Literature Review
On
Youth Sexual and Reproductive Health In Uganda

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I. Executive Summary

Over the past twenty years, Uganda has made significant strides in decreasing HIV prevalence and in improving reproductive health indicators particularly among its youth. Today, Uganda is widely recognized as the most successful sub-Sahara African example of population-wide HIV prevalence reduction. In spite of these accomplishments, youth in Uganda age 15-24 years continue to face significant reproductive health risks that threaten to counter this downward trend, including disproportionate vulnerability for HIV and STI infection and increased risk of complication due to early and mistimed pregnancies.

This document describes the key issues that leave Ugandan youth particularly vulnerable to negative health outcomes, particularly, HIV, STIs and early pregnancy. In doing so, it will form the basis for effective communication strategies designed to mitigate these problems. Key amongst these issues are the risks youth face that encourage them to engage in sexual activity early; their own perception of their risk for HIV, STI infection and early pregnancy; social norms and values that limit access to services and information; the impact of gender in sexual relations and social expectations; and the relationship between education and vulnerability. This summary is not intended to be exhaustive. While it will briefly summarize some of the more well-known issues of youth vulnerability, it will also introduce some of the less explored dynamics of sexual relationships, gender relations and social expectations that influence and involve young people.

The document references numerous qualitative and quantitative studies of adolescent sexual and reproductive health conducted between 2000-2003. The studies referenced are those that were conducted as either formative research for reproductive health interventions, government based research, or population-based studies by research institutions.

Important to this summary is the inclusion of youth perspectives. The report quotes youth who have written to Straight Talk Foundation and comments from youth who participated in a 3-country study by the Alan Guttmacher Institute.

In March, 2004, Straight Talk Foundation, asked young readers of 'Straight Talk' newsletters the following questions:

- "Do you think your peers still have unprotected sex?
- "Why do they continue to take the risk?" and,
- "Have you ever had unprotected sex? If so, tell us your story"

It is important to note that these letters are not representative of all Ugandan adolescents due to the fact that they come primarily from regular Straight Talk readers who are students in secondary school and are heavily represented by young men. Nonetheless, the letters provide rich insight into the thoughts and feelings of Ugandan youth regarding their sexual and reproductive health, vulnerabilities and experiences, and those of their peers. Excerpts from some of the most poignant letters are included in this summary.

Also referenced in this summary are comments from youth who participated in a not yet published qualitative study conducted in 4 countries including Uganda – the other three countries represented are Burkina Faso, Malawi, and Ghana. This research was conducted by the Alan Guttmacher Institute as part of its "Protecting the Next Generation: Understanding HIV Risk Among Youth" project supported by the Bill and Melinda Gates Foundation. The data was collected through a series of 55 focus group discussions among young people aged 14-19 years representing rural and urban communities and in and out of school environments. Youth were led through discussions designed to describe how young people understand a variety of sexual and reproductive health issues, and their perception of their own vulnerability and that of their peers. Some of the findings and comments from the youth in this study are also referenced in this summary paper

II. Description of Youth in Uganda

Youth in Uganda typically become sexually active, marry, and bear children early in life and there have been indications in recent years that youth sexual behavior in Uganda is becoming more risky. National statistics indicate increasing trends of multiple partners among young men and an increased proportion of young men who are sexually active as compared to the 1995 UDHS (Singh, et al, 2003). According to a comparative analysis of UDHS data from 1988 to 2000, there has been a

steady increase in the proportion of young, unmarried men aged 15-25 who have two or more partners. (Singh, et al 2003). Additionally, the most recent UDHS showed the highest percentage of young women who are both sexually active and single than ever before. (UDHS, 2000-2001)

According to trend analyses of youth between 1994 – 2002 from the Rakai Health Sciences Program, multiple sexual partnerships and non-marital relationships are increasing, and sexual debut among youth starts at an earlier age in the cohort followed for more than ten years. For example, the proportion of youth reporting two or more partners increased from 25% to 39% among males and from 8% to 12% among females between 1994-2002; the proportion of adolescents reporting non-marital relationships increased during the same period from 22.7% to 36.2% among males and from 14.2% to 27.5% among females. During the same eight-year period, the proportion of 15-year-olds who became sexually active increased from 30% to 37% among males and 33% to 39% among females. (Namukwaya, Gray, 2003)

While both males and females are at unique risk for reproductive health problems, young women are particularly vulnerable. For instance, by age 15, 30% of women have had sexual intercourse; by 17, 43% have had their first child; and by 18, 56% have married. (UDHS, 2000-2001)

Many births for these young women are neither planned nor desired. According to the Ugandan Demographic and Health Survey 2000/1, of women 15 – 19 years old who had a child in the five years preceding the survey, nearly 1/3 did not want to have a child at that time. This pattern of early childbearing is a major contributor to Uganda's TFR of 6.9, one of the highest in the world. (USAID, 2002-2007)

Low contraceptive use contributes greatly to this problem. Very few sexually active 15 – 19 year olds use modern family planning methods, including condoms. While knowledge of modern contraceptive methods is almost universal, according to the UDHS, only 10% of 15 to 19-year-old women use modern family planning methods. Married adolescents are less likely than unmarried sexually active adolescents to use modern contraceptives. Condoms are the most popular method of contraception among unmarried sexually active adolescents, yet few use them regularly. Only 19% of 15 to 19-year-old girls and 42% of 15 to 19-year-old boys reportedly used condoms at last sex, according to the UDHS.

Numerous social, cultural and economic factors contribute to the increased risk Ugandan youth face. Specifically, while young people continue to initiate sexual activity during their adolescence, they still indicate a lack of adequate information about their sexual and

reproductive health. For instance, 33% of young women and 30% of young men aged 15-19 indicate they have no knowledge of STIs (UDHS). Lack of access to reproductive health information and services is very often due to cultural and social norms and economic barriers that limit the level of capacity and willingness in communities to address adolescent sexual and reproductive health issues. Additionally, gender differences continue to persist as the foundation for disempowering relationships and expectations that influence the behaviour and sexual activity of males and females.

Gender disparities also impact young women disproportionately. While youth represent the highest percentage of new HIV infections in Uganda, young women between 15 and 19 years of age are more than twice as likely to become infected with HIV than young men; young women also bear the burden of health risk from mistimed pregnancies and are least likely to complete their education. (UDHS, 2000-2001).

Another contributor to youths' increased vulnerability to reproductive health risks is level of education. Youth who are inadequately educated are often more at risk for poor reproductive health; and, paradoxically, youth, particularly girls, affected by pregnancy and HIV, are often as a result, forced to end their education.

There are also recent indications that Ugandan youth face unique risks because of the tremendous fall in national HIV prevalence. Some data suggest that increased likelihood for unprotected sex and other risky behavior by youth may be linked to a lack of perceived risk, particularly for HIV infection, and hence, a decrease in likelihood of delaying sex, reducing number of partners, or using condoms.

III. Early Sexual Initiation is Common and Risky Among Ugandan Youth

The circumstances and reasons why young people engage in early sexual activity are varied. In AGIs study, youth generally described sex as happening under one of several circumstances: as part of an intimate relationship (boyfriend/girlfriend); in exchange for money or material goods; as something you are forced or pressured into; or as something you 'just do' (Amuyunzu-Nyamongo, et al, 2004).

For many youth, because their first sexual experience is clandestine or rushed, there are often limited opportunities to take precautions. Additionally, a profound lack of correct information about sexual and reproductive health often leads youth to initiate sex with a false or exaggerated sense of safety concerning infection and pregnancy.

Although UDHS reports significant regional variations in 'age at first sex', those in the Eastern region have sex earliest and those in the West typically latest, generally 92% of all women and 79% of all men in Uganda have had sexual intercourse by the age of 25. While age at first sex has increased over the past decade in Uganda, most Ugandans still begin sexual activity during their adolescence. Additionally, in 2000, there were more sexually active men and women who had never married than in previous years of DHS reporting. In 2000, 59% of sexually experienced young women 15-17 had never married compared to 46% in 1988 indicating a trend in increasing years of sexual activity outside of marriage (Singh, et al, 2003)

Many youth indicate that their initial sexual encounter is coerced or conducted under considerable pressure. Young women are under particular risk for sexual coercion and the risks of unbalanced sexual relationships. A Ugandan study of sexually active young women aged 15-19 found that those who had experienced sexual coercion, compared to those who had not, were significantly more likely to be nonusers of contraception, to have unintended pregnancies and to not use condoms at last sex. (Luke and Kurz, 2002)

Ugandan women are on average 2 years younger than men at first sex. While there is no reported standard age difference between partners, various studies have placed the average age difference between girls and their older sexual partners ranging between two and seven years (Luke and Kurz, 2002). One study in Uganda reported that 11% of women who had sex before the age of 25 reported their first sexual partner was at least 10 years older. (ORC Macro, 2002). Additionally, due to the gender and age imbalances and the fact that gifts or money may be exchanged, these younger girls are more likely to have less influence in the frequency of, and precautions taken, during these sexual acts.

Young people between the ages of 15-24 are also least likely to regularly use condoms. When youth do use condoms they are inconsistent. Interestingly, young women indicate that when they do use condoms, they are more likely to use them for the contraceptive reasons than for disease prevention. (UDHS, 2001-2002)

Another study, which summarized DHS figures on girls reporting recently receiving money or gifts for sex indicated 31% of young women in Uganda reported recently receiving money for sex. (ORC Macro, 2002) In PSI's study of youth in rural Uganda, 90% of the three most recent relationships of girls (aged 15-19) involved some 'economic support.' (Luke and Kurz, 2002)

It is fairly widely understood that most sexual decisions, and particularly those made by youth, are not based on a rational decision making process. Safe sex knowledge rarely translates into safer behavior. When asked, many sexually active youth provide various explanations for how the condom and other preventive measures such as abstinence or delaying sexual initiation are unreasonable and often contradict prevailing values about what constitutes enjoyable sexual intercourse (largely in the case of boys) or necessary social achievements. (Amuyyunzu-Nyamongo, et al, 2004)

While condoms are the most preferred method of contraception and protection against infection and pregnancy among youth and while condom use has increased over time, use among youth is still comparatively low. According to the most recent UDHS data, 50% of girls 15-19 years used a condom for disease prevention with their non-cohabiting partner and only 2.8% with their live in partner at last sex.

The urban and rural disparities were even more dramatic with only 30% of rural girls versus 58% of urban girls using condoms at their last sex act. For boys in this age group just over 50% indicated using a condom during last sex with a non-cohabiting partner with 80% of urban boys and just over 50% of rural boys using a condom. (UDHS 2000-2001)

The level of precautions taken seemingly varies depending on the risk one is trying to avoid. UDHS data reports very different male condom use rates for young women depending on whether they are seeking to prevent HIV versus pregnancy. Sexually active unmarried women aged 15-19 and 20-22 report comparatively high rates of condoms for pregnancy prevention – 65% and 56% respectively compared to rates of 50% for disease prevention.

In another study conducted in Mbale, young men indicated low interest in taking precautions particularly in pregnancy prevention because the ability to impregnate women was often seen as a status symbol (Hulton et al, 2000)

In a letter to Straight Talk, one young man wrote,

> " They also admire having unprotected sex because they want to have babies and you also know that these days death is for [a] little time. You can die easily but you can leave a child behind." ***(Boy, Lumino High School)***

In other *Straight Talk* letters youth who were asked why they still have unprotected sex cited some of the following reasons: lack of correct information- condoms are ineffective, they get stuck in the girls body; condoms reduce 'manhood' – sperm trapped in condoms is wasted; it is embarrassing to buy condoms; they are too expensive; using condoms means you don't love or trust your partner; girls have no control especially if they have taken money or gifts.

When asked to tell their own story or explain why their peers still have unprotected sex, two youth made the following comments:

> "…He decided to go for the second round without the condom and since we trusted each other and all of us did not know how to use condoms effectively we ended up having unprotected sex…" (***Secondary school girl, Mbale***)

> "I think many young people want to prove their fertility and I think some want to show their lover that they love each other by having unprotected sex…Why I say so is that one day I asked my friend who is a girl, "do you have a boy lover?' She said yes. Then I asked how do you prove that he loves you. She said, 'we have unprotected sex." ***(Kampala, boy, Memorial College)***

IV. Low Perception of Risk Influences Risk-Taking Behavior

Risk perception also plays a large role in the extent to which precautions are taken and is often described differently by boys and girls. Additionally, boys and girls seem to distinguish their level of perceived risk differently for pregnancy and STI infection. In a study conducted in Uganda assessing reproductive health risk perception among youth, participants, particularly young women, offered very detailed and personal assessments describing perception of their own risk or that of their peers for pregnancy while male participants claimed they did not even consider pregnancy when having sex because they 'did not intend to get the girl pregnant'. (Hulton, et al, 2000)

Female participants of the same study gave very remote or third person accounts when asked about their perceived risk for HIV infection and the young men were reported as being less fearful of infection and confident

they could behave 'safely' to protect themselves when having sex. (Hulton, et al, 2000)

Straight Talk letter writers gave varying insight into the level of risk perception for disease and pregnancy in several letters. In reference to HIV or STI risk, some mentioned that they were too young to be infected or that at night everything is asleep, including disease. Others indicated feelings if invulnerability often based on misinformation:

> "Some people have unprotected sex knowing they have already tested and they are HIV negative so they are free to have sex because they won't be infected." ***(Girl, secondary school, Mbale)***

> " Most younger people are having unprotected sex because they all went for blood testing, both partners were negative and a girl is not in her period. Why can't they enjoy that sex minus a condom for just one day?" ***(Boy, Lumino High School)***

V. Use of Alcohol and Drugs increases Risk-taking Behaviour

Many youth are less likely to engage in regular alcohol and other substance abuse than adults often due to lack of money. However, when alcohol and or other drugs are present, decision-making skills are greatly impaired and the risks increase. (Amuyunzu-Nyamongo, 2004)

Young men are more likely to report their own previous alcohol or substance abuse then young girls. In AGI's study, young women often discussed how substance abuse made young men take advantage of young women who themselves were drunk, and how young men sometimes drug women in order to have sex. The groups reported that even if young people have the intention of using a condom they often forget or abandon these intentions because of the effects of drugs or alcohol.

Among the *Straight Talk* letters, several respondents mentioned substance abuse as a reason for risk taking among their peers or themselves.

For example,

> "Some of our young people they take drugs like alcohol therefore forget about condoms. They just play sex without condoms." (***boy, secondary school)***

> "It was last year Christmas. I and my boyfriend went out to a certain pub and boozed as much as we could until I lost all my senses. Despite the fact that we had been in our relationship for 4 years, we had never had sex. The fellow then approached me to at least give in for the first time to show that our friendship had strengthened even more. I foolishly gave in because I didn't understand what I was doing at the time because I had been disturbed by the alcohol. We both hastily did it and I think that's when I lost my virginity.
> ***(secondary school girl 17, Bushenyi)***

VI. Lack Comprehensive and Reliable Information and Services about their SRH

Lack of access to correct information is directly related to increased risk taking behavior, and increased risk for early and unwanted pregnancy, STI and HIV infection. Limited access to information also impacts the timeliness or even likelihood that young people will seek reproductive health services (ORC Macro, 2002). Knowledge among youth (15-19 years) is high for modern contraceptive methods. Some 95% and nearly 100% for females and males respectively- know at least one modern contraceptive method (UDHS 2000-2001).

Similarly, awareness of HIV/AIDS is almost universal among youth. Nonetheless, young people continue to face considerable social and cultural barriers to accessing more comprehensive sexual and reproductive health information and services. Because discussing sex and related matters if often taboo, they are left to handle issues of new sexual feelings, physical changes disease prevention and avoidance of pregnancy alone.

In a study conducted by Straight Talk Foundation in which they asked youth in Uganda to describe how they handle their sexual feelings, one young man wrote,

> "To me, sexual feelings are a very big problem in my life and an obstacle to my education." (***male student, Mayuge)*** (Straight Talk Foundation, 2003)

Additionally, when youth do access this information it is often after they have already started to have sex or already realized they have been infected or become pregnant and are seeking treatment or medical services. (Hulton et al, 2000)

AGI's study reports that young people receive information about sexual and reproductive health from four main sources: 1) the media, 2) schools/teachers 3) health care providers and 4) family and friends. However, in the same study young people indicated their preference for sources of information based on the source's level of knowledge and ability to maintain confidentiality. (Amuynzu-Nyamongo et al, 2004) Unfortunately, because many youth perceive many sources as not confidential (e.g. Teachers and health providers), or uninformed (e.g., parents), they fail to seek information early enough to make sound decisions.

In the same study, youth had mixed emotions about parents as sources of information. While parents were generally seen as experienced and a good source of information, they were often not preferred because many youth felt their parents had a hard time separating the need to provide complete information to their child and the desire to protect or control their children. Two young men, one from the from the AGI focus group study, and the other from Straight Talk, made comments about information from parents and families:

> "Usually relatives tell you only problems of condoms even when you are using a condom that it is not safe. They say you should abstain, so relatives control you." ***(boy, in-school, AGI focus group)***

> "My guardian does not talk to me about sex and as such I was deeply rooted in unprotected sex with very many girls but since I joined STC in 2001 up to now I have not had any unprotected sex." ***(Gulu secondary school, boy)***

Schools provide a good opportunity to allow youth access to information and services. However, many communities and schools are uncomfortable teaching reproductive health education to youth or referring them to clinical services which many perceive as condom distribution or abortion services. Some feel that access to information will encourage youth to engage in sex when just the opposite is often true – young people allowed early and complete access to sexual and reproductive health education

take less risks when they initiate sexual activity. (Straight Talk Foundation, 2003)

Recently, and in recognition of the needs of youth and the important role of the school setting for providing information, the new PIASCY-led ASRH curriculum is being introduced in primary school. While the initiative is promising, it has several limitations primarily that the curriculum is based upon a limited number of key messages that are didactically administered.

False, late and incorrect information can reduce the risk perception for pregnancy among youth engaged in unprotected sex. For instance lack of information regarding the signs of pregnancy, 'fertile' periods and/or 'safe days' often leads to incorrect perceptions of safety. One example,

> "Yes I had unprotected sex after finishing my menstrual periods and after two days I saw some things coming out of my vagina but my friends told me that those were sperms and after three days I again received my periods so I don't know what is really happening and I feel my stomach can pain every time and I am thinking that I am pregnant. ***"(Mbale-Sironko (S3 Girl)***

Despite the wealth of information about means to prevent and detect HIV, the lack of information regarding concepts like the 'window period' for HIV can also lead to false security. This is indicated in several of the Straight Talk letters.

> "when I realized I was having unprotected sex I was so scared because I thought I had exposed myself to HIV/AIDS but the following day both me and my boyfriend went to the health center and tested for HIV and we were both negative…" (***Lira, girl)***

As indicated earlier, lack of adequate information and community support also limits likelihood to access services. UDHS reports that 34% of all youth between 15-19 years do not seek any advice or treatment when they suspect they are infected with an STI. Additionally, nearly 20% indicated when they do seek advice, it is from friends or relatives, many of whom are often uninformed themselves.

One study conducted in 8 districts in Uganda indicated that while services for guidance and counseling in ASRH were fairly well used, other services including STI prevention and treatment, contraceptive services, and antenatal care were considerably underutilized. Young women and

men are less likely to report sexually transmitted diseases, often because they are less likely to be aware of the symptoms. Additionally, young people in the study indicated their primary reasons for lack of access to services as including the following: fear or embarrassment, lack of money, poor reception by health center staff, refusal by a partner, and lack of knowledge about where to get the services. (MOGLSD, UNFPA, 2000)

VII. Socially defined Gender Norms Influence Vulnerability

Gender disparities underlie and fuel risky sexual and reproductive health practices among youth. While they are struggling with the dramatic changes that characterize adolescence and youth, young people often have few positive models of gender equity at home or in their community. As a result, they are particularly vulnerable to gender-based social and cultural expectations, which influence their health-seeking behaviour, decision-making and choices, level of empowerment and the means with which they interpret relationships. Girls are often disproportionately vulnerable due to lower social empowerment and, cultural expectations to marry or prepare for marriage. Boys are often forced to battle with strong peer pressure that requires them to demonstrate their power and virility. Both boys and girls often have very limited access to skills that will allow them to understand the dynamics of partnering in relationships, shared decision making and mutual respect.

Young men face significant social and cultural pressure to initiate sex and to do so early. The same friends, peers, relatives and other community members who condemn young women who become pregnant outside marriage, are often described by young men as exerting undue pressure on them to engage in sexual activity, to 'conquer' women sexually early and often and to even sometimes impregnate to prove their 'manhood'.

In regards to dealing with peer pressure to engage in sex early, one recent writer to Straight Talk indicates,

> "I first had sex when I was in S1. I had gone to a burial ceremony in company of mature boys. They started talking about sex. As they talked happily I wondered what they really meant. They later encouraged me to have a girlfriend who demanded for sex immediately. I was fearing and trembling. She pulled me to the rear of the school. I tried to resist. When I screamed, one of the boys who came with that girl came near and told me to not cry because people will laugh at

me. It was a painful experience. ***(15 years secondary school, boy, Ntungamo)***

At the same time, young girls are often defined in terms of their marriagiability because marriage and bearing children are often the only means for young girls and women to secure their identity within their families and communities. The emphasis placed on domestic work, submissiveness and obedience often limits their ability to be assertive and protect their own rights particularly in relationships with their male partners. (Mathur, Green, Malhotra, 2003). This is a particular risk in Uganda where the median age for first marriage for girls is 18 years.

Because a young girl's sexuality is usually not considered to be under her control but under the control of her father, husband, family or clan, an importance is placed on virginity that is not the same with young men. As a result, young girls often have a limited understanding of their bodies and sexuality, have sexual feelings that conflict with social expectations and are unable to discuss them in public.

Because young girls are often less informed and less empowered to negotiate than young men, they are often at increased risk for sexual coercion and rape. UNFPA reports that many young men and young women characterize relationships among as lacking respect for each other. Boys perceive girls as being primarily interested in money and material goods and in refusing sex upon this exchange; girls face the possibility of rape.

One study on unwanted or coerced sex indicated that while only 4% of women reported their first sex as forced, another 19% reported it as unwanted. (Youthnet, 2004). Additionally, while social dynamics limit the extent of power many young women have in relationships, some social norms and peer influence characterize what is considered rape and coercion. In AGIs study, young men mentioned different levels and circumstances of rape including what was described as 'soft rape' or slight vaginal penetration initiated after a girl had teased a boy and not completed the sex act. Others said that forced sex was not as serious if there had been an exchange of gifts of money. (Amuyunzu-Nyamongo et al, 2004)

Young people also often lack the skills necessary for initiating and understanding true balanced partnerships between men and women and the role sex plays in these relationships. In several studies of adolescent sexual behaviour, both boys and girls often describe their first sexual experience as one in which there was some type of manipulation as opposed to an intimate sharing partnership, even with longer termed

partners. In both the *Straight Talk* Letters and in the AGI study, young men described their first sexual experience alternatively as one in which they either 'conned' a girl to have sex in order to quell their sexual 'urges' or were alternatively, deceived or tricked by a girl who wanted to have sex with them. They also seemed to describe feelings that these methods were expected or understood to be the norm.

While love was mentioned and some basic concepts of romantic male/female relationships in some of the Straight Talk letters, the terms 'love' and 'romance' were often described as a necessary statements or actions. Respondents mentioned 'to romance', as a means to initiate sex, similar to foreplay. Love, or 'being in love' was also described as justification for having sex or for not using a condom.

One young female writer, feeling pressured to have sex to express love to her boyfriend wrote to Straight Talk asking for advice,

> "There is a boy who felt in love with me and assured to marry me if at all I agree to love him but he is interested in sex and with me. I hate sex because of its dangers. I have always explained this to him but his usual comment is that I am trying to fool him around." ***(Girl, Mbale Secondary School)***

In the AGI study young women reported that some men were 'bullies' who could have their way if they did not want to use condoms. Many of the girls indicated that there were often powerless to negotiate condom use (AGI)

> "Normally girls have no clear statement about their feelings to their boy lover, so that can lead or make a boy use force to the girl. This easily leads to unprotected sex." ***(girl, Arua)***

Alternatively, many of the young men quoted in the Straight Talk Letters seemed to feel that because they were pressured into sex by a young woman, the girl was behaving deviously and it was his role to 'punish' her for challenging him. The language used often indicates a sense of inequality in the relationship. One such letter is quoted as the following,

> "It was 2002 when my girlfriend who was my colleague visited me at home…I was not capable to deal with rousing body sexual feelings and ended up having sexual intercourse [unprotected] with her although she congratulated my manhood I was not

> happy about that incidence. I rebuked and cursed her behaviour and I challenged to leave her if [she] attempted to repeat this ill deed. Since that time, she has been paying me regular visits as a friend and has never requested for sex." (***Bungoma Secondary School, Boy)***

Resources and skills that empower effective decisions are also often distributed along gender lines. When asked, young women are more likely than young men to mention social conditions or events like poverty, that increase their risk for unprotected sex. Undoubtedly, this is because it is the young women who are disproportionately affected and more likely to face the need to exchange sex for money or basic necessities. In Uganda, girls are less likely to complete primary school, attend secondary school, or go on to institutions of higher learning than boys and mostly for economic reasons. Additionally, on almost every health statistic, women who have not attended secondary school are at greater risk than those who have. (DHED, 2000)

One young woman is quoted from the AGI study,

> "We get born in poverty-ridden households. If you get born from a poverty-ridden household and you don't have patience you can land into many problems. Because your parent can be poor without money, you want a good dress but you can't have it. You end up playing sex and doing all other bad things to sustain yourself." ***(Girl, rural Uganda, in-school)***

Gender roles also impact service seeking behavior, as it is often men who dictate the extent to which health services are accessed due usually to financial control or personal interest. In a Ugandan study of youth aged 14-21 years who had sought VCT, young women reported that their access to testing was greatly influenced by their male partners. Those who decided to get tested tended to do so if they were about to be married, had their partners support and knew their partners would pay for the test. Nearly 2 out of 3 girls said their partners encouraged them to be tested. In contrast, boys were more likely to decide on their own to be tested and to pay for the testing themselves. (Youthnet)

The UDHS also reports a disparity between young men and women regarding access to condoms. Among youth age 15-19, 28% of young women indicated they could get condoms if they wanted them versus 64% for men. These figures indicate that less than half of the women 15-24

who know using condoms reduce the risk of HIV can actually get them themselves. (ORC Macro, 2002)

While girls are often powerless in dictating condom use or other methods of contraception, they also bear the brunt of social condemnation if they become pregnant. In AGI's study, participants said that young unmarried pregnant women were often made fun of and insulted. Young men, on the other hand were often merely 'gossiped about'. Overwhelmingly in this study, young men were described as often denying responsibility for their sexual behavior. While laws in Uganda that require a young boys family to pay a fine for impregnating a girl under 18, statutory law requires only the girl to leave school upon becoming pregnant, creating longer term economic challenges.

Risks are also shared disproportionately between married men and women. In Uganda, nearly 50% of women are married by age 24. Additionally, the younger the woman is, the greater the age disparity between her and her husband creating a situation of unequal balance. While, historically, marriage and monogamy were generally indicated as a protective factors against HIV and STI infection, the 2000-2001 UDHS, data suggest that young, married girls are more likely to have reported a recent infection for an STI than unmarried adults, indicating lack of monogamy and 'faithfulness' to one partner, inability to negotiate protection, and perhaps foreboding future resurgence of increased HIV incidence. (UDHS, 2000-2001)

Of course early marriage also means early sex and has never been a protective factor for early pregnancy or unwanted children for which many young, married women are at particular risk. Additionally, while young women aged 15-19 are the least likely to be involved in a polygynous marriage, according to the UDHS survey 21% of women aged 15-19 had at least 1 co-wife and one in every 3 women in Uganda are in polygynous unions, increasing their risk for infection.

In the AGI study, young men indicated they used the fact that they were engaged as a means of convincing their future brides that they should have unprotected sex. In regards to the undue burden young married women face, one young in-school girl in a focus group discussion in Uganda states,

> " You just accept – you have nothing to do because you are married…you have to accept everything he says. You just check for blood…now if you are married – your husband might not be faithful to you. You might be faithful

but your husband sleeps with an infected person and it becomes a problem…you see the problem you are already married." (Amuyunzu-Nyamongo, 2004)

VIII. Education Level Has Direct Impact on Vulnerability

Education plays an important role in shaping a person's outlook, behavior in general and health-seeking behavior in particular. In addition to the skills gained through formal school curriculum, education provides an opportunity for young people to gain self-understanding, self-esteem and develop relationships with peers and adults outside of their families that increases their sources of information and skills. This is particularly important for young girls in asserting their rights, and protecting their sexual and reproductive health (UNFPA, 2003)

While the level of education attained in Uganda has increased for both men and women in the period between 1989 and 2001, men continue to be better educated than women and as a result, women are often more vulnerable to negative health outcomes. As mentioned earlier, young women are more likely to leave school earlier and to start school later than young men often due to the need for their labor at home. (DHS ED Data,) At age 15-19, 69% of all men are still in school but more than half of women in the same age are no longer attending school. Additionally, when students drop out, they are more likely to drop out early, after finishing primary or just before secondary.

According to UDHS, families' ability to pay school fees is the most often cited reason for children to drop out of school. However, approximately 13% of young girls drop out due to early pregnancy and marriage. Regionally, this number varies with the lowest dropout rate for pregnancy or marriage existing in Central Uganda (8.6%) and the highest at 33.8% existing in Eastern Uganda. Again girls are disproportionately affected. For instance, according to UDHS, only 17% of girls surveyed with secondary education or higher had had one or more children, opposed to 59% of those with no education and 33% with only primary level education.

Research has also shown that young girls in school are also at risk for lower participation and lower levels of learning due to teacher bias and menstruation. Teachers often undermine girls' participation in the classroom and have lower academic expectations (UNFPA, 2003). Girls

also often miss school due to menstruation, particularly when they have no information about their hygiene and sexual development.

Incidentally, the fear of being forced from school is one of the greatest motivating factors for girls in having protected sex. When girls are less educated they are often less able to negotiate condom use, are less aware of the symptoms of STIs and are also less concerned about early pregnancy.

IX. Protective Factors

While the vulnerabilities youth face for HIV, STI and early pregnancy may seem overwhelmingly negative, there exists evidence of protective factors that can limit the extent of this risk. Young people do have some understanding that they are at risk; some youth can identify an individual whom they trust to give correct information; and many youth indicate that the media provides a good opportunity for reliable information; youth indicate more openness to alternatives to sex.

In AGI's report, while youth seemed to underestimate the level of their risks, most of the participants were generally aware of their risk and the risk of their peers and this perception of risk pointed to an increased likelihood to take precaution.

Some youth also indicated that there was at least someone within their family whom they trusted to give them good information. One out-of school Ugandan youth mentioned in the AGI study,

> "Even when you have a problem, you go to your mother first then she tells your father."

Youth also mention the importance of the media and the opportunities it provides to give them correct and reliable information. While this may be relatively rare, one Ghanaian participant from the AGI study indicated that television programming that covered sexual related topics was used as an opportunity by his parents to educate him on sex.

Recently, Straight Talk readers have begun to write about masturbation as an alternative to sex.

In the study conducted by Straight Talk Foundation to understand the sexual feelings of youth and how they handle them, one young girl made reference to masturbation as a solution to sexual feelings.

> "I sit in warm water. I imagine I am with someone. I place my finger as if I am giving birth. I release fluids. I clean myself, then become okay and forget." ***(Female student, Iganga)***

Admittedly, more research is necessary to fully understand deeper issues of protective factors and resiliency as they relate to HIV, STI, and pregnancy risk reduction.

X. Conclusion

While evidence of increased risk-taking behaviour among Ugandan youth leaves cause for concern regarding the resulting impact of risk of pregnancy, HIV, and STIs, there seems to be evidence for potentially effective solutions.

The varied voices and experiences of young people throughout Uganda are now calling out for more sophisticated and comprehensive information that includes all issues of their sexual and reproductive health; that recognizes the fact that youth are not homogenous and have varying needs; that directly answers their questions; and that acknowledges that while delaying sex may be ideal, many youth are engaging in sex already. Sexually active youth need to have correct information and skills to enable them to make effective decisions and lower their risk for reproductive health problems. Additionally, those who have not yet begun to have sex also need comprehensive information on their sexual development that will prepare them for their inevitable sexual initiation and reduce their risk of STIs, HIV and unwanted pregnancy.

The gender dynamics of youth and the importance of interpersonal and social relations has not been adequate researched. Integrating issues of gender disparities, social expectations related to gender, appropriate role modeling, is crucial to sound ASRH programs. Youth in Uganda are challenged in their sexual relationships often due to the fact that they themselves don't understand the importance of balance relationships and how the lack of which influences their level of risk.

Communications programs and other interventions must incorporate youth from the very beginning and not as an afterthought in order to cull their viewpoints and enable the development of realistic programs. Additionally, ASRH communication may be well served if the adults often leading it could remember their own confusion and misinformation when they themselves began to have sex.

In a Ugandan study documenting youth's risk perception, the authors concluded that interventions targeting youth must focus on helping youth understand that they are responsible for their own sexual and reproductive health and that both boys and girls have a responsibility for the consequences of early or unprotected sex. They also stipulate that in order to advance toward such an understanding, a partnership is necessary between the two sexes in their sexual interaction. (Source: Percepts of the Risks of Sexual Activity and their Consequences, 2000) This level of intervention must target both the youth and their supportive networks, which reinforce norms and expectations.

In order to address the risks of youth, entire communities must take a role to ensure that knowledge-based interventions and messages provide youth with information and skills necessary to make sound decisions. Young people who are having sex early must be allowed access to information, skills and services to lower their risk for infections and early pregnancy; and concepts of gender and relationships must be addressed. Both boys and girls need community-led, positive reinforcement for healthy relationships that are not based on manipulation but on shared choices and decision-making.

At the center of each community is the home, and effective communication for ASRH must include useful communication tools for parents and guardians to interact with their children about their sexual and reproductive health and enable them to support social structures that decrease gender-based risk. Families and communities must also understand that access to education is the basis for empowering all their children and is crucial in lowering the risk of young people for negative reproductive health outcomes.

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