YOUNG MEN AS EQUAL PARTNERS PROJECT

BASELINE SURVEY AMONG FEMALE YOUTH IN PROJECT AREAS OF HOIMA AND BUSHENYI DISTRICTS

FINAL REPORT

BY

Richard Kibombo (Consultant)
Makerere Institute of Social Research,
P.O.Box 16022, Kampala, Uganda
Tel: 256-772-428109
Email: rkibombo@yahoo.com or
rkibombo@misr.mak.ac.ug

SUBMITTED TO

FAMILY PLANNING ASSOCIATION OF UGANDA

April 2007

TABLE OF CONTENTS

ACKNOWLEDGEMENT

This report is the result of collective and participatory work of various individuals and organisations who were involved in the management and implementation of the study, without whose assistance, support and cooperation this report would not have been put together.
This study was conducted within the YMEP-project, a collaboration between:

RFSU – The Swedish Association for Sexuality Education,
UMATI – The Family Planning Association of Tanzania,
FHOK – Family Health Options of Kenya
FPAU – The Family Planning Association of Uganda and
PPAZ – Planned Parenthood Association of Zambia.

The associations are all Member Associations of IPPF, The International Planned Parenthood Federation

This study was funded by The Swedish International Development Cooperation (Sida) and the Norwegian Ministry of Foreign Affairs.

Sida

NORWEGIAN MINISTRY OF FOREIGN AFFAIRS

The views expressed in the report do not necessarily reflect that of the agency's policies.

Special appreciation goes to Mr. Elly Mugumya, FPAU Executive Director, Mr. Jackson Chekweko and Dr. Ismail Ndifuna (FPAU staff) for the continuous technical support they extended throughout the study preparation and data collection process and for ensuring that all the logistical and material support were put in place at the right time.

I wish to register my sincere gratitude to the Chief Administrative Officers of Bushenyi and Hoima Districts for allowing us to conduct the study in their districts. Special thanks also go to the local council leaders in the study areas who assisted the field team in compiling the enumeration area household listings; identifying and introducing the members of the field team to the sampled households; and mobilising FGD participants.

I am equally grateful to the in-charges of the various health facilities visited and the youth who participated in the interviews and focus group discussions for the time they devoted to the exercise and more so for their insightful contribution during the interviews and group discussions. I learnt a lot from them and I am very hopeful that their individual and group inputs will help further to improve the delivery of sexual and reproductive health services to the youth in their districts as well as the entire country.

A vast amount of work needed to be covered in such a short period, and this would not have been possible without the tireless help of our Research Assistants (Jacqueline Karuhanga, Adrine Kusasira, Brenda Kajumba, Juliet Musanase, Assisi Maria, Clare Arinitwe, Jonathan Ngobi, Joyce Katigo, Jane Atugonza, Lilian Kiiza, Jacqueline Katusabe and Violet Atuhurra) and Data Entry Clerks. To all, I can only say that I am short of ways to show my gratitude.

Any shortcomings and errors of fact or opinion that remain, despite so much assistance, is my own responsibility.

Richard Kibombo
Consultant

Executive Summary

Introduction

The Family Planning Association of Uganda (FPAU) in partnership with the Swedish Association for Sexuality Education (RFSU) is implementing a 4-year project called "Young Men as Equal Partners" (YMEP) in three districts of Uganda namely, Hoima, Bushenyi and Arua. The overall goal of the Project is to improve the Sexual and Reproductive Health and Rights (SRHR) of young people in Uganda through increasing adoption of safer sexual practices and utilization of SRHR services by young men aged 10 to 24 years. The project is premised on the assumption that men in Uganda, and indeed most of sub-Saharan Africa, play a key role in decisions regarding utilisation of SRH services. Thus, by increasing men's adoption of safer sexual practices, the SRH status of the partners would also be improved.

In order to facilitate the monitoring and evaluation of the project, a baseline survey covering males aged 10-24 years of age was conducted in February- March 2006 to collect benchmark data for the key indicators of the project. However, it would have been impossible to have a complete picture of the project impacts without measuring the changes in access and utilisation of SRHR services among the female youth as well. Hence, this female survey was designed to fill this gap as well as to address some of the limitations in the male youth survey. Specifically, the female survey aimed at collecting baseline data on: SRH knowledge and attitudes; Attitudes towards gender equity; SRH behaviours and practices; and level of preparedness and readiness of health centre IIIs and similar facilities to provide adolescent youth friendly services.

Study design

The female survey employed a research design (and tools) similar to what was used in the male youth survey. It was a cross-sectional, household-based survey targeting females aged 10-24 years of age in two of the three YMEP districts (Bushenyi and Hoima). It covered a total of 200 female youth (i.e. 100 female youth per district randomly selected across three sub-counties covered by YMEP in each district). In addition, in each of the two districts, 6 focus group discussions (3 for male youth and 3 for female youth) were held to gather their collective views on arrange of SRHR issues, particularly regarding gender equity. Furthermore, 11 Health Centre IIIs and similar facilities (5 in Hoima and 6 in Bushenyi) where young people are expected to seek SRH services were visited to collect data on their state of preparedness to provide youth friendly SRHR services.

Key Findings

- Nearly all female youth have ever attended school but the majority (75%) do not go beyond primary.
- One out of every two female youth does not live with any biological parent.

- Although nearly all (98%) of the female youth are aware of HIV/AIDS and the majority knew how it is transmitted sexually and how it can be avoided, a substantial proportion still harbour false perceptions about the disease. For example, one out of every three female youth who are aware of HIV/AIDS did not believe that a perfectly health-looking person could be having HIV.

- Most female youth are aware of STIs (other than HIV) and how they can be avoided. However, the majority only know of two STIs: Gonorrhea and Syphillis.

- Although the majority of the female youth (88%) are aware that there are methods one can use to avoid pregnancy, this knowledge was not very deep. For example, most female youth could only mention the pill; the injection and the male condom as the family planning methods they had heard about. The majority could also not tell when a woman is most likely to get pregnant during her menstrual cycle.

- Cultural gender norms and stereotypes which often put young men and their families at risk are still prevalent. For example, two out of every three female youth interviewed held the view that a woman should tolerate violence for the sake of her family and about four out of every 10 females interviewed believed that a man needs other women even when he is not experiencing in the relationship with his wife or girl friend.

- Although about three quarters of the female youth have never been in any form of marital union, about one in three have had sex and age at sexual debut is about 17 years. However, of those unmarried female youth who have ever had sex, about a half are practicing secondary abstinence while the other half continues to have sex.

- Sexual harassment and abuse is widespread particularly among the older females with one out every two such females having experienced some form of sexual harassment/abuse.

- Exposure to SRH information among the female youth is fairly high; with the majority accessing it through radio, schools, mothers and friends. However, only 16% of the female youth had ever been talked to by a peer educator and 6% had ever visited an FPAU youth centre.

- About three quarters of the sexually experienced, 15-24-year-old females had ever used a condom and slightly over half (56%) of them had ever initiated a discussion with a sexual partner regarding using a condom.

- STIs appear to be widely prevalent in the project areas with about a half (51%) of the sexually experienced, 15-24-year-old females reporting that they had ever experienced STI-related symptoms in the 6 months prior to the study. However, one in four (27%) of these youth did not seek treatment.

- ❖ Four out of every ten 15-24-year-old females had tested for HIV and the majority (86%) had shared the results with someone – mostly parents and relatives.

- ❖ Affordability and poor handling of clients were identified as the main barriers limiting accessibility and utilisation of SRH services among the youth.

- ❖ Other than FPAU clinics, most of the existing Health Centre IIIs and similar facilities where youth are expected to seek services offer only a limited range of SRH services. These health facilities also lack staff trained in provision of youth friendly health services and the majority do not have any special arrangements (such as youth corners) in place for providing SRH services to the youth.

Conclusions and Recommendations

- ☞ Universal secondary education which has been recently instituted is a welcome initiative and needs to be strongly supported as it is likely to positively impact on the health and reproductive outcomes of women and the entire population particularly through delaying early marriages.

- ☞ Given that a half of the female youth do not live with their biological parents, special interventions are required to raise awareness among guardians for them to fully appreciate the diverse and challenging parental roles and responsibilities they have to meet in order to make the youth under their charge less vulnerable.

- ☞ The ABC strategy which Uganda adopted to control the spread of HIV/AIDS needs to be further promoted.

- ☞ There is need to raise awareness among the youth and the general public about the evil of gender-based violence in all its forms. Appropriate legislation also needs to be put in place to stem it.

- ☞ Program implementers need to continue identifying the risky misconceptions held by many youth about various SRH issues, such as the belief that a health-looking person cannot be having HIV/AIDS and that a woman is most likely to get pregnant right after her monthly periods, with the aim of developing specific messages and interventions to counter them.

- ☞ There is need to intensify sensitisation among the youth about STIs and the importance of seeking timely treatment.

- ☞ To increase uptake of SRH services among the youth, service providers need to put more effort in eliminating or reducing the major barriers, particularly cost and poor client handling, that prevent youth from accessing the services.

1.0 INTRODUCTION

In Sub-Saharan Africa and most of the developing world, women and girls have born the biggest brunt of the HIV/AIDS pandemic. There are a host of social, cultural and economic factors that make women and girls especially vulnerable to HIV/AIDS. In most of the developing world, girls drop out of school much earlier than boys which denies them skills and knowledge they need to access information, enter the labour force, and rise above the poverty that makes them all the more vulnerable to infection. Pressure to earn an income for themselves or their families leads many girls to engage in "transactional sex" often with much older men ("sugar daddies"), who give them money, school fees, or gifts in exchange for sex. According to the 2002 Uganda Demographic and Health Survey (UDHS), half of all Ugandan girls have had sex by age 16.7. Because of culture and due to poverty, girls tend to marry before they are 18 and all too often, marry older, sexually experienced men who may already be infected with HIV/AIDS and or unfaithful. These young girls often know very little about sex, HIV, or how to protect themselves and have limited capacity to negotiate condom use. Sexual violence against women also increases their vulnerability. One in three women worldwide will be raped, beaten, coerced into sex, or otherwise abused in her lifetime. A woman who experiences sexual violence is at a physically greater risk of contracting HIV, and if she is in an abusive relationship, she is rarely able to negotiate terms to protect herself from infection.

Women and girls are not only vulnerable to HIV infection but also to other STIs and unintended or unwanted pregnancies all of which are detrimental of their health and general welfare. Early childbearing is a serious problem among youth. According to the UDHS (2002), teenage pregnancy represents 31% of all pregnancies. It further reveals that children born to mothers under 20 have a 30% higher risk of dying before their first birthday than children born to mothers aged 20-29. The UDHS also shows that 16% of women as opposed to 6% of men aged 15-24 reported having an STI or symptoms in the 12 months preceding the survey.

It is against this background that Family Planning Association of Uganda (FPAU) in partnership with the Swedish Association for Sexuality Education (RFSU) is implementing a project called “Young Men as Equal Partners” (YMEP) in three districts of Uganda namely, Hoima, Bushenyi and Arua. The overall goal of the Project is to improve the Sexual and Reproductive Health and Rights (SRHR) of young people in Uganda. The Project is based on the premise that men in most African countries play a major role in decision making and influencing matters of sexual and reproductive health such as whether or not to have protected sex and the number of children to be produced by a family. Despite this, men have received inadequate strategic interventions aimed at their access to SRHR services and information. The YMEP, therefore, seeks to increase adoption of safer sexual practices and utilization of SRHR services by young men aged 10 to 24 years in the project sites (RFSU, 2005). The specific Project outputs/results that are expected of the 4-year project include, among others:

1) Increased access to information and education on gender and SRHR among young men and women increased.

2) Increased utilization of SRH services by young men and young women increased.
3) Increased use of voluntary counseling and testing (VCT) services by young men and young women increased.

As part of the monitoring and evaluation process for the YMEP Project, a baseline survey aimed at collecting benchmark data on key Project indicators was conducted in February – March 2006 by Family Health International (FHI). The survey covered only young males aged 10 – 24 years in the three Project districts. However, it would be impossible to get a complete picture of the changes in the Project indicators without conducting a female youth survey - just as it was done among their male counterparts. Specifically, the female survey aimed at collecting data that will measure changes among young women 10-24 years on the following indicators:

1. Sexual and reproductive health knowledge and attitudes;
2. Attitudes towards gender equity;
3. Sexual and reproductive health behaviours.

In addition, an attempt was made in the female survey to cover some of the gaps and study limitations of the male survey.

1.1 STUDY DESIGN

The female survey used a research design (and tools) similar to that used in the males survey. The survey was household-based and targeted females aged 10-24 years in two YMEP districts of Hoima and Bushenyi. Unlike the male survey, collection of primary data for the female survey was restricted to only two districts due to unavailability of financial resources to cover all the three YMEP districts.

In addition to the household-based female survey, supplementary data was collected on readiness of public and NGO health facilities existing in the survey areas to provide adolescent friendly sexual and reproductive health (AFSRH) services. Focus Group Discussions (FGDs) were also conducted among both male and female youth in the selected study areas to further enrich, triangulate and clarify the data collected through the household and health facility surveys.

1.1.2 Target Population

For the household-based female survey, the target population consisted of all female household members aged 10 to 24 years as of their last birthday. The definition for household membership was the same as that used in the male survey; that is all persons who regularly live together and share meals. The study was conducted in the same study sub-counties covered in the male youth survey in the two districts of Bushenyi and Hoima. However, with regard to the focus group discussions, it is only the older youth (15-24 years), both male and female, who comprised the target population. Young adolescents (10 – 14 years) were excluded in the FGDs because of the limited resources and the fact that few of

them are actually sexually experienced and hence their additional contribution to the issues that were to be discussed was considered to be minimal.

With regard to the health facility survey, managers or in-charges of the Health Centre III/II and similar NGO facilities including FPAU facilities where youth in the study sites are expected to seek for SRH services were targeted.

1.1.3 Female Survey

Sample Size and Selection
Due to the limited financial resources that were available for this component of the study, it was planned that 100 respondents per study district (compared to 500 in the male's survey) were to be interviewed giving a total sample size of 200 females from the two districts. Consequently, even though all the three (3) sub-counties covered in the male youth survey were also covered in this survey, only a quarter of the original enumeration areas (EAs) in each of the sub-counties was included given the much smaller sample size of female youth who were to be interviewed. Hence, only one (1) EA – the one with the highest household population – was selected from each of the three study sub-counties in each of the two study districts. Approximately, 33 interviews were to be conducted per each enumeration area. Drawing from the experience of the male youth survey, on average, it was expected that each eligible household would have at least 1.5 eligible female adolescents. Thus, about 22 eligible households (those with female household members in the age range 10 – 24 years) were required to obtain 33 eligible female respondents. The 22 households were randomly selected using systematic random sampling from a household listing of eligible households in a given enumeration area. The household listings used in the sample selection of the eligible households had been developed during the male survey but were updated with the assistance of the local council (LCI) leaders. The updating involved removal of households that no longer exist and adding new ones and those that had females in the age-group 10 – 24 years. The local leaders also assisted in locating the randomly selected households as well as introducing members of the field research team to these households.

1.1.4 Focus Group Discussions

In each of selected enumeration areas (villages), 2 focus group discussions, each comprising of 8 – 12 participants, were held with separate groups of 15 – 24-year-old males and females. Since the study covered three (3) sub-counties per district, 6 FGDs were conducted per district giving in a total of 12 FGDs from the two districts. Local leaders were used to mobilize the adolescents who participated in the FGDs.

1.1.5 Health Centre Sample Size

In each of the study sub-counties, 2 health facilities were visited to collect data on the nature and type of SRH services, arrangements in place to provide SRH services to youth, level of demand for SRH services among the youth and challenges faced in providing AFSRH services. In total, 11 key informant interviews with managers of health facilities were

conducted. The expected number fell short by one because in one of the sub-county, only one eligible health facility was available.

1.2 STUDY LIMITATIONS

Due to limited funding, the female survey (unlike the male survey) did not cover Arua District which is one of the YMEP districts. Hence, baseline data on female youth indicators are unavailable for this district. One possible solution to this problem is to use secondary data. Straight Talk Foundation (STF), which conducted an evaluation survey of its programme in 2005 in Arua and five other districts and collected data on many of the aspects covered in the YMEP surveys, is one potential source of such data.

Another limitation of the female survey is the relatively small sample size used. This limits the depth of analysis and also comparisons with results from the male survey are restricted.

2.0 BACKGROUND CHARACTERISTICS OF SURVEY RESPONDENTS

It is important to have a good understanding of the social and demographic characteristics of the respondents because they provide very important background for interpreting young people's vulnerability to HIV and unwanted pregnancy. In this chapter, data is presented on a number of important aspects of young people's lives including their education, family situations and social ties.

2.1 EDUCATION ATTAINMENT

School attendance and educational attainment are very important factors with regard to sexual and reproductive health behaviour. Table 2.1 indicates that there is near universal school enrolment with only 1% of the female youth indicating that they have never attended school. However, the majority of the female youth never go beyond primary school as evidenced by the high percentage (75%) of 15-24-year-olds whose educational attainment is only primary. This high school drop out rate has many likely negative impacts on the future lives of female adolescents especially their sexual and reproductive health in terms of early marriages and pregnancies; high fertility; maternal mortality and morbidity; and exposure to HIV/STI infections.

Table 2.1 Percentage distributions of female youth by education experience and age

Characteristic	*10-14 (N=103)*	*15-24 (N=104)*	*Total (N=207)*
Ever attended school			
Yes	99	99	99
No	1	1	1
Currently attending school			
Yes	89	30	60
No	11	70	40
Highest level of education attained			
None	1	1	1
Primary	95	75	85
Secondary	4	22	13
Higher	-	2	1

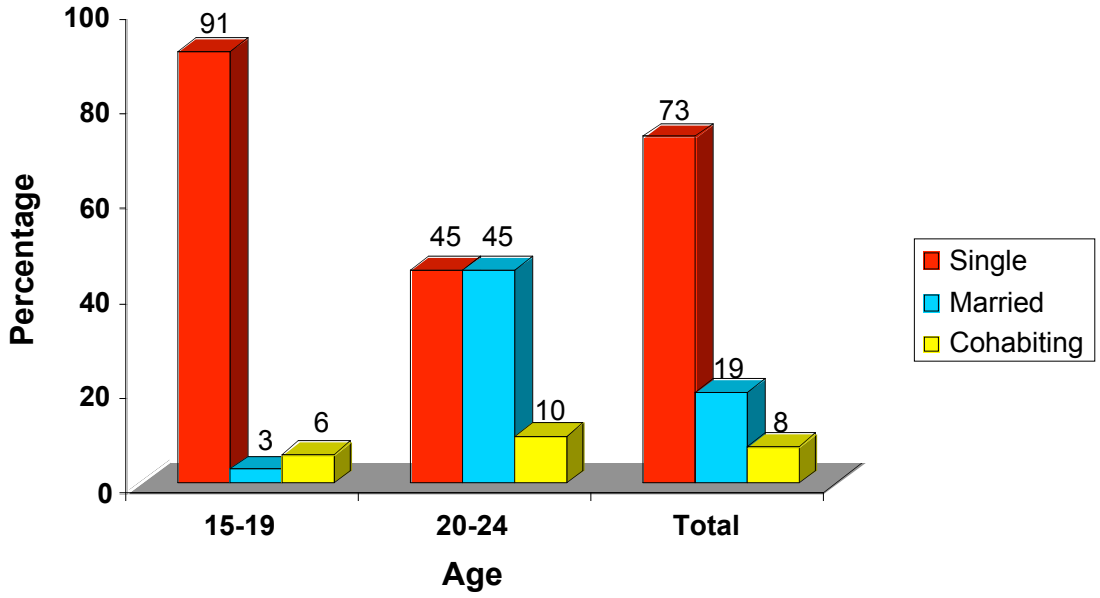
Ns unweighted.

2.2 FAMILY SITUATION

Marital Status

The sexual and reproductive issues of female youth who are in marital union (including cohabiting) are often different from those who are not - especially considering that the former often cannot independently make key decisions regarding their sexual and reproductive lives. Specifically, female adolescents who are in union are exposed to a high risk of early pregnancies that might result in severe complications such as prolonged labour, postpartum haemorrhage or even death. Available evidence also shows that HIV infections rates are now higher among married couples than among persons who have never been married (HIV/AIDS Sero-Behavioural Survey, 2004-05). Table 2.2 shows that about one in every four (27%) of the 15-24-year-old female adolescents was currently in a marital union. Further analysis (Figure 1) shows that, among the 15-19-year-olds, about one out of every eleven (9%) are in marital union.

Figure 1: Percentage distribution of 15-24-year-old female youth by marital status



Status of biological parents

Besides providing for the physical and psychosocial needs of their children, parents play the role of key "gatekeepers" in terms of monitoring and regulating their children's freedoms and social behaviours. The death of a parent robs children of that care and protection and, for adolescents – especially females, it significantly increases their vulnerability to risky sexual behaviour such as early marriage and engagement in transactional sex in order to meet basic needs. One out of every three (36%) of all female youth reported that they had lost at least one parent – and in most cases the father. Orphan-hood was observed to be much more prevalent among older adolescents with one out of every two (50%) of the 15-24-year-olds reporting that they had lost at least one parent.

Furthermore, the relationship of an adolescent with the household head is a proxy indicator of the level of access such an adolescent has to the household resources as well as her relative freedom in terms of being monitored. Thus, adolescents who do not live with their biological parents may be more vulnerable to risky sexual behaviours. The study findings reveal that the majority of the female youth (64%) do not live with both their biological parents and this is true even among young females (12-14) among whom one out of every three does not live with both parents.

Table 2.2 Percentage distributions of female youth by union status, orphan hood, living arrangements and other basic socio-demographic characteristics by age category

Characteristic	*10-14 (N=103)*	*15-24 (N=104)*	*Total (N=207)*
Current union status			
Not in union	100	73	86
In union	-	27	14
Whether biological parents are alive			
Both are alive	78	50	64
Only father is alive	5	11	8
Only mother is alive	13	25	19
Both are dead	5	14	9
Whether respondent lives with biological parents			
Lives with both	48	24	36
Lives with only father	6	4	5
Lives with only mother	14	8	11
Doesn't live with any	33	64	49

Ns unweighted.

Membership of Social and Religious Groups

Membership and participation in activities of religious and other social groups offers yet another avenue through which young people may receive information and advice which might promote positive sexual and reproductive health behaviours and hence reduce their vulnerability to HIV and unwanted pregnancies. Table 2.3 shows that 84% of the female youth belonged to the Christian faith while 16% professed to Islam. An overwhelming majority (86%) reported that they attend religious services at least once a week suggesting that religion is an important factor in many lives of young people. However, membership of other social groups was quite low across all age groups with only 15% of the female youth indicating that they belonged to such groups.

Table 2.3 Percentage distributions of female youth by religion and membership of other social groups by age category

Characteristic	*10-14 (N=103)*	*15-24 (N=104)*	*Total (N=207)*
Religion			
Moslem	18	13	16
Catholic	31	39	35
Protestant	47	40	44
Other (SDA/Born-again)	4	7	5
Frequency of attending religious functions			
More than once a week	14	13	14
Once a week	76	69	72
A couple of times a month	7	10	8
Once a month or less	3	8	6
Participation in religious activities or programmes			
Yes	29	39	34
No	71	61	66
Membership to a youth group/organisation			
Yes	12	19	15
No	88	81	85
Frequency of attending activities of youth group			
More than once a week	8	20	16
Once a week	67	35	47
A couple of times a month	8	35	25
Once a month or less	17	10	12

Ns unweighted.

3.0 KNOWLEDGE AND ATTITUDES ABOUT SRH ISSUES AMONG FEMALE YOUTH

A number of national surveys, such as the UDHS, have shown that awareness among Ugandan adolescents about SRH issues such as HIV is high but this knowledge is often not deep and many adolescents continue to harbour misconceptions about a wide range of SRH issues which may hinder them from taking action to protect themselves. This chapter presents information on adolescents' knowledge and attitudes towards a range of SRH issues including contraception, HIV/STIs and SRH gender stereotypes.

3.1 KNOWLEDGE AND ATTITUDES ABOUT HIV/AIDS

Table 3.1 shows that there is near universal awareness about HIV/AIDS with 98% of the female youth respondents saying that they have ever heard of HIV/AIDS. In fact, all the 15-24-year-olds said they had ever heard of HIV/AIDS and among the 10-14-year-olds only 4% had not heard of it. When asked how one can get HIV, an overwhelming majority (95%) of those who were aware of HIV/AIDS spontaneously mentioned that it is spread through sexual intercourse. In addition, 56% of the 10-14-year-olds and 81% of 15-24-year-olds mentioned that HIV is also spread through sharing of body piercing instruments such as needles, razor blades and injections. However, very few female youth mentioned other modes of HIV transmission such as blood transfusions and breast feeding. A few (4%) revealed that although they were aware of HIV/AIDS they did not how it is spread while others (15%) believed that the virus can be transmitted through mother to foetus, mosquito bites, kissing and casual contact. Asked as to when it is possible for a mother to transmit HIV to her child, about three out of every four female youth believed that HIV transmission was possible during pregnancy, at the time of delivery and during breast feeding. About one out of every three female youth (34%) who had heard of HIV did not think that a person can look completely health when they have HIV.

Female youth who were aware of HIV/AIDS were also asked how one can avoid getting HIV/AIDS. The majority (86%) across all age groups were of the view that HIV can be avoided through abstinence. Sixty percent of the older females and 29% of the younger ones stated that use of condoms can prevent HIV transmission. About one in three (36%) also indicated that HIV transmission can be prevented by avoiding sharing of body piercing instruments. However, only a very small proportion (14%) mentioned limiting sex (being faithful) to one partner as one of the means through which one can avoid getting HIV. When asked as to how persons living with HIV/AIDS (PLHAs) in their community should be treated, opinions were divided with 44% of the female youth saying they should be treated like everybody else while others (43%) were of the view that they should be treated with more sympathy. A few, particularly the younger adolescents (17%), felt that PLHAs should be isolated from the community.

Table 3.1 Percentage Distribution of female youth by their knowledge and attitudes about HIV by age category

Characteristic	*10-14 (N=103)*	*15-24 (N=103)*	*Total (N=206)*
Have you ever heard of HIV or AIDS?			
Yes	96	100	98
No	4	-	2
How can a person get HIV/AIDS? †			
Sexual intercourse	93	97	95
Sharing needles/blades	56	81	68
Blood transfusions	7	15	11
Kissing	-	5	2
Mother to fetus	5	11	8
Breast feeding	1	1	1
Mosquito bites	-	2	1
Casual contact	6	4	5
Others (e.g through accidents)	6	7	7
Don't know	6	1	4
What can a person do avoid getting HIV?†			
Abstinence	86	85	86
Use of condoms	29	60	45
Limit sex to one partner	8	19	14
Avoid sharing body piercing instruments	32	43	36
Others (avoid sex with prostitutes, avoid sex with people with multiple partners, test for HIV before marriage)	9	10	9
Others (avoid kissing/mosquito bites/casual contact, use oral contraceptives)	3	6	4
Is it possible to have HIV but appear completely health?			
Yes	56	74	65
No	41	26	34
Don't know	3	-	1
Is it possible for mother to transmit HIV to child during:			
-Pregnancy? Yes	76	71	73
No	9	25	17
Don't know	15	4	9
-Delivery? Yes	65	89	77
No	18	9	13
Don't know	17	2	9
-Breastfeeding? Yes	78	89	84
No	4	6	5
Don't know	18	5	11
How should PLHA be treated in your community?			
Like everybody else	30	57	44
With more sympathy	49	38	43
Should be isolated from the community	17	6	11
Should be mistreated by the community	2	-	1
I don't know	1	-	-

† **Multiple responses apply. Ns unweighted.**

3.2 KNOWLEDGE ABOUT STI:S OTHER THAN HIV/AIDS

All female youth (13-24 years old) were asked whether they had ever heard of diseases/infections that are transmitted through sex, apart from HIV/AIDS. Those who had were further asked what types of STIs they had heard of and how one can avoid getting such diseases. Table 3.2 shows that 92% of the females had heard of other STIs than HIV/AIDS. Syphilis and gonorrhoea appear to be the most known. These were spontaneously mentioned by 75% and 67% of the respondents respectively. Few respondents were able to spontaneously name other STDs, although after being prompted, over half of the respondents claimed they had heard of herpes, genital warts and chanchroid. Regarding what one can do to avoid getting STDs, similar responses were obtained when female youth were asked the same question with respect to HIV. The majority of the respondents were of the view that abstinence (85%) and use of condoms (66%) were the best ways of avoiding STDs. Again, few (17%) mentioned limiting sex to one partner as an effective way of avoiding STDs.

Table 3.2 Percentage Distribution of female youth by knowledge of STIs by age

Characteristic		*13-14 (N=49)*	*15-24 (N=104)*	*Total (N=153)*
Have you heard of diseases that can be transmitted through sex?				
Yes		92	92	92
No		8	8	8
What type of STIs do you know of?				
Gonorrhea:	Spontaneously mentioned the STD	52	75	67
	Mentioned after prompting	33	24	27
	Has not heard about the STD	15	1	6
Syphilis:	Spontaneously mentioned the STD	70	77	75
	Mentioned after prompting	20	22	21
	Has not heard about the STD	11	1	4
Chanchroid:	Spontaneously mentioned the STD	-	2	1
	Mentioned after prompting	39	65	56
	Has not heard about the STD	61	33	42
Genital warts:	Spontaneously mentioned the STD	-	4	3
	Mentioned after prompting	28	67	54
	Has not heard about the STD	72	29	43
Herpes:	Spontaneously mentioned the STD	4	6	6
	Mentioned after prompting	61	84	77
	Has not heard about the STD	35	10	18
Others (e.g. Candida): Spontaneously mentioned other STD		20	22	21
	Didn't mention any other the STD	80	78	79
What can a person do to avoid getting STIs? †				
Abstinence		87	83	85
Use of condoms		55	72	66
Limit sex to one partner		17	18	18
Others (e,g, avoid sex with people with multiple partners/prostitutes)		7	10	9

† **Multiple responses apply. Ns unweighted.**

3.3 KNOWLEDGE AND ATTITUDES REGARDING CONTRACEPTION

Female youth 13-24 year old were asked a number of questions regarding a range of issues related to contraception in order to gauge their knowledge and gain a deeper understanding of their perceptions towards pregnancy. Table 3.3 shows that 88% of the female youth are aware that there are ways one can prevent a pregnancy. However, this awareness varies considerably with age with 29% of the 13-14-year-olds indicating that they are not aware compared to only 4% among the 15-24-year-olds.

Female youth who were aware of any family planning methods were asked which methods they knew about. The pill, injection and male condom – in that order of importance- were the most spontaneously mentioned methods that can be used to prevent pregnancy. However, there appears to be some knowledge differences between the younger adolescents and their older counterparts. The majority of the older adolescents spontaneously mentioned the pill (79%), injection (69%) and male condom (65%) as the methods they knew that can be used to prevent pregnancy while the majority of the younger adolescents mentioned the male condom (64%), pill (44%) and injection (31%).

However, very few female youth spontaneously mentioned the other methods of pregnancy prevention such as using the female condom, the implant or even the natural methods like the rhythm and withdrawal. Even when prompted, many of the female youth particularly the younger ones revealed that that they were not aware of these methods. For example, over 70% of the younger female youth had never had of implants or the withdraw method and among the older female youth, over 40% had never had of these methods of pregnancy prevention as well.

Given that the condom is only method that protects both against HIV as well as unwanted pregnancy, female youth were asked about their views regarding the efficacy of the male condom in pregnancy prevention. The majority (69%) were of the opinion that, if used correctly, the male condom can protect a person from getting a pregnancy most of the time. However, about one out of every four female youth was of the view that it only protects sometimes and 4% believed that condoms do not protect one against pregnancy.

Given the difficulties many women experience in accessing and/or using modern contraceptives due to unavailability of services or due to negative attitudes towards modern contraception, natural methods such as the rhythm may offer the only recourse to some women especially in rural areas. However, knowledge about this method was quite low. Only about a half of the female youth had ever heard of this method of preventing pregnancy. Even among the 15-24-year-olds, only 13% spontaneously mentioned it as a method of pregnancy prevention although 57% said they had heard about it after being prompted. Knowledge regarding the correct application of the rhythm method was even lower as evidenced by the small proportion (only 21%) of the female youth who knew that a woman is most likely to get pregnant two weeks before her monthly menstrual bleeding starts (Table 3.4). The apparent low level of knowledge regarding when a woman is most likely to get pregnant during her monthly cycle was further confirmed in the focus group discussions conducted with both male and female youth in the study areas. The quotation

below is representative of what was said in most FGDs, particularly in Bushenyi District, when participants were asked whether a woman/girl can get pregnant when she plays sex for the first time or when plays sex only once.

"If a woman is in her monthly periods, she can conceive, but if she is not, she cannot."

Female Youth FGD, Kakanju Su b-county (rural), Bushenyi District.

Female youth (13-24-year-olds) were further asked for their views regarding what was likely to happen to them or to a young woman who falls pregnant. The majority of the respondents mentioned dropping out of school (50%), life being in danger (47%) and disapproval by family (32%) as the major negative consequences that are likely to befall a young woman who gets pregnant. Only 3% of the female youth felt that pregnancy would have no negative consequences. In fact, 77% described the consequences as very bad if they themselves were to fall pregnant in the next 3 months from the time of interview. It is only a small proportion (10%) of the 15-24-year-olds (70% of whom were actually in marital union) who said they would be happy to fall pregnant.

FGD participants also reflected similar views regarding pregnancy outside marriage. There was general consensus among participants, in both male and female FGDs, that they fear pregnancy outside marriage – although for varying reasons. Female participants in almost all FGDs revealed that dropping out of school, being disowned by their families and the boy not taking responsibility for the pregnancy were their major fears regarding pregnancy outside marriage. On the other hand, most male FGDs revealed that getting imprisoned for defilement was their major fear.

Table 3.3 Percentage Distribution of female youth by their knowledge about contraceptives by age category

Characteristic	*10-14 (N=103)*	*15-24 (N=103)*	*Total (N=206)*
Have you ever heard of any methods of avoiding pregnancy?			
Yes	71	96	88
No	29	4	12
Which methods of avoiding pregnancy have you heard of?			
Pill			
Spontaneously mentioned method	44	79	70
Mentioned after prompting	50	19	27
Has not heard about method	6	2	3
Injection			
Spontaneously mentioned method	31	69	59
Mentioned after prompting	56	30	37
Has not heard about method	14	1	4
Male condom			
Spontaneously mentioned method	64	65	65
Mentioned after prompting	31	32	32
Has not heard about method	6	3	4
Female condom			
Spontaneously mentioned method	11	12	12
Mentioned after prompting	42	55	51
Has not heard about method	47	33	37
Rhythm			
Spontaneously mentioned method	6	13	11
Mentioned after prompting	33	57	51
Has not heard about method	61	30	37
Withdrawal			
Spontaneously mentioned method	-	7	5
Mentioned after prompting	28	52	46
Has not heard about method	72	41	49
Implant			
Spontaneously mentioned method	-	11	8
Mentioned after prompting	14	44	36
Has not heard about method	86	45	56
Other methods			
Spontaneously mentioned other method	14	7	9
Didn't mention any other method	86	93	91
Do you think a condom can protect against pregnancy if used correctly?			
Protects most of the time	62	72	69
Protects sometimes	32	22	25
Does not protect	3	4	4
Don't know	3	2	2

Ns unweighted.

Table 3.4 Percentage Distribution of female youth by their knowledge and attitudes regarding pregnancy by age category

Characteristic	*13-14 (N=51)*	*15-24 (N=104)*	*Total (N=155)*
If a woman is not using a family planning method, what is the most likely time she can get pregnant during her menstruation cycle?			
Right after her monthly bleeding stops	33	59	50
During her monthly bleeding	18	8	11
2 weeks before monthly bleeding starts	16	23	21
Don't know	33	11	18
What are the negative consequences that can happen to a young woman who gets pregnant? †			
Nothing at all	4	2	3
Dropping out of school	59	46	50
Running away from home	8	8	8
Early marriage	8	1	3
Has to support the child	20	21	21
Disapproval by the family	29	34	32
Disapproval by the community	6	11	9
Her life might be in danger	33	54	47
Other	12	18	16
Describe the consequences if you were to become pregnant in the next 3 months †			
Good	-	10	6
Not so good	2	5	4
Somewhat bad	4	14	11
Very bad	92	70	77
Don't know	2	1	1

† **Multiple responses apply. Ns unweighted.**

3.4 ATTITUDES TOWARDS COMMON GENDER STEREOTYPES

Culture and personal attitudes are some of key factors that are known to have a big influence on an individual's behaviour – including health seeking behaviour. Female youth (15-24-year-olds) were asked a number of questions on common gender stereotypes in order to get a deeper understanding of their perceptions regarding such issues some of which significantly impact on their welfare particularly their sexual and reproductive health. Table 3.5 shows that the views of the majority of the female youth tally with the common gender stereotypes. For example, over 70% of the female youth agree with the traditional roles of a woman in a home – that is – cooking for husband family; taking care of children; and the husband having the final say on major decisions affecting the household. However, the majority of young women are opposed to wife battery. For example, 81% of the female youth felt it was wrong for a man to hit wife if she refuses to have sex with him; and 64% felt it is unacceptable for a woman to tolerate violence in order to keep her family together.

Although the majority of female youth appear to approve the use of a condom in a relationship – judging from the proportion (52%) that wouldn't be offended if their husbands asked to use a condom, it is also apparent most of them feel it is the responsibility of the male partner to provide condom during sex. Most female youth expressed disapproval of females who carry condoms as evidenced by the majority (62%) who were of the view that a woman who carries a condom must be loose.

Table 3.5 Percentage Distribution of female youth by their attitudes regarding common gender stereotypes

Characteristic	N = 104 *(Row percentages used)*		
	Agree	*Partially agree*	*Disagree*
It is the man who decides what type of sex to have	56	8	37
A woman's most important role is to take care of her home and cook	71	9	20
Men need sex more than women do	76	9	15
You don't talk about sex, you just do it	37	13	50
Women who carry condoms with them are easy	62	10	29
Changing diapers, giving kids a bath etc are a mother's responsibility	81	6	14
It is a woman's responsibility to avoid getting pregnant	78	11	12
A man should have the final word about decisions in his home	71	11	18
Men are always ready to have sex	64	15	21
There are times when a woman deserves to be beaten	27	12	62
A man needs other women, even if things with his wife/girlfriend are fine	37	2	62
If someone insults you, you defend your reputation with force if you have to	53	6	41
A woman should tolerate violence in order to keep her family together	64	8	28
I would be outraged if my husband asked me to use a condom	39	9	52
It is okay for a man to hit his wife if she won't have sex with him	15	5	81
It disgusts me when I see a man acting like a woman	64	10	26

Ns unweighted.

FGD participants, both male and female, also echoed similar views confirming that these traditional gender norms and stereotypes are still deep-rooted within the communities. There

was general consensus among participants across all FGDs regarding certain roles that are deemed exclusively for males and those for females. In all FGDs, all house keeping roles (such as cooking, serving food, laying a bed, taking care of the children, doing laundry, fetching water/firewood, taking water to the bathroom for the husband etc) were considered by both male and female participants as work that is exclusively for women while the men are supposed to take care of the family financial needs as well as handling the 'tougher' jobs such as putting up a family home, being a mechanic or riding 'boda-boda'.

"A woman cannot buy clothes for a man because it is the man's responsibility. (If she does), she will tell the rest about it or if you separate, she will take away the clothes from you. … A woman came from the man's ribs so you take charge of everything. It is also embarrassing to put on a woman's clothes. People will say it is your wife fending for you."

Male Youth FGD, Hoima Town Council (Urban), Hoima District.

In some FGDs – particularly in Hoima, some participants expressed the view that, unlike for women, it is acceptable for men to have multiple sexual partners. Men are also the ones who are supposed to initiate a relationship; they decide whether or not to use protection during sex; when and how to have sex; and how many children to have.

"Culturally, men are allowed to have more than one woman but not a woman. … A man can have a child outside wedlock but not a woman."

Male Youth FGD, Buhanika Sub-county (Rural), Hoima District.

4.0 SEXUAL BEHAVIOUR AMONG FEMALE YOUTH

The initiation of sexual intercourse among adolescents marks a very important transition in their lives especially because it exposes them to unwanted pregnancies, HIV and STIs. This transition accentuates the adolescent's immediate need for information and services to protect them from these risks. This chapter presents evidence on the sexual experiences of 13-24-year–old female youth on a range of sexual reproductive issues including the timing of their first sexual intercourse, characteristics of the first and most recent sexual partners, and number of sex partners.

4.1 FIRST SEXUAL EXPERIENCE

Female youth aged 13-24 years who are not in marital union were asked whether they have ever had sex; age at sexual debut; characteristics of their partners at first sex; and the reasons for having sex the first time. Those who have never had sex were asked the reasons why they have not; whether they feel any pressures to have sex and the source of that pressure. Figure 2 shows that 30% of unmarried female youth have ever had sex. It further shows that sexual activity increases dramatically with increasing age from 10% among the 13-14-year-olds to 78% among the 20-24-year olds.

Figure 2: Percentage distribution of 13-24-year-old unmarried female youth by whether they have ever had sexual intercourse

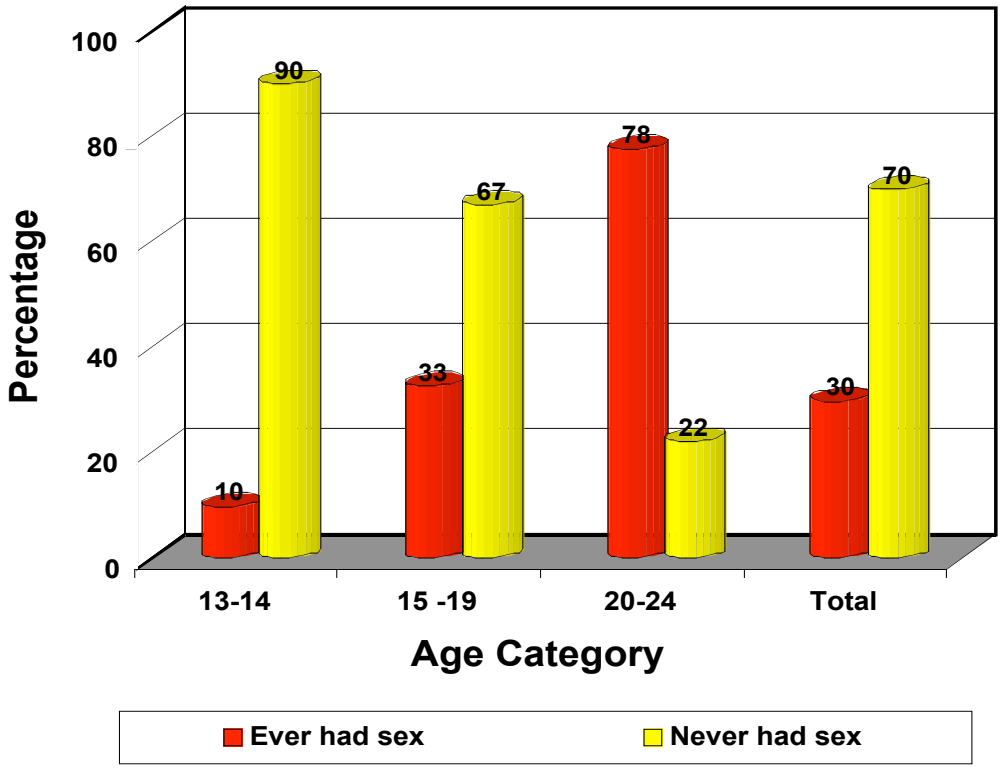


Table 4.1 shows that many (43%) of the female youth who have never had sex plan to continue not to have sex until they finish school or after achieving certain goals. This finding further confirms that attendance of school in itself plays a vital role in moderating sexual behaviour among unmarried female adolescents and ultimately impacts on their sexual and reproductive health outcomes. About a quarter of the female youth reported that they plan to abstain until marriage and a slightly smaller proportion (22%) plan to abstain until they are about 19 years old. Contrary to the general perception, the majority of these adolescents (80%) reported that they actually don't feel pressured to have sex. Those who feel pressured to have sex said that it is mainly friends who are pressurising them to engage in sex.

Table 4.1 Percentage distributions of female youth who have never had sex by when they plan to do so and pressure to have sex by age category

Characteristic	*13-14 (N=46)*	*15-24 (N=43)*	*Total (N=89)*
How long do you plan to continue not to have sexual intercourse?			
When opportunity comes	-	2	1
Until marriage	24	28	26
Until when emotionally ready	7	-	3
After finishing school/fulfilling my plans	40	47	43
Don't Know	7	5	6
When am a certain age:	22	21	22
Median Age (in years)when ready to have sex	*20*	*18*	*19*
Do you feels pressure to have sex?			
Yes	11	30	20
No	89	70	80
Source of pressure to have sex[†]:			
Friends	80	100	94
Relatives	20	8	11

[†] **Multiple responses apply. Ns unweighted.**

Regarding those female youth who have ever had sex, Table 4.2 shows that the median age at sexual debut is about 17 years which is consistent with the national average (UDHS, 2001-02). The data also shows that the majority (86%) of the female youth had their first sexual experience with an older sex partner who in most cases was a boy friend. Only one out of every four 15-24-year-old females reported that they first had their first sexual experience with their husband. The main reasons given as to why they had sex for the first were that they wanted to (35%) or to show love to their partners (27%).

Table 4.2 Distribution of female youth who have ever had sex by age at sexual debut and characteristics of partner

Characteristic	*13-14 (N=5)* ♪	*15-24 (N=61)*	*Total (N=66)*
Median age (in years) at first sex	[12]	17	17
Was first sex partner younger, same age or older			
Younger	[33]	9	10
About same age	-	4	4
Older	[67]	87	86
Type of relationship with first sex partner			
Husband	-	25	23
Boyfriend	[25]	52	51
Friend	[25]	15	15
Stranger	[25]	5	6
Family member/relative	[25]	3	5
Reasons you had sex for the first time†			
Wanted to	[40]	34	35
It just happened	[20]	13	14
Got married	-	8	8
To show love to partner	-	30	27
Sweet talked into it by partner	-	7	6
Was forced	[40]	7	9
Wanted to have a baby	-	8	8
Others (e.g. experimenting, tricked, peer pressure etc)	-	10	9

♪ **Results for the 13-14-year-olds should be interpreted with caution due to small sample size**

† **Multiple responses apply. Ns unweighted.**

4.2 RECENT SEXUAL EXPERIENCES

Female youth who have ever had sex were asked how frequently they have had sex in the past six months prior to the study; the number of male sexual partners they have had sex with over this period; and for those who reported that they had not sex in the past 6 months - the main reason for not doing so. Table 4.3 shows that about a half of the unmarried female youth who have ever had sexual intercourse had not engaged sex in the past six months prior to the study. The main reason given by these youth as to why they had not had sex over this period was that they did not want to or were not interested (59%). On the other hand, the majority (94%) of those who had sex over this period reported that they had had sex with only one male sex partner.

Table 4.3 Percentage Distribution of unmarried female youth who have ever had sex by recent sexual activity by age category

Characteristic	*13-14 (N=4)* ♪	*15-24 (N=33)*	*Total (N=37)*
Has had sex in past 6 months			
Yes	[50]	48	49
No	[50]	52	51
Main reason for not having sex			
Don't want/not interested	-	67	59
Want to finish school	[50]	7	12
Afraid of STD/HIV	-	7	6
Other	[50]	20	24
Number of sex partners in past 6 months			
One	[100]	94	94
Two	-	6	6

♪ Results for the 13-14-year-olds should be interpreted with caution due to small sample size
Ns unweighted.

4.3 SEXUAL ABUSE AND COERCION

Several studies indicate that sexual coercion can affect the victim in a number of ways- from sexual and reproductive health to emotional damage. Young people who have experienced sexual coercion are said to be more likely than other young people to engage in high-risk consensual sexual behaviour including early sex debut, multiple partners, non-use of condoms or even prostitution. Hence, it is quite important to have a full understanding of the extent of this problem particularly in light of the HIV pandemic.

Table 4.4 shows that 39% of all 13-24-year females have experienced some form of sexual abuse/gender violence and this increased with age. Among the older females (15-24-year olds), nearly one out of every two adolescents reported that they have experienced sexual abuse/gender violence compared to only one in four among the 13-14-year-olds. Unwanted sexual touches (e.g. fondling, touching breasts or buttocks) was the commonest form of sexual abuse reported by 85% of the female youth who have experienced sexual abuse. The perpetrators were mainly people known to the victims particularly friends (47%) although strangers were also mentioned. Female youth who have ever had sex were further asked whether they have ever been forced to have sex. The data reveals that about one in four (23%) of sexually experienced female youth have ever been forced to have sex intercourse and this was highest among the 13-14-year-olds (40%) compared to their older counterparts.

Table 4.4 Percentage Distribution of female youth by experience of sexual abuse by age

Characteristic	*13-14 (N=51)*	*15-24 (N=76)*	*Total (N=127)*
Ever been subjected to any form of sexual abuse/ gender violence?			
Yes	25	49	39
No	75	51	61
Type of gender violence/sexual abuse experienced[†♪]			
Offensive sexual remarks	[31]	22	24
Unwanted sexual touches	[85]	76	78
Rape/defilement	[15]	16	16
Others	-	3	2
Perpetrators of acts of sexual abuse/gender violence[†♪]			
Boyfriend	[15]	11	12
Friend	[31]	52	47
Teacher	-	9	7
Stranger/Just met/Men along the road	[38]	26	29
House worker	-	2	2
School mates	[31]	4	10
Have you ever been forced to have sex? [♪]			
Yes	[40]	21	23
No	[60]	79	77

[†] **Multiple responses apply. Ns unweighted.**

[♪] **Results for the 13-14-year-olds should be interpreted with caution due to small sample size**

5.0 ACCESS TO AND UTILISATION OF SRH INFORMATION AND SERVICES

This Chapter presents data on female youth regarding their awareness, preferences and utilisation of different types and sources of information and providers for contraceptive methods, treatment of STIs, HIV prevention and voluntary counselling and testing for HIV.

5.1 ACCESS TO THE MASS MEDIA

In Uganda, the mass media has been one of the major channels of providing information on SRH issues to the youth as well as the general public. The major advantage of this mode of communication is that it has the furthest reach at the least cost but the major disadvantage is that some cross section of the target population may not have access to it. In this survey, an attempt was made to ascertain the current level of access, among the female youth, to various types of mass media including newspapers, radio and television. Table 5.1 shows that the majority of the female youth across all age groups (73%) listen to the radio almost every day but with listenership increasing with age. The data further shows that access to other forms of the media (TV and newspapers) is still quite limited with 65% and 77% of the female youth reporting that they do not read newspapers or watch TV respectively.

Table 5.1 Percentage Distribution of female youth by their access to SRH through schools by age category

Characteristic	*10-14 (N=101)*	*15-24 (N=101)*	*Total (N=202)*
How often do you read a newspaper or magazine?			
Almost every day	3	8	5
At least once a week	14	14	14
Less than once a week	14	17	15
Not at all	70	61	65
How often do you listen to the radio?			
Almost every day	62	83	73
At least once a week	23	10	16
Less than once a week	3	4	3
Not at all	13	3	8
How often do you watch television?			
Almost every day	4	3	3
At least once a week	5	14	10
Less than once a week	7	13	10
Not at all	84	70	77

† **Multiple responses apply. Ns unweighted.**

5.2 ACCESS TO SRH INFORMATION

5.2.1 Access to SRH information through schools

All female youth who have ever attended school were asked whether they have ever had a lecture/lesson on sexual-related issues; issues that were discussed; and if they found the discussions useful. Table 5.2 shows that the majority (74%) of female youth who have ever attended school have ever had a lecture/lesson on sexual-related issues although older adolescents (81%) are more likely to have attended such lectures than their younger counterparts (67%). HIV/AIDS was the most commonly reported issue that was discussed in the lectures.

Table 5.2 Percentage Distribution of female youth by their access to SRH through schools by age

Characteristic	*10-14 (N=101)*	*15-24 (N=101)*	*Total (N=202)*
Ever had a lecture/lesson in school on any issue related to sex, pregnancy, STIs, or use of medical/health services?			
Yes	67	81	74
No	33	19	26
What were the lectures/lessons about? †			
Puberty, menstruation, reproduction	32	30	31
Sexual relationships, harassment, coercion	31	24	27
Abstinence	43	35	39
Pregnancy & childbirth	15	27	21
STIs	7	35	23
HIV/AIDS	71	50	59
Family Planning Methods	7	12	10
Methods to prevent STIs and HIV/AIDS	3	13	9
Effectiveness of condoms in preventing HIV/AIDS	-	7	4
Sources of family planning methods	-	4	2
Places for testing of HIV/AIDS and treating STIs	3	6	5
Others	3	_	1
How useful were the lectures/lessons?			
Very useful	92	89	90
Somewhat useful	8	8	6
Not very useful/not sure	3	4	4

† **Multiple responses apply. Ns unweighted.**

Other fairly common issues included abstinence (reported by 39% of the respondents); puberty, menstruation and reproduction (31%); and sexual relationships, harassment and coercion (27%). However, other SRH issues such as Family Planning, condom use, HIV testing and treatment of STIs did not appear to have featured prominently in these lectures a they were reported by only a few respondents. Asked about the relevance of these lectures/lessons, an overwhelming majority (90%) of the female youth across all age categories reported that they found them very useful.

5.2.2 Access to SRH information through peer educators

Several studies have indicated that adolescents are often reluctant to talk to adults including their own parents regarding sexual-related matters. However, they often share their knowledge (or lack of it), experiences and concerns with their own peers. Their behaviours are often influenced by the views and behaviours of their peers. Hence, many behaviour change programs seek to change adolescent behaviour through peer-to-peer approaches. In this survey, all respondents were asked whether they have ever been talked to by a peer educator; the topics discussed; where the discussion took place; whether they found the peer educator knowledgeable and friendly; and whether they would like to talk to the same peer educator again. Table 5.3 shows that, regardless of age group, not many (only 16%) of the female youth had ever been talked to by a peer educator. It can be observed from the Table that the SRH issues discussed by the peer educators follow a similar trend as those discussed in school lectures/lessons. Moreover, most (85%) of the female youth reported that they had been talked to by the peer educators in a school setting as compared to only 25% who were talked to outside school. Hence, the trend and overlap in content is perhaps not surprising. Asked whether the peer educators referred them to any other services, only 52% of the female youth reported that they had been referred indicating a communication gap or lack of services where youth can be referred.

Regarding the peer educators character, the majority of the female youth indicated that they found them very polite, patient, friendly as well as knowledgeable. Not surprisingly, when asked whether they would like to talk to the same peer educators, the majority (91%) of the adolescents responded in the affirmative.

All female youths were also asked whether they have ever visited an FPAU Youth Centre – a place where youth living in the Project areas can receive counselling and guidance about SRH issues from peer educators. Only 6% of the respondents reported that they have ever visited such a centre. This is not surprising given that these centres have newly been established and are currently only available in the major towns within the Project districts.

Table 5.3 Percentage Distribution of female youth by their access to SRH through peer educators by age

Characteristic	*10-14 (N=103)*	*15-24 (N=104)*	*Total (N=207)*
Has a peer educator ever talked to you?			
Yes	12	20	16
No	88	80	85
Where did the peer educator talk to you? ♪†			
In school	83	86	85
Out of school	18	29	25
What topics did you discuss? ♪†			
Puberty, menstruation, reproduction	17	5	9
Sexual relationships, harassment, coercion	25	55	44
Abstinence	33	33	33
Pregnancy & childbirth	17	5	9
STIs	17	29	24
HIV/AIDS	58	43	48
Family Planning Methods	-	5	3
Methods to prevent STIs and HIV/AIDS	-	10	6
Effectiveness of condoms in preventing HIV/AIDS	17	10	13
Sources of family planning methods	-	5	3
Places for testing of HIV/AIDS and treating STIs	-	-	-
Others	-	5	3
Was the peer educator♪†			
Polite?	100	100	100
Patient?	100	100	100
Someone who can keep secrets?	92	90	91
Respectful	100	100	100
Friendly?	92	100	97
Knowledgeable?	100	100	100
Did the peer educator refer you to any other services? ♪			
Yes	42	57	52
No	58	43	48
Would you like to talk to the same peer educator again? ♪			
Yes	92	90	91
No	8	10	9
Have you ever visited an FPAU Youth Centre?			
Yes	3	10	6
No	97	90	94

♪ These figures should be interpreted with caution due to the small sample size
† Multiple responses apply. Ns unweighted.

5.2.3 Access to SRH information through family and other individuals

In order to ascertain individual practices and preferences towards accessing SRH information, female youth were asked which one person from whom they mostly get SRH information and from whom would they prefer to get this information. The majority (37%) of the female youth across all age groups indicated that the person from whom they mostly receive information on sexual matters is the mother (Table 5.4 and Figure 3). However, a higher proportion (44%) of the younger females reported to be currently receiving SRH information from their mothers compared to their older counterparts (31%). This is perhaps not surprising since younger females are more likely to be living with their parents compared to older females (as was shown in Table 2.2). Furthermore, compared to their older counterparts, younger females are more likely to be closer to their mothers than to outsiders and their sexual concerns less contentious. The data further shows that teachers were next most important individual source of information with 18% of the female youth reporting that they currently receive SRH information from this particular source. It can also be noted that fathers as well as other family members were rarely mentioned as important sources of SRH information. Friends (including casual friends as well as boy friends/partners) were mentioned by only 3% of the female youth as their current most important source of SRH information. Another point to note is that a fairly substantial number of female youth (15%) reported that they did not have any source where they receive SRH information.

On the other hand, data collected on male youth casts a totally different picture regarding the sources males use to receive information on SRH issues. Unlike their female counterparts, male youth do not appear to have a single dominant source. The majority of the male youth (only 21%) reported that the teacher was their current most important individual source of SRH information. However, parents also came closely with 15% of the male youth reporting that their most important source of SRH information was the father and an equal proportion saying that it was the mother. Furthermore, a relatively higher proportion of male youth (12%) reported that friends were currently their most important source of SRH information.

Figure 3: Percentage distribution of 10-24-year-old male and female youth by person they considered to be their current most important source of SRH information

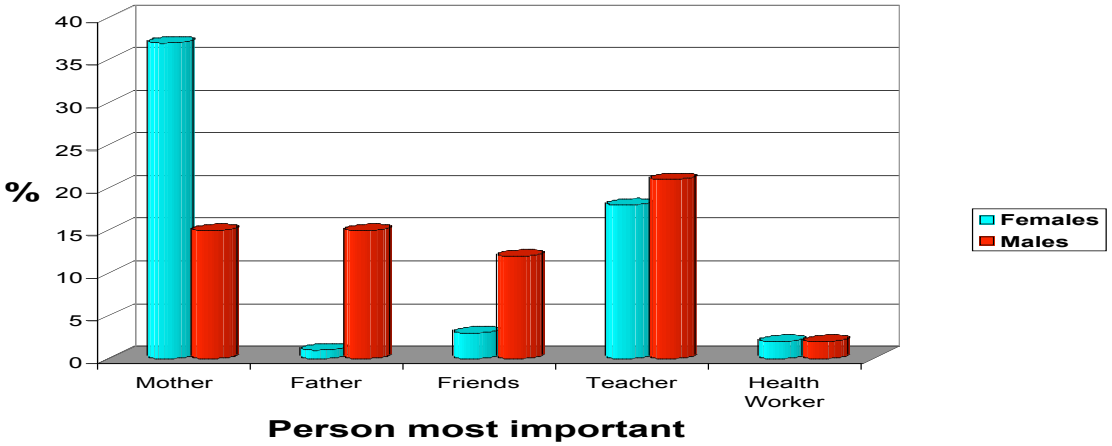


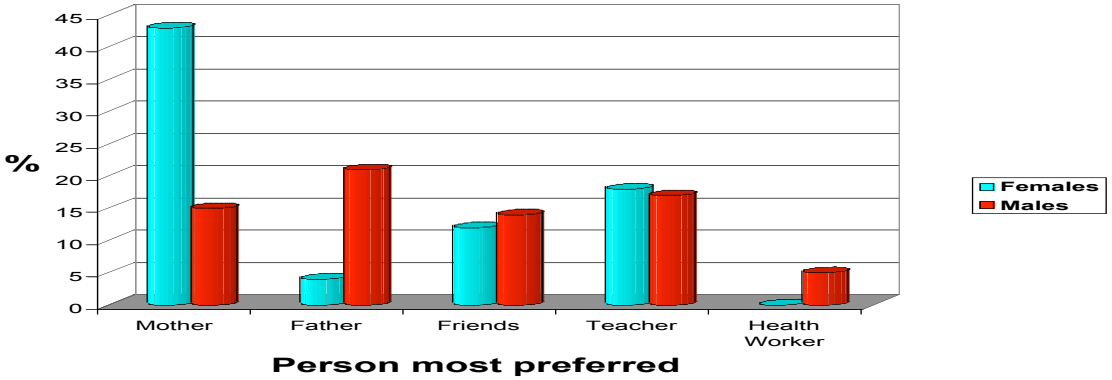
Table 5.4 Percentage Distribution of female and male youth by the person they considered to be their current most important source information on SRH issues

	Females			*Males*		
Characteristic	*10-14 (N=103)*	*15-24 (N=104)*	*Total (N=207)*	*10-14 (N=591)*	*15-24 (N=657)*	*Total (N=1248)*
Which one person do you mostly get information on sexual matters from?						
Mother	44	31	37	19	11	15
Father	3	-	1	14	15	15
Sister	4	4	4	1	1	1
Brother	-	1	0	8	6	7
Boyfriend/girlfriend/partner	-	2	1	0	1	1
Other friend	2	3	2	7	15	11
Aunt	6	9	7	3	3	3
Uncle	_	_	_	1	4	2
Grandmother/grandfather	6	7	6	3	1	2
Other relative	2	3	2	0	0	0
Teacher	13	23	18	20	21	21
Health worker	1	3	2	1	3	2
Religious leader	-	1	-	1	2	1
Myself	-	1	-	0	1	0
No one	20	11	15	1	2	2
Other	-	3	1	18	9	13

Ns unweighted.

Regarding preferred sources for information on SRH issues, a similar trend was observed among the female youth with the majority (43%) across all age groups indicating that they would prefer to get it from their mothers (Table 5.5 and Figure 4). Teachers again emerged as the second most preferred source among the female youth with 18% indicating this preference. Interestingly, higher proportions of the older females indicated teachers as their current most important source of SRH information compared to their younger counterparts but the converse is true regarding their preferred sources. It is also worth noting that whereas only about 3% of the female youth indicated friends as their current most important source for SRH information, four times that number indicated that they would prefer a friend as a source for this type of information.

Figure 4: Percentage distribution of 10-24-year-old male and female youth by person from whom they would prefer to receive SRH information



It can again be observed that, unlike among the females, there appears to be no clear preferred source of SRH information among the male youth. However, the majority (only 21%) indicated that they would prefer to get this information from their fathers while 15% would prefer to get it from their mothers. Seventeen percent would prefer to get it from teachers while 14% preferred friends.

Table 5.5 Percentage Distribution of male and female youth by person from whom they would prefer to receive information on SRH issues

	Females			***Males***		
Characteristic	*10-14 (N=103)*	*15-24 (N=104)*	*Total (N=207)*	*10-14 (N=591)*	*15-24 (N=657)*	*Total (N=1248)*
From which one person would you prefer to receive information on these topics?						
Mother	41	45	43	20	10	15
Father	7	1	4	24	19	21
Sister	4	3	3	1	1	1
Brother	-	1	-	9	8	8
Boyfriend/girlfriend/partner	1	5	3	1	2	1
Other friend	3	16	9	7	18	13
Aunt	2	-	1	2	2	2
Uncle	_	_	_	5	6	5
Grandmother/grandfather	7	5	6	3	2	2
Other relative	3	2	2	0	1	1
Teacher	25	12	18	18	15	17
Health worker	-	1	-	2	8	5
Religious leader	-	2	1	0	2	1
Myself	-	1	-	0	1	0
No one	7	5	6	1	2	1
Other	1	3	2	5	1	3

Ns unweighted.

5.3 UTILISATION OF SRH SERVICES

5.3.1 Discussion and utilisation of condoms and other contraceptives

Use of contraceptives particularly condoms for prevention of unwanted pregnancies, HIV or other STIs is an important indicator of protective behaviour among young people. Female youth (13 – 24 years old) who had ever had sex were asked whether they have ever discussed with their sexual partners about using a condom and those who are currently sexually active (have had sex in the past 6 months prior to the study) were asked whether they used protection the last time they had sexual intercourse. Similar questions were asked among 15-24-year-old males in the males' survey. In this particular analysis, the 13-14-year-old females who have ever had sex have been excluded not only because they are very few (only 5 cases) but also to enable comparison with the same age-cohort (15-24 years) of males. The analysis has also been limited to sexual activities with a regular partner since only one female youth reported to have had sex with an irregular partner in the past 6 months prior to the study.

Discussion about protection against STIs and unwanted pregnancies with a sexual partner

This question was asked only among the female youth in the survey but was also discussed among both male and female participants in the focus group discussions. Table 5.6 shows that slightly over a half (56%) of the sexually experienced 15-24-year-old female youth had ever initiated a discussion about condom use with their sexual partners. It can further be noted that there is slightly more discussion about condom use among unmarried female youth compared to their married counterparts.

Table 5.6 Percentage Distribution of 15-24-year-old female youth by their initiation of discussion on condom use by marital status

Characteristic	*Not married (N=33)*	*Married (N=28)* ♪	*Total (N=61)*
Ever initiated a discussion with a sexual partner about using a condom?			
Yes	61	50	56
No	39	50	44

♪ **These figures should be interpreted with caution due to the small sample size**

However, results from the focus group discussions suggest that there is very limited discussion about protection against STIs and unwanted pregnancies among sexual partners. Most participants in nearly all FGDs, both male and female, were of the view that such discussions only take place among a few sexual partners especially if they are intending to get married or if they are already married and want to use family planning. A number of reasons were advanced as to why there is very limited discussion regarding protection. Most male youth who are not yet married argued that the sexual relationships they have are often secretive and if they are to have sex they have to do it quickly and therefore get no time to discuss issues of protection. Secondly, most of the male youth felt that discussing issues of protection when you are going to have sex is a "total turn off" because it makes you quite apprehensive. Another reason given by the males was that discussing issues of protection gives a female partner the impression that you take the relationship seriously and you have intentions of marrying her in which case she gets 'stuck on you'.

"If you discuss that, she will assume that you are going to marry her and will start pressuring you. … There is even no time to do that because we are always hiding and hurrying such that in case you get her pregnant, you can easily deny since nobody saw you together."

Male Youth FGD, Kyeizooba Sub-county (Rural), Bushenyi District.

"You cannot get a girl and start discussing such issues because they will put both of you on tension even before you start playing sex. …It is like bringing porridge in a bar".

Male Youth FGD, Buhanika Sub-county (Rural), Hoima District.

Female youth, on the other hand, were of the view that most men do not want to hear about such things so it is up to the women to take precautionary measures such as secretly taking pills or injections if they want to avoid unwanted pregnancies. Another reason given was that most females do not have the courage (feel shy) to bring up such issues and they just go with whatever their male partner proposes. Some participants, particularly in Hoima District, attributed this submissiveness to culture which does not encourage women to stand up to men. It was also reported in some male and female FGDs that some people do not want to discuss issues of protection because they are already infected or perceive themselves to be already infected and therefore see no need for protection while others are simply ignorant of the usefulness of such discussions.

"It is not possible. He just says 'let us do it' without any discussions about the risks. Men are not willing to discuss such things so it is up to the woman to protect herself."

Female Youth FGD, Kitooba Sub-county (Rural), Hoima District.

Utilisation of condoms and other contraceptives

Results from both the male and female youth surveys indicates fairly high use of contraceptives, particularly the condom, among the 15-24-year-old males compared to their female counterparts. Seventy four percent (74%) of the males reported that they had used a method of protection against STIs/HIV/AIDS or unwanted pregnancy in the past 6 months prior to the study as compared to only 55% of the females (Table 5.7). Regardless of gender, the male condom emerged to be the most commonly used method of protection but with big differences between males and females. Eighty eight percent (88%) of all males who reported use of contraceptives with their sexual partner had used a condom compared to only 45% of the female respondents who reported this method. This wide difference is not surprising and only emphasizes the fact that usage of the male condom is predominantly male controlled. Other methods female youth reportedly use included the injection (23%) and the pill (18%). Regarding the sources of these contraceptives, the majority of the youth reported that they obtained their contraceptives mainly from private health clinics followed by ordinary shops.

Given the importance of the condom as the only contraceptive which provides dual protection against both pregnancy and STIs/HIV, respondents who reported using this particular method were asked the main reason why they had used it and the regularity of use. Despite the small sample of female youth who had used contraceptives, it may be worth noting the rather wide gender differences in the main reasons given as to why a condom was

used whereby the majority of the males (53%) reported it was to prevent pregnancy while the majority of the females said it was to prevent HIV/AIDS. Contrary to common belief, the findings seem to suggest that males have started putting emphasis on avoidance of pregnancy (more than the females) and this could be due to the severe consequences many male youth often face when they make girls below 18 years pregnant. Regarding consistent use of condoms, higher proportions (73%) of females reported using the condom every time they had sex as compared to their male counterparts (57%).

It should be noted that some of the above results, particularly those regarding the female youth, may have been affected by the small sample sizes involved. Hence, there is need to interpret such findings with caution.

Table 5.7 Percentage Distribution of 15-24-year-old sexually active youth by utilisation of contraceptives in past 6 months by gender

Characteristic	*Female (N=40)*	*Male (N=123)*
In the past 6 months when you had sex with your regular partner(s), did you or your partner use any method of protection?		
Yes	55	74
No	45	26
Which methods did you or your regular partner(s) use? †♪		
Pill	18	12
Injection	23	9
Male condom	45	88
Female condom	5	1
Rhythm	-	7
Withdraw	9	1
Other	5	-
What was your main source of methods of protection you/your partner used? ♪		
Hospital	16	12
Health clinic	52	34
Pharmacy	4	7
Shop	28	30
(In case a condom was used), what was the main reason that you used a condom in the last six months? ♪		
To prevent STIs/HIV	55	21
To prevent pregnancy	36	53
To prevent both pregnancy and STIs/HIV	9	22
Did not trust partner	-	4
How often did you or your regular partner use a condom in the past 6 months? ♪		
Every time	73	57
Most of the time	-	19
Some times	27	19
Rarely	-	6

† Multiple responses apply. Ns unweighted.
♪ These figures should be interpreted with caution due to the small female youth sample size

5.3.2 Utilisation of STI and HIV/AIDS Services

Prevalence and Utilisation of STI Services

All sexually experienced 15-24-year-old females were asked whether they had experienced any STI-related symptoms in the 6 months prior to the study. Those who had had such symptoms were asked if they had received treatment and from where. Those who had not received treatment were asked for the reasons why they had not done so. Similar questions had also been asked in the male youth survey.

The data shows a high prevalence of STIs particularly among females. One out of every two 15-24-year-old female youth (51%) who had ever had sex reported having experienced an STI-related symptom in the 6 months prior to the study compared to only one out of every four (25%) among the males (Table 5.8). However, higher proportions of females (73%) said they had received treatment as opposed to only 38% of the males. The majority of both the male and female youth received treatment from a health facility (hospitals and health centres – most of which are public and services free) although some especially the males (23%) sought treatment from private clinics. Use of home remedies (self treatment or treatment by family member/friend) was also commonly mentioned especially among the males. On the other hand, the reasons advanced by those who did not seek treatment appear to vary across gender. The majority of the males said they did not seek treatment because the symptoms disappeared on their own (36%) or because they did not think they had an STI (25%). On the other hand, the majority of the females said the drugs failed to cure them (43%) while others reported that they simply couldn't afford the cost (29%). Again, given the small sample size of the female youth involved, there is need to exercise caution when interpreting some of the results which have been flagged in the Table.

Utilisation of HIV Testing Services

All 15-24-year-old females were asked whether they have tested for HIV; the reasons for testing; whether they learnt of the results; and with whom they have shared the results. The same questions had also been asked in the males' survey. This analysis compares the findings from the two surveys. Table 5.9 indicates wide gender differences in utilisation of HIV testing services. As was the case with STI services, a higher proportion (43%) of the female youth reported that they have ever been tested for HIV compared to only 20% of their male counterparts. However, both male and female youth gave similar reasons as to why they got tested; the most dominant one being getting to know their status. The data further reveals gender differences in sharing results of the HIV tests with others whereby 86% of the females have shared their results with someone as compared to 68% of the males have done so. There are also apparent gender differences in the types of persons with whom the results are shared. The majority (55%) of the males reported sharing the results with a friend; 47% with a relative; 45% with parents/guardian; and 24% with a sexual partner. On the other hand, the majority (33%) of the female youth reported that they shared the results with parents/guardians; 25% with a relative; 22% with a sexual partner; and only 14% with a friend.

Table 5.8 Percentage Distribution of 15-24-year-old sexually active youth by utilisation of STI services in past 6 months by gender

Characteristic	*Female (N=59)*	*Male (N=292)*
Has had any STI symptoms in the past 6 months?		
Yes	51	25
No	49	75
Have had the following symptom in past 6 months[†♪]	25	9
Genital discharge	31	14
Pain while urinating	7	6
Sores in the genital area	3	5
Warts in genital/anal area	39	15
Itching/burning sensation in genital area	7	6
Swellings in genital area		
Was treatment received? [♪]		
Yes	73	38
No	27	62
Type of facility where treatment was first sought [♪]		
Hospital	47	38
Health Centre	26	8
Private clinic	5	23
Traditional Healer	5	-
Self treatment	16	23
Family member/friend	-	8
(If not treated), what was the main reason treatment was not sought? [♪]		
Services are too far away/inaccessible	-	2
Cannot afford services	29	5
Didn't know where to go	-	9
Did not think it was an STD	14	25
Symptoms disappeared	14	36
Others (drugs failed to cure the condition)	43	-

[†] **Multiple responses apply. Ns unweighted.**

[♪] **These figures should be interpreted with caution due to the small female youth sample size**

Table 5.9 Percentage Distribution of 15-24-year-old youth by utilisation of HIV Testing Services by Gender

Characteristic	*Female (N=103)*	*Male (N=656)*
Have ever been tested?	43	20
Yes	57	80
No		
What is the main reason you got tested[†♪]		
To know status	89	71
Was ill	6	5
My past risky behaviour	-	6
Partners risky behaviour	3	2
Contemplating marriage	3	2
To get a visa/employment/insurance	-	1
To start a new relationship	-	1
Was donating blood	-	9
ARVs now available	-	1
Others	-	4
Did you learn of the results of your test? [♪]		
Yes	95	96
No	5	4
Have you shared with anyone your results [♪]		
Yes	86	68
No	14	32
What is the main reason you have not been tested? [♪]		
Spouse	-	10
Sexual partner	22	24
Parents/Guardian	33	45
Relative	25	47
Religious person	3	-
Friend	14	55
Other	3	2

[†] **Multiple responses apply. Ns unweighted.**
[♪] **These figures should be interpreted with caution due to the small female youth sample size**

5.3.3 Nature, type and level of utilisation of SRH Services in existing Health Facilities

In order to gauge the level of preparedness of existing SRH service providers to provide adolescent friendly sexual and reproductive health services, managers of selected public and NGO health facilities in the Project areas were asked to provide data on the nature, type and range of SRH services they offer; the arrangements they have in place to extend SRH services to young people; and the level of utilisation of SRH services by young people. This data has been summarised and is presented by facility in Table 5.10 and 5.11. The study findings reveal that, among the health units covered, FPAU clinics clearly stand out as the facilities that provide the widest range of SRH services in both districts. However, it can also be noted that none of the health facilities visited provide the full range of SRH services. The

findings show that condom issuance, FP counselling and provisions of contraceptives were being offered in all the health facilities visited except Bujumbura Health Centre (in Hoima Town Council) which is Catholic-founded. Kakanju Health Centre (Bushenyi District) which is Muslim-founded was also offering these services. Sexual dysfunctions and infertility management services were being offered by only FPAU clinics.

Regarding the range of contraceptives provided, only two (FPAU Clinic in Hoima Town[1] Council and Bushenyi Medical Centre[2] in Bushenyi District) out of the 11 facilities indicated that they provide permanent family methods (tubal ligation and vasectomy). The majority of the facilities offer only the male condom, pills, injections and information on natural family planning methods. The findings further reveal that all the facilities visited, except the FPAU Clinic in Bushenyi, had no staff trained in providing youth friendly sexual and reproductive health services. None of the five health facilities in Hoima District had peer counsellors and in Bushenyi, only two (FPAU Clinic and Kakanju HC III) out of the six had. Furthermore, most of the health facilities did not have in place adequate youth friendly arrangements to promote utilisation of SRH services among young people. For example, most of the facilities did not have special arrangements for receiving young people, youth corners, signs to show that SRH services are available or SRH IEC materials targeting young people. "Male Only" clinics were also not available in any of the 11 facilities visited.

Regarding level of utilisation of SRH services by young people, it was noted that most of the facilities – except FPAU clinics and a few Health Centre IIIs in Bushenyi – do not keep detailed records on most of the SRH services they offer. Some of the government health centres appear not to keep any records at all on SRH services. Record keeping is particularly poor for services such as counselling and referral where only information is given. Furthermore, where records are kept, the information is often not disaggregated by gender or age. All these make it quite difficult, if not impossible, to determine the extent and nature of utilisation of SRH services at these facilities.

[1] It is not clear whether the FPAU Clinic provides this service on site or simply offers referral services to clients seeking the service

[2] The service is provided by Marie Stopes through Bushenyi Medical Centre