and use a Condom.
‡Correctly replied to direct questions that HIV transmission can be reduced by having sex with only one, faithful, uninfected partner and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites and that a person cannot get HIV from sharing food with someone who is infected.
§Among respondents who had ever had sex.

	% who know of any STI other than HIV	% who have ever talked with a family member about sex-related matters	% who have attended sex education classes or talks in school	% who know a source for contraceptives	% who say cost is a barrier to obtaining contraceptives	% who say feeling shy, embarrassed or fearful is a barrier to obtaining contraceptives	% who know a place to get an HIV test	% who have ever been tested for HIV§
	54.4	**45.6**	**42.0**	**43.9**	**23.2**	**38.0**	**58.5**	**13.7**
	52.7	45.0	40.5	42.8	23.1	37.3	56.7	12.0
	67.9	50.2	53.3	52.6	24.2	43.0	71.9	25.8
	64.1	47.6	37.5	57.3	24.1	38.0	64.6	16.0
	50.6	44.9	43.7	38.6	22.9	38.0	56.0	9.5
	52.7	45.0	42.4	40.8	22.3	37.5	57.2	11.3
	70.7	51.2	36.7	74.0	31.8	41.2	70.2	18.7
	43.0	42.7	31.1	39.1	20.4	33.3	48.5	6.2
	52.3	44.1	42.0	42.4	23.7	38.0	57.1	12.9
	70.7	52.6	51.8	52.5	24.6	42.2	70.9	21.4
	37.5	**39.2**	**33.7**	**29.9**	**18.8**	**32.9**	**47.6**	**4.1**
	37.0	38.6	32.6	30.2	18.7	33.2	46.2	4.3
	43.4	44.7	45.2	27.0	20.0	30.4	61.7	0.0
	29.2	34.8	20.2	22.5	11.2	25.8	34.8	0.0
	38.2	39.5	34.8	30.4	19.4	33.4	48.6	4.7
	31.3	38.2	23.6	26.7	17.4	29.2	39.9	0.0
	36.3	37.5	35.2	30.7	19.3	33.9	46.6	4.5
	49.2	45.5	41.4	31.2	19.0	34.6	60.3	8.3
	71.0	**52.0**	**50.0**	**57.6**	**27.5**	**43.0**	**69.0**	**15.2**
	69.0	51.7	48.7	55.9	27.7	41.6	67.6	13.3
	82.3	53.6	58.1	68.1	26.6	50.8	78.0	26.7
	68.8	49.4	39.8	62.1	25.8	39.6	68.8	16.4
	73.1	54.5	59.9	53.2	29.2	46.2	69.5	12.0
	71.0	52.0	52.9	53.9	26.5	43.2	68.8	13.1
	70.7	51.2	36.7	74.0	31.8	41.2	70.2	18.7
	58.0	48.0	40.8	55.2	24.2	38.8	59.6	7.4
	68.2	50.6	48.8	54.0	28.0	42.2	67.6	14.4
	86.0	57.5	59.1	67.9	28.7	47.6	78.7	22.4

APPENDIX TABLE 3B	Knowledge and use of sexual and reproductive health information and services among 12–19-year-old males, by age-group, Uganda, 2004						
Characteristic	All		% who know there are certain days when a woman is more likely to get pregnant	% with adequate pregnancy prevention knowledge*	% who know three main ways to avoid HIV†	% with adequate HIV/AIDS knowledge‡	% who know someone who has HIV or who has died from AIDS
	N	% distribution (weighted)					
MALES AGED 12–19	**2,510**	**100.0**	**47.5**	**23.2**	**81.1**	**27.0**	**87.4**
RESIDENCE							
Rural	2,269	90.3	46.2	21.9	80.2	24.9	87.8
Urban	241	9.7	59.1	36.2	88.8	45.9	84.3
ATTENDING SCHOOL							
No	487	19.1	61.4	33.2	87.3	32.4	91.4
Yes	2,023	80.9	44.2	20.9	79.6	25.7	86.4
HOUSEHOLD WEALTH							
Lowest quintile	509	20.6	40.4	17.5	75.3	21.6	84.5
Middle quintiles	1,543	61.4	47.7	22.7	81.1	25.0	88.7
Highest quintile	449	18.0	54.7	31.8	87.4	39.9	86.3
MALES AGED 12–14	**1,198**	**100.0**	**29.4**	**11.3**	**74.8**	**16.8**	**82.6**
RESIDENCE							
Rural	1,100	91.9	28.3	10.7	74.2	15.4	84.0
Urban	98	8.1	41.8	18.4	81.6	32.7	68.4
ATTENDING SCHOOL							
No	53	4.3	19.2	7.7	71.2	13.5	75.0
Yes	1,145	95.7	29.8	11.5	75.0	16.9	83.0
HOUSEHOLD WEALTH							
Lowest quintile	275	23.3	25.4	8.2	70.7	12.9	81.4
Middle quintiles	726	60.8	29.8	11.3	74.9	15.5	84.6
Highest quintile	192	15.9	34.4	16.1	81.3	27.1	77.1
MALES AGED 15–19	**1,312**	**100.0**	**64.2**	**34.3**	**86.9**	**36.5**	**91.8**
RESIDENCE							
Rural	1,169	88.9	63.5	32.6	86.0	34.1	91.4
Urban	143	11.1	70.8	47.9	93.8	54.9	95.1
ATTENDING SCHOOL							
No	434	32.8	66.6	36.3	89.2	34.7	93.4
Yes	878	67.2	63.1	33.4	85.7	37.2	91.0
HOUSEHOLD WEALTH							
Lowest quintile	234	18.1	58.3	28.5	80.9	31.9	88.1
Middle quintiles	817	62.0	64.1	33.0	87.0	33.6	92.4
Highest quintile	257	19.9	69.8	43.4	91.9	49.2	93.1

*Correctly replied to direct questions that there are certain days when a woman is more likely to get pregnant; that a woman can get pregnant the very first time she has sexual intercourse; that a woman can get pregnant if she has sex standing up; and knows of at least one modern method of contraception.
†Abstain, Be faithful and use a Condom.
‡Correctly replied to direct questions that HIV transmission can be reduced by having sex with only one, faithful, uninfected partner and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites and that a person cannot get HIV from sharing food with someone who is infected.
§Among respondents who had ever had sex.

	% who know of any STI other than HIV	% who have ever talked with a family member about sex-related matters	% who have attended sex education classes or talks in school	% who know a source for contraceptives	% who say cost is a barrier to obtaining contraceptives	% who say feeling shy, embarrassed or fearful is a barrier to obtaining contraceptives	% who know a place to get an HIV test	% who have ever been tested for HIV§
	56.0	**28.0**	**33.4**	**51.4**	**15.5**	**37.8**	**64.2**	**5.8**
	54.4	27.0	31.8	49.4	15.5	37.6	62.2	5.5
	71.8	37.3	49.2	69.8	16.0	39.7	83.1	8.9
	69.9	24.4	33.0	63.5	17.7	43.4	68.1	5.5
	52.8	28.9	33.5	48.5	15.0	36.5	63.4	6.2
	44.4	27.1	26.2	46.6	14.1	34.7	56.5	2.6
	56.8	26.2	32.3	48.5	16.4	37.2	62.3	6.1
	66.8	35.1	45.5	66.2	13.7	43.0	79.2	8.6
	37.7	**25.2**	**22.0**	**39.1**	**12.3**	**30.9**	**53.6**	**0.6**
	36.0	24.4	20.2	37.8	12.2	31.1	51.5	0.6
	57.1	34.7	41.8	54.1	13.3	30.3	78.6	0.0
	29.4	9.6	3.8	34.6	7.8	29.4	40.4	0.0
	38.1	25.9	22.8	39.3	12.5	31.0	54.2	0.6
	30.7	27.8	20.4	41.1	12.9	30.7	46.3	0.0
	37.9	23.0	20.8	35.8	12.8	30.2	51.6	0.8
	47.9	29.7	29.2	48.4	9.4	33.3	71.4	0.0
	73.0	**30.6**	**44.1**	**62.7**	**18.4**	**44.2**	**74.1**	**7.3**
	71.9	29.6	42.8	60.5	18.6	43.9	72.5	7.0
	82.4	39.2	53.8	80.6	17.4	46.2	86.8	9.9
	74.9	26.2	36.5	67.0	19.0	45.0	71.4	5.7
	72.1	32.8	47.7	60.6	18.2	43.7	75.4	8.8
	60.9	26.4	33.2	53.2	15.7	39.1	68.9	3.5
	73.9	29.2	42.8	59.9	19.5	43.5	72.0	7.8
	81.3	39.1	57.8	79.2	16.7	50.2	84.9	9.8

APPENDIX TABLE 4	**Adolescents' rights in Uganda as related to sexual and reproductive health**
TOPIC	POLICY
ABORTION	▪ Written or appropriate consent should be obtained from the patient or a legal guardian for evacuation for incomplete abortion, examination under general anesthesia and any surgical interventions. ▪ For a patient whose physical condition does not enable her to give a written consent, the procedure should be performed to save her life.
CONTRACEPTION	▪ All sexually active males and females in need of contraceptives are eligible for family planning services, provided that they have been educated and counseled on all available family planning methods and choices. ▪ No verbal or written consent is required from a parent, guardian or spouse before a client can be given family planning services.
MARRIAGE	▪ Marriage can be contracted for a person younger than 21 with the written consent of a parent. ▪ The Customary Marriages (Registration) Decree 16 of 1973 states that the minimum age of marriage is 16 for males and 18 for females. ▪ The Marriage and Divorce of Mohammedans Act allows a minor to apply to have his or her marriage registered if the lawful guardian fails to apply for it. The Act does not define a minor and does not set the minimum age of marriage.
PREGNANCY AND SCHOOLING	Pregnant adolescents have to leave school and are unable to register at the same school after delivery.
RIGHT TO HEALTH CARE	All adolescents are eligible for health services, which should be provided in a friendly environment and in a manner that meets their needs.
STATUTORY RAPE	Under the 1996 Uganda AIDS Commission guidelines (which regulate current HIV/AIDS policies), legislation against sexual abuse of minors was revised, but these further restrictions were not advertised.
STI TESTING	Under the 1996 Uganda AIDS Commission guidelines (which regulate current HIV/AIDS policies) annual, mandatory HIV testing was instituted for students under public scholarship at tertiary institutions, but these guidelines have never been enforced and there is little push to institute this policy.
VOLUNTARY COUNSELING AND TESTING	▪ Children aged 12 and older may receive HIV testing services at all HIV counseling and testing sites without knowledge or consent of parents or guardians, provided they have the capacity to understand the implications of the results of the HIV test. ▪ Youth aged 12 and older may be provided services if they seek the services freely and without coercion on the part of parents or others. ▪ Results may be provided to children aged 12 or older after proper counseling and may not be shared with parents or guardians, except at the request of the child. ▪ For children younger than 12, consent by parents or guardians must be documented. For those who do not have a parent or guardian, the head of the institution, health center, hospital or clinic, or any other responsible person may give consent. • Children younger than 12 should be given results only with the consent of parents or guardians and after proper counseling.

Sources: Abortion—Ministry of Health, National policy guidelines and service standards for reproductive health services, 4.13.4, <http://www.youth-policy.com/Policies/Uganda_Standards_for_RH_Services.cfm>, accessed. Dec. 5, 2007. **Contraception**—Ministry of Health, National policy guidelines and service standards for reproductive health services, 3.5, <http://www.youth-policy.com/Policies/Uganda_Standards_for_RH_Services.cfm>, accessed. Dec. 5, 2007. **Marriage**—United Nations, Initial reports of states parties due in 1992: Uganda, 1996, <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CRC.C.3.Add.40.En?Opendocument>, accessed Dec. 5, 2007. **Pregnancy and schooling**—Report submitted by Ms. Katarina Tomasevski K, special rapporteur on the Right to Education Addendum Mission to Uganda, UN Commission on Human Rights, 1999, <http://www.right-to-education.org/content/unreports/ unreport3prt1. html>, accessed Dec. 5, 2007. **Right to health care**—Ministry of Health, National policy guidelines and service standards for reproductive health services, 6.1, <http://www.youth-policy.com/Policies/Uganda_Standards_for_RH_Services.cfm>, accessed. Dec. 5, 2007. **Statutory rape**—Asingwire N, Kyomuhendo S, Development of a National Overarching HIV/AIDS policy for Uganda, A review of the HIV/AIDS Policy Environment, 2003; <http://www.aidsuganda.org/pdf/Review_of_AIDS_policy_environment.pdf>, accessed Dec. 5, 2007. **STI testing**—Asingwire N and Kyomuhendo S; A review of the HIV/AIDS policy environment, 2003, <http://www.aidsuganda.org/pdf/Review_of_AIDS_policy_environment.pdf>, accessed Dec. 5, 2007. **Voluntary counseling and testing**—Ministry of Health, National policy guidelines for HIV counseling and testing, 2003, <http://www.who.int/hiv/topics/vct/UG_HCT%20Policy%20DRAFTFeb05.pdf>, accessed Dec. 5, 2007.

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