

Adolescents in Uganda: Sexual and Reproductive Health

Nearly one-quarter of Uganda's population is between the ages of 10 and 19. Many of these young people are at risk or already struggling with the consequences of an unplanned pregnancy or a sexually transmitted infection (STI), including HIV/AIDS. To minimize these risks and secure a healthy future for adolescents, it is necessary that policymakers, journalists, service providers and advocates have solid evidence regarding the sexual and reproductive health needs of Ugandan youth. This Research in Brief summarizes key research findings on Ugandan adolescents' sexual and reproductive health behaviors and needs, with particular emphasis on HIV/AIDS, and points the way forward toward improving policies and programs.

SEXUAL ACTIVITY

- Half of Ugandan women and nearly four in 10 men aged 15–19 have ever had sex. Among 18–19-year-olds, this proportion is much higher for both sexes: 77% and 59%, respectively.

- Adolescents are waiting longer before having sex (Chart A): The median age at first sex for 15–19-year-old women was 16.3 in 1995 and 17.1 in 2000–2001. For men the same age, the median age at first sex was 17.7 in 1995 and 18.3 in 2000–2001.

- Among sexually experienced* 15–19-year-olds, 4% of

women and 15% of men reported having had two or more partners in the 12 months before the survey.

- Sexual coercion occurs among adolescents. For example, in a study among secondary school students in the Kabale district, 31% of females and 15% of males reported having been forced to have sex.

CONTRACEPTION

- Although more than three-quarters of 15–19-year-olds approve of family planning, a much smaller proportion of sexually active† teenagers use contraceptives: Among sexually active adolescents in this age-group, only 19% of females and 42% of males currently use any modern method.

- Thirty-five percent of sexually experienced 15–19-year-old women and 44% of sexually experienced men the same age have ever used a modern method of contraception. The condom is the most commonly

used method among both young men and young women.

- More than half of all 15–19-year-olds (53% of women and 63% of men) know where to obtain a condom.

MARRIAGE

- Young people are waiting longer to get married: In 1995, nearly 50% of 15–19-year-old women and 11% of men the same age had ever been married. By 2000–2001, the proportions had dropped to 32% and 7%, respectively.

- Women marry at a younger age than do men: The median age at first marriage is 17.7 for women and 21.9 for men.

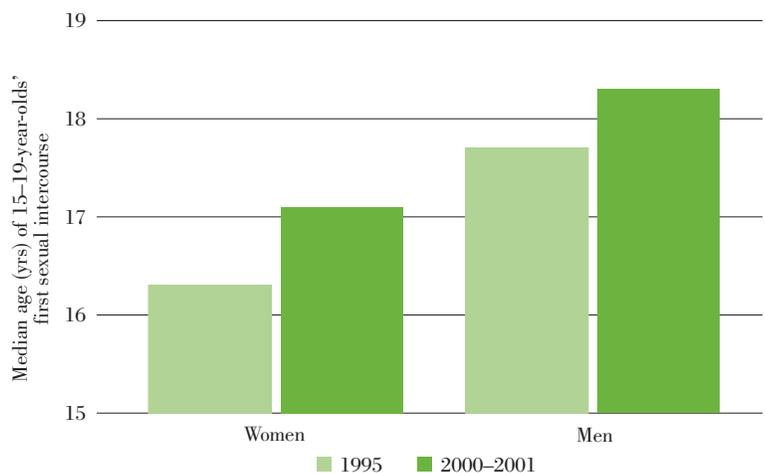
- By age 20, three-quarters of women have been married, compared with just one-quarter of men.

CHILDBEARING

- Twenty-six percent of women and 5% of men aged 15–19 have ever had a child.

chart a
Sexual Initiation

Adolescents are delaying their first sexual experience.



*Those who have ever had sexual intercourse.

†Those who have had sexual intercourse in the three months prior to the survey.

Focus on HIV/AIDS

- Among 18–19-year-olds, nearly half of women have had a child, and 16% are currently pregnant.

- However, childbearing among very young adolescents is less common now than in previous generations: In 2000–2001, just 2% of 15–19-year-old women reported having had a child before age 15, compared with 10% of Ugandan women aged 30–34.

ABORTION

- Local studies suggest that abortion occurs among adolescents, although national data do not exist to assess the frequency. Most abortions are performed under unsafe conditions because abortion is illegal in Uganda, except to save a woman’s life.

- A survey in Mbarara district found that 78% of female adolescents knew someone who had had an abortion.

- More than two-thirds of patients receiving care for abortion complications at a local teaching hospital were 15–19-year-olds.

STIs

- Adolescents aged 15–19 have some awareness of STIs beyond HIV: At least two-thirds of young women and young men are able to name another STI.

- Among sexually experienced 15–19-year-olds, 7% of women and 2% of men reported having had an STI or STI symptoms in the 12 months prior to the interview.

- According to data from the Naguru Teenage and Information Centre in Kampala, 64% of all clinical problems at that facility were related to STIs.

Uganda’s successful response to HIV/AIDS has been held up as a model for other countries. In 1986, soon after the threat of HIV was recognized, the Ugandan government launched a multi-sectoral approach to openly address the pandemic—a bold move that involved a wide range of partners. Leaders adopted a comprehensive behavior-change approach that focused simultaneously on abstinence, partner reduction and condom use, as well as on reducing stigma and increasing testing and treatment. As a result of this pioneering initiative, HIV prevalence declined from 18% in 1992 to an estimated 5% in 2001.

Who Is at Risk and Why?

Adolescents are disproportionately affected by HIV infection. Young people aged 10–24 comprise 33% of the total Ugandan population but nearly 50% of the country’s HIV/AIDS cases. Young women are particularly vulnerable: They are four times as likely to be infected as their male counterparts.

Unmarried adolescents. The gap between first intercourse and first marriage leaves a window of time when adolescents are potentially at high risk of HIV and other STIs, as well as unplanned pregnancies. In Uganda, this window of risk is approximately one year for women and 3.5 years for men, and is a crucial period for adolescents to protect their health.

Married adolescents. Over half of Ugandan women marry while still in their teens. Those who marry early

may have older husbands who are likely to have had many sexual partners; some of these men may have acquired HIV or another STI that they may transmit to their young wife.

Adolescents who experience sexual coercion. A substantial proportion of young women experience sexual coercion. Because they are not prepared for sex and may not be able to protect themselves, those who are coerced into sex are at risk of infection and unintended pregnancy.

Adolescents who engage in multiple sexual partnerships. Fifteen percent of sexually experienced young men have had two or more partners, putting themselves and their partners at increased risk of infection.

Where Do Young People Get Information About HIV/AIDS?

Adolescents are increasingly turning to peer groups, schools, churches, the media and nongovernmental organizations (NGOs) for informa-

tion about sex. Reliance on traditional sources of sex information—typically community elders or the *Senga* (paternal aunt)—is weakening, despite recent initiatives in the Buganda Kingdom to revive the role of the *Senga* as a way to improve adolescents’ access to reproductive health information.

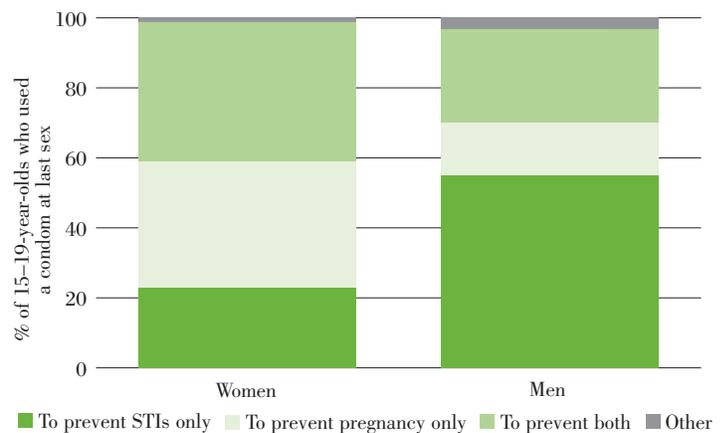
Social and cultural norms have largely prohibited parents and children from directly discussing sex. However, because traditional sources of information are weakening, parents may have a new role to play. More information is needed to uncover whether parents may play a larger role in helping their adolescent children manage sexual and reproductive health risks.

How Do Adolescents Protect Themselves?

Virtually all Ugandan adolescents are aware of HIV/AIDS, and among 15–19-year-olds, nearly 80% of women and almost 90% of men can name two or more

chart b
Protective Behavior

Young men and women use condoms for different reasons.



effective ways to avoid infection. Yet knowledge alone has not necessarily translated into protective behavior. For example, among sexually active 15–19-year-olds, slightly more than one in 10 women and four in 10 men report using condoms. In addition, young women and men use condoms for different reasons. Among condom users, 23% of women and 55% of men do so to prevent STIs only, 36% of women and 15% of men to prevent pregnancy only, and 40% of women and 27% of men to prevent both—which indicates that preventing unintended pregnancy is also an important concern among sexually active adolescents (Chart B).

Knowing one’s HIV status and that of one’s partner can encourage protective behaviors. Among 15–19-year-olds who have not been tested, approximately seven in 10 report that they would like to be; however, only 6% of young women and 3% of young men report that they have been tested for HIV (Chart C).

Stigma remains a large obstacle in addressing HIV/AIDS. For example, over half of adolescents (54% of females and 55% of males) do not believe that HIV-positive teachers should be allowed to keep teaching.

What Policies and Programs Are Available to Young People?

The Ugandan government has adopted policies that create an environment supportive of adolescent sexual and reproductive health. The 1996 National AIDS Control Policy addresses adolescent sexual and reproductive health as well as access to

voluntary testing and counseling (VCT). Additionally, the 1999 National Youth Policy commits the government to fulfill youth development goals as spelled out at the 1994 International Conference on Population and Development in Cairo. Furthermore, the 2000 National Health Policy specifically addresses the sexual and reproductive health needs of youth.

Several other relevant policies currently exist in draft form:

- the National Adolescent Health Policy aspires to mainstream adolescent health concerns in the national development process to improve the quality of life, participation and standard of living in young people;
- the Reproductive Health Policy promotes increased availability and accessibility of services and
- the National Policy on Young People and HIV/AIDS addresses rates of HIV transmission passed from teenage mothers to their infants.

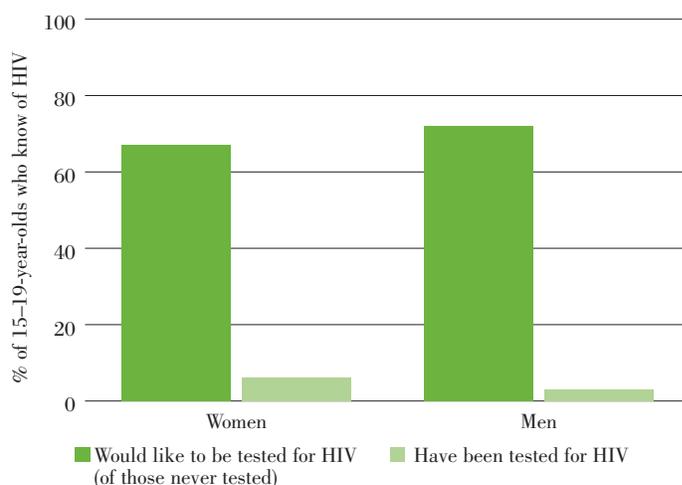
These policies are a critical step, but appropriate implementation of the policies is equally important. Much remains to be done in this respect.

A variety of programs for sexual and reproductive health information and services for young people are available, including media campaigns, peer education and outreach programs, youth development programs and community health facilities. Programs also exist within the school system and in other, informal settings.

- International and national organizations, such as

chart c
HIV Testing

Most adolescents would like to be tested for HIV, but few have been.



UNICEF, UNFPA, the Programme for Enhancing Adolescent Reproductive Lives and the Family Life Education Programme have developed interventions aimed at behavior change and service delivery for adolescents.

- The African Medical and Research Foundation and the African Youth Alliance (which will end in 2005) aim to improve health, provide resources and support to encourage healthy behavior among youth, and reduce the incidence of HIV/AIDS, other STIs and unwanted pregnancies.

- Religious institutions, such as the Kampala Diocese (Anglican), the Uganda Muslim Supreme Council and the Uganda Catholic Secretariat, have many programs on adolescent sexual and reproductive health.

- Peer-support interventions, such as Straight Talk (for 15–19-year-olds) and Young Talk (for 10–14-year-olds), enhance youths’ skills in communicating, negotiating sex, responding to peer pres-

sure and developing positive relationships with the opposite sex.

- The Naguru Teenage and Information Centre in Kampala distributes condoms and provides VCT, referrals and medical services for STIs and pregnancy.

- The School Health Education Project, Health Education Network and Save Youth from AIDS integrate HIV prevention into school curricula and build capacity of teachers to handle HIV/AIDS-related topics.

- AIDS Challenge clubs hold interschool debates on HIV/AIDS-related topics.

- The Care and Support Project began as a pilot project to address HIV prevention, medical care and psychosocial support for out-of-school youth.

These services have opened up avenues for the delivery of sexual and reproductive health information to many adolescents; however, most of these services are located in urban areas. Rural adolescents, who comprise approxi-

The Way Forward—Filling the Gaps

Examine the progress toward national policy goals. Systematic measurement of the risk and protective behaviors of Ugandan adolescents over time is necessary to assess how well the country is meeting the sexual and reproductive health needs of the next generation.

Find out why. Much of the existing evidence shows the levels and patterns of risky sexual and health behaviors and of outcomes among adolescents, but very little evidence exists to explain the reasons why young people engage in risky or protective behaviors. Understanding these issues is critical to design and implement effective programs.

Understand health-seeking behaviors. More information is needed to explain the gap between awareness of sexual and reproductive health services and actual utilization of these services.

Assess existing interventions. There is a lack of information about the implementation, monitoring and, most importantly, evaluation of interventions aimed at improving the sexual and reproductive health of Ugandan youth. Without this information, it is difficult to know which interventions are most effective and worth supporting.

mately 80% of all teenagers, are still largely underserved. Furthermore, many Ugandan reproductive health services are not “youth friendly.” That is, services are not specifically prepared for, convenient to and utilized by youth, and have not attracted many adolescents because of a lack of confidentiality, the discourteousness of providers toward youth or young people’s fear of embarrassment. Additionally, health services targeting adolescents are often based in schools and therefore do not reach vulnerable out-of-school adolescents.

Special Groups

Certain subgroups of disadvantaged youth are particularly at risk of HIV, other STIs and unintended pregnancy:

Street youth. These adolescents are especially vulnerable to substance abuse and exchanging sex for money.

Young sex workers. Anecdotal evidence suggests that adolescent sex workers are on the increase in Uganda. They may not have much power to negotiate condom use with their clients.

Orphans. Many of the estimated 1.7 million orphans in Uganda are shuttled between relatives and often make crucial life decisions without guidance or support. Orphaned adolescent women are sometimes coerced into sex or engage in sexual activities in exchange for basic necessities at home.

Adolescents in conflict areas. In northern and parts of western Uganda, insurgency and civil strife have been occurring for some time, and many young women have been raped or forced to marry soldiers at an early age. These factors, coupled with limited access to health care services, make many adolescents—particularly women—susceptible to HIV infection.

Refugee populations. Uganda has received many refugees from surrounding countries who also suffer circumstances of crowded settlements, poor health care services and forced sex.

Little information exists on the health status of orphans, refugees, sex workers or street youth because these groups are often missed in household surveys or school-based initiatives.

Where Do We Go From Here?

Although this report shows that a great deal is known about adolescents’ sexual and reproductive health knowledge and behavior, much remains unclear. Uganda has done much to stem the rising HIV/AIDS pandemic within its borders, but Ugandan adolescents remain vulnerable—in large part because knowledge alone does not prompt them to take action to protect themselves. As a first step toward improving the options available to adolescents to protect their sexual and reproductive health, we need to understand what lies behind this gap. We also need to know more about whether and where adolescents go for health-related information and care, and how to make it easier for them to obtain the services they need. The strategies for meeting these challenges are of concern to government at all levels—national, district and local—in addition to program managers, parents and young people themselves. The end goal is a secure and healthy future for Uganda’s youth.

This publication is drawn from Neema S, Musisi N and Kibombo R, Adolescent Sexual and Reproductive Health in Uganda: A Synthesis of Research Evidence, *Occasional Report*, New York: The Alan Guttmacher Institute, 2004, No. 14. It was written by Melanie Croce-Galis. Except where noted, all statistics in this document are from the 2000–2001 Demographic and Health Survey, a nationally representative survey. A complete listing of references can be found in the Occasional Report.

Both publications are part of the project *Protecting the Next Generation: Understanding HIV Risk Among Youth* and were supported by The Bill & Melinda Gates Foundation, the Rockefeller Foundation and the National Institute of Child Health and Human Development (grant no. 5 R24 HD043610). The project, being carried out in Burkina Faso, Ghana, Malawi and Uganda, seeks to contribute to the global fight against the growing HIV/AIDS epidemic among adolescents by raising awareness of young people’s sexual and reproductive health needs with regard to HIV/AIDS, STIs and unintended pregnancy; communicating the new knowledge to a broader audience, including policymakers, health care providers, and the media in each country, regionally and internationally; and, stimulating the development of improved youth-serving policies and programs.



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