

**Adolescent Sexual and Reproductive
Health in Uganda:
Results from the 2004 National
Survey of Adolescents**

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Executive Summary

Adolescents in Sub-Saharan Africa face many hurdles, including balancing the expectations of the traditional, often conservative, norms against the increasing exposure, through the mass media, to modern ideals. The sexual and reproductive health of adolescents is one area in which this struggle is often apparent, and many young people engage in sexual activities with little or no knowledge about how to protect themselves against the risks of infection and unwanted pregnancy. An estimated 6.9 percent of women and 2.2 percent of men aged 15–24 in the region were living with HIV at the end of 2004. Furthermore, about one in 10 young women have had a premarital birth by age 20. In Uganda, evidence from the AIDS Information Centre shows that, among 15–24-year-olds who were first-time testers, HIV seroprevalence was 3% among men and 10% among women in 2002. Furthermore, in 2000–2001, 39% of recent births to Ugandan adolescents were either mistimed or unwanted.

In light of such issues, addressing adolescents' sexual and reproductive health needs is an important and urgent policy and programmatic concern in Uganda. To address young people's needs effectively, it is important to have a better understanding of the various aspects of adolescents' sexual and reproductive health and needs. This report provides a comprehensive overview of the sexual and reproductive health of adolescents in Uganda. Specifically, the report assesses the current knowledge, attitudes and behaviors among adolescents and factors that put them at risk for HIV transmission and unwanted pregnancy. It examines why some adolescents are at higher risk of HIV transmission and unwanted pregnancy than others. It documents barriers that prevent adolescents from seeking sexual and reproductive health services and information, and provides new information about what very young adolescents know and do with respect to sexual and reproductive health. The report is based on data from a 2004 nationally representative survey of 5,112 males and females aged 12–19.

Key Findings

Background characteristics

One in 10 females aged 12–19 in Uganda is currently in union. But this proportion is almost double (19%) among older females aged 15–19. On the other hand, very few young men are in union—fewer than 2% among 15–19-year-olds. Nearly equal proportions of female and male respondents live in an urban area: 12% of female adolescents and 10% of their male counterparts. Similar percentages of young people—approximately 20%—belong to the lowest and highest wealth quintiles.

Among older females aged 15–19, 13% are in union and have already had a child, while nearly 10% are not in union and have had a child. Fewer than half of adolescents in Uganda live with both their biological parents: This proportion is 40% among females and 44% among males. Many adolescents in Uganda live in a household headed by someone other than their parent. For instance, 40% of the females and more than 30% of the males surveyed report that they are not the son or daughter of the head of their household.

Sexual activity and relationships

Sexual activity is fairly common—but often sporadic—among young people in Uganda. About 30% of female and male 12–19-year-old adolescents have had sexual intercourse. Among younger adolescents, males are twice as likely to be sexually experienced than females, however as adolescents get older, this gap between the sexes closes. One in five young people reported having had sexual intercourse in the last 12 months. A higher proportion of female 15–19-year-olds had sex in the three months prior to the survey, compared with their male counterparts.

For those adolescents who have not yet had sex, the most common reason why they have abstained is to avoid STIs and AIDS (69% of females and 72% of males). Fear of getting pregnant or getting someone pregnant is another common reason cited by 64% of fe-

males and 34% of males who have never had sex. Interestingly, the same reasons were reported for being abstinent in the past year among those who have had sex, but not in the previous year. For instance, a large percentage indicated that they wanted to avoid STIs/AIDS (73% of females and 81% of males).

Contraception

Awareness of contraceptive methods is almost universal among adolescents in Uganda. Ninety-two percent of females and 96% of male adolescents aged 12–19 know of at least one method and almost all adolescents who know of a method know of at least one modern method. Overall, the most commonly known methods among adolescents in Uganda are the male condom, the pill and injectables, which are all known by more than half of all female and male adolescents.

Adolescent females are more likely to have ever used a contraceptive method than males: Some 57% of sexually experienced females aged 12–19 have used a method, compared with 47% of their male counterparts. However, the reverse is true among those who have had sex in the past three months. Approximately 56% of males and 42% of females reported currently relying on a contraceptive method. The majority of current users are relying on a modern method. The most common method adolescents are using is the male condom, reported by both females and males.

The most common reason cited by female adolescents for using a condom at last intercourse is preventing pregnancy (47%). One-third indicated that their reason was both pregnancy and STI prevention. Among male adolescents, 39% reported using a condom at last intercourse for pregnancy prevention only, another 39% used the method for STI prevention only and one in five reported using it for both purposes.

Pregnancy and childbearing

Pregnancy and childbearing experiences start early in Uganda, especially among females. Most young females in Uganda become pregnant or give birth while they are in union. For instance, 70% of female adolescents in union have given birth, compared with only 11% of those who are not in union. In addition, nearly 30% of female adolescents in union were pregnant at the time of the survey, in comparison to 2% of those not in union. However, of the women in union who were pregnant, more than half (60%) want the pregnancy either later or not at all, indicating that this is a group of adolescents who need special attention when it comes to pregnancy prevention.

HIV and other STIs

Awareness of HIV is nearly universal among Uganda adolescents. Furthermore, their knowledge of ways the virus can be transmitted or prevented is very high. The majority believe that the transmission of the AIDS virus can be reduced by not having sex at all (92–93%), having just one partner who is not infected and who has no other partners (89%), using a condom correctly at every sexual intercourse (86–91%) and avoiding sharing needles (88–91%). However, incorrect knowledge of how HIV can be transmitted is not uncommon among adolescents. For example, more than 40% of female and male adolescents who were aware of HIV reported that the virus can be transmitted via a mosquito bite.

Compared with Ugandan adolescents' awareness of HIV, their knowledge of other STIs is quite limited. Slightly more than half of young people (54% of females and 56% of males) have heard of STIs other than HIV. The level of knowledge about specific STI symptoms among young people is even more limited: Fewer than half of adolescents who have heard of STIs could spontaneously name an STI symptom. Nearly 14% of females and 5% of males who are aware of STIs have had an STI or experienced an STI symptom.

Young people's risk and protective behaviors

Ugandan adolescents' perceptions of their risk of contracting HIV is fairly high. More than 40% of adolescents perceived themselves to be at great risk of contracting the virus.

The proportion of all young women aged 15–19 who were sexually active ranged from 15% among 15-year-olds to 66% among 19-year-olds. At each age (15–19), condom use was less prevalent with cohabiting than with noncohabiting partners. Young women are more likely to use a condom with a noncohabiting partner than with a cohabiting partner. For example, fewer than 5% of young women used a condom at their last intercourse with a cohabiting partner, compared to almost 10% of young women who used a condom with a noncohabiting partner. Among young men aged 15–19, 17% of 15-year-olds were sexually active, and this percentage increased to 48% by the time the young men reached 19.

Although condom use among adolescent females and males who have sex with noncohabiting partners or with more than one partner is moderately high, evidence among young men shows that the majority of young people are not using condoms consistently. About one in three (35%) of young men used the

method every time they had sex in the last three months, while almost half (48%) did not use condoms at all.

Sexual and reproductive health information and services

Most adolescents in Uganda are exposed to STI and pregnancy prevention information and services through a variety of sources. They most commonly report obtaining their reproductive health information from school/teachers, the mass media and family, but they would like to obtain such information from their school/teachers, health care workers and the media in that order. With respect to reproductive health services, the most commonly mentioned sources are also the most preferred sources: government hospitals and clinics, private hospitals and clinics, although some go to and prefer pharmacy or drug shops. Notably, very few mentioned using or preferring information and services from traditional healers.

However, adolescents identified some barriers and concerns about obtaining STI and contraceptive information and services. The majority reported being fearful or feeling embarrassed to seek sexual and reproductive health information and services. Other reported barriers included costs and not knowing where to go. Thus, to promote adolescents' access to these information and services such services should be user-friendly and inexpensive.

At least two-thirds of adolescents who have never been tested for HIV would like to be tested. But the reasons for not doing so vary and include not being sexually active, not being able to afford an HIV test and not being at risk of HIV for other reasons. Among younger adolescents, not being sexually active was the most common reason given (41% among females and 29% among males). Cost was considered a major barrier among both females and males, with about one in five reporting the cost of accessing such services as the main reason they have not been tested.

Conclusion

This report indicates that many Ugandan adolescents are sexually active and are aware of risks of unprotected intercourse. Moreover, many are interested in obtaining sexual and reproductive information and services from reliable sources, such as the formal health care system, but they express a number of problems with doing so under the existing health care system. There is a need for both governmental and nongovernmental organizations to put more effort, through poli-

cies and programs, into helping young people access the services they need to live healthy sexual and reproductive lives. The government of Uganda has instituted a number of policies and laws aimed at improving the lives of adolescents by keeping children and adolescents in school, promoting access to and use of contraception, and increasing the number deliveries that are attended by trained health professionals. These policies include the National Youth Policy, the National Policy on Young People and HIV/AIDS, the Sexual and Reproductive Health Minimum Package, the Affirmative Action Policy, instituting a minimum age of sexual consent, a universal primary education statute and laws prohibiting harmful customary practices, including early marriage. However, these policies have not been fully implemented. The findings in this report point to the need for expanding upon these existing policies and ensuring that they are operational and effective in meeting the sexual and reproductive health needs of young people in Uganda.

Chapter 1

Introduction

Adolescent sexual and reproductive health is a critically important policy and programmatic area in Sub-Saharan Africa. An estimated 6.9 percent of women and 2.2 percent of men aged 15–24 were living with HIV at the end of 2004.¹ About one in 10 young women have had a premarital birth by age 20: eight percent in West/Central Africa and 15% in South/East Africa.² Given the urgency and scope of addressing adolescents' sexual and reproductive health needs, it is important to assess current levels of adolescent knowledge, attitudes and behaviors that put adolescents at risk for HIV transmission or unwanted pregnancy. At the same time, we need to examine why some adolescents are at higher risk of HIV transmission and unwanted pregnancy than others, and why some adolescents seek sexual and reproductive health services while others do not.

In 2004, a nationally representative survey of adolescents aged 12–19 years old in Uganda was conducted to address these information and service needs. The survey data contain more detailed information on a range of issues than is available in other surveys, such as adolescents' views on health information and service sources; sexual relationships and partner characteristics; the consistency and correctness of condom use; exposure to and content of sex education in schools; family and peer influences; and knowledge and attitudes about HIV and other STIs and pregnancy risk and prevention. An important strength of the survey is that it contains information on very young adolescents (those aged 12–14 years), about whom very little has been known up to now. The survey also includes a substantial number of interviews with male adolescents, another group often neglected in other data sources.

The purpose of this report is to provide a comprehensive overview of the sexual and reproductive health of 12–19-year-old females and males in Uganda in 2004. Results are mainly descriptive of the knowledge, attitudes and behaviors of adolescents. Relevant policy and programmatic implications for adolescent in-

formation and service needs are noted throughout the report.

The 2004 survey is part of a larger, five-year study of adolescent sexual and reproductive health issues called Protecting the Next Generation: Understanding HIV Risk Among Youth (PNG). The project, which is being carried out in Burkina Faso, Ghana, Malawi and Uganda, seeks to contribute to the global fight against the HIV/AIDS epidemic among adolescents by raising awareness of young people's sexual and reproductive health needs with regard to HIV/AIDS, other STIs and unwanted pregnancy. It also seeks to communicate new knowledge to a broader audience, including policy-makers, health care providers and the media, in each country, regionally and internationally; and stimulate the development of improved policies and programs that serve young people.

In addition to the national surveys, the project includes evidence from multiple perspectives and methods of data collection in order to provide a comprehensive range of information on adolescent sexual and reproductive health knowledge, attitudes and behaviors. Fifty-five focus group discussions were conducted in 2003 with adolescents in the four countries to increase understanding of the perceptions and beliefs that influence adolescents' behaviors and their use of health information and services.³ Also in 2003, about 100 in-depth interviews with adolescents were conducted in each country in order to understand the social context of young people's romantic and sexual relationships and their health-seeking behaviors. Finally, 60 in-depth interviews in each country were conducted in 2005 with health providers, teachers and parents/guardians/adult community leaders in order to hear adults' perceptions of issues related to adolescent sexual and reproductive health, and to learn about adult-adolescent communication on issues related to sexual and reproductive health in order to provide a better understanding of how adults perceive their role and responsibilities regarding adolescent sexual and reproductive

health. Information from the qualitative data is presented in separate Occasional Reports.

Social and Demographic Characteristics of Adolescents

In Uganda, young people aged 10–24 constitute a third of the total population, with 24% aged between 10 and 19 years old.⁴ Based on a population growth rate of about 3.24 percent, adolescents aged 15–24 were estimated to number 4.7 million in 2000 and 5.5 million in 2005.⁵ Poverty is an important factor affecting adolescent sexual and reproductive health, as well as physiological development, and unemployment is a characteristic problem among youth in the country. Youth (10–24 years old) who are out of school often work as housemaids, barmaids and food vendors and in other low-income jobs. Data from the 2000–2001 Uganda Demographic and Health Survey (UDHS) show that the majority of young people aged 15–24 who were employed were engaged in agricultural activities (77% of females and 52% of males).⁶

Universal primary education was implemented by the government in 1997 to ensure that the majority of children of primary school age attend school. As part of this policy, user fees for primary schools were eliminated for four children per family. As a result of this policy, more young people are now enrolled in school, with fewer adolescents reporting that they never attended school. For instance, the proportion of 15–19-year-old females who never attended school decreased from 21% in 1988–1999 to 9% in 2000–2001, and among 20–24-year-olds, the proportion fell from 30% to 15% in the same time period. A gender gap in school enrollment still exists however, with young women aged 15–24 being more likely to have never attended school (12%) compared with young men (2%). Nearly one-quarter (23%) of young women 15–24 years old attained secondary education and above, compared with 29% of young men aged 15–24.⁷

HIV and Other STIs

HIV/AIDS in Uganda is recognized as a serious health and development concern. Fuelled by poverty, gender inequality and lack of information and prevention services, adolescents are exposed to the risk of HIV and eventually AIDS. HIV prevalence was, until the end of 2000, highest among adolescents (aged 15–19 years), with females three to six times more likely to be infected than males. The highest infection rate is now amongst married females (5.9%)—the rate among those not in union is 2.7%.⁸ The same study shows that

that 6.4 percent of Ugandan adults are infected with HIV, with higher prevalence among women aged 15–49 (7.7%), compared with men (5.0%) in the same age-group. Among the young people 15–19 years, the prevalence rate among women is 2.6%, compared with 0.3% among men.

Data from the AIDS Information Centre (AIC), the main NGO providing voluntary counseling and testing (VCT), show that among 15–24-year-olds who were first time testers, HIV seroprevalence declined among males from 11% in 1992 to 3% in 2002, and among females from 29% in 1992 to 10% in 2002.⁹ Data from the African Youth Alliance show that other types of STIs are fairly common among young people in Uganda: Survey data from 24 districts collected in 2002 showed that approximately 5% of 10–14-year-olds reported that they had ever contracted an STI (6% of females and 4% of males); 9% of 15–19-year-old females and 5% of males reported having had an STI; and about 10% of 20–24-year-olds reported ever contracting an STI (14% of females and 10% of males).¹⁰

Civil strife in the northern districts of Uganda stemming from the insurgency that has characterized the area since 1987 has jeopardized the health of adolescents through the abduction, rape and internal displacement of young people and their families.¹¹

Sexual Activity Among Adolescents

Although young people in Uganda are now starting sexual activity at a later age than in the past, the age at sexual initiation is still early. Fourteen percent of both men and women aged 15–24 reported they had had sex before age 15, and 63% of women and 47% of young men had had sex before the age of 18. Among 20–24-year-olds, the median age at first sex is 16.6 for women and 18.4 among for men, and by age 18, 71% and 43% of these women and men, respectively, have had sex.¹²

Early and Unintended Childbearing

The proportion of women in Uganda who have had a first birth before age 15—those at very high risk for poor health outcomes—have decreased over time. About 10% of women aged 30–34 reported giving birth before age 15, compared with only 2% of 15–19-year-olds. In 1995, 43% of 15–19-year-old females were pregnant or had already had a child, compared with 35% in 2000–2001. However, unwanted childbearing among Ugandan adolescents is still a challenge: Ten percent of births to 15–19-year-old women in the five years prior to the 2000–2001 survey were not wanted at all and 23% were mistimed.¹³

Contraceptive Use

Adolescents are known to be poor users of contraceptives, despite high levels of knowledge and approval of contraceptives. According to the UDHS 2000–2001, 96% of 15–19-year-old women and virtually all of their male counterparts know of at least one contraceptive method, yet only 22% of these women reported ever-use of any method and 10% were currently using.¹⁴ Unmet need for contraception is fairly high among adolescent women: About one in four married women aged 15–19 wanted to delay having a birth or did not want any (more) children but were not using contraceptives.¹⁵ The low level of protection against unplanned pregnancy is a major cause of the high level of unplanned births and induced abortions among young Ugandan women.¹⁶

Health Care Service Utilization

Health services targeting adolescents are often limited to schools. These services include curative services and information, education and communication (IEC) on growth and development through film shows, plays and seminar talks. IEC found in schools, health units and religious institutions mainly focuses on AIDS and other STI, sex education, growth and development, life skills education and behavior change. These are being offered by NGOs, churches and health care providers. Studies show that most of the sexual and reproductive health services in Uganda are not youth-friendly and have not attracted many adolescent clients.¹⁷ Limited access to youth-friendly services and information is another problem affecting adolescents in the bid to have protected sex or postpone sex.

Major Policies and Programmatic Activities

The Government of Uganda has put in place policies aimed at improving the sexual and reproductive health of adolescents. Through the relevant policies and laws the government of Uganda recognizes and emphasizes the salience of addressing adolescent sexual and reproductive health by keeping children and adolescents in school, and increasing contraceptive use and levels of supervised delivery by trained health personnel. These policies include the National Youth Policy (still in draft form),¹⁸ the National Policy on Young People and HIV/AIDS,¹⁹ and the Affirmative Action Policy.²⁰ Other national policies that have beneficial implications for adolescent sexual and reproductive health are the National Population Policy,²¹ National Health Policy,²² National Gender Policy,²³ Reproductive Health Policy (draft), national reproductive health service de-

livery policy guidelines, Sexual and Reproductive Health Minimum Package for Uganda and national AIDS control policy proposals.²⁴ Although some of the policies are not fully implemented yet, they will provide a supportive and conducive environment for adolescent sexual and reproductive health.

In 2002, the president of Uganda proposed a way of improving communication on HIV/AIDS among young people whereby head teachers would address school assemblies on HIV/AIDS every two weeks and teachers would also take the discussion into the classrooms and school clubs. The Uganda AIDS Commission, a body responsible for coordinating the country's HIV/AIDS response and providing oversight to HIV/AIDS policy and implementation, took up the initiative and, in partnership with the Ministry of Education and donor agencies, the Presidential Initiative on AIDS Strategy for Communication to Youth was established in 2003. The first phase of its implementation started in 2004 and involved the provision of handbooks to teachers and pupils in every primary school in the country. In addition, three primary school teachers throughout the country were trained in delivering information on HIV/AIDS prevention and life skills.

Various organizations have developed interventions aimed at behavior change and service delivery strategies for adolescents. These organizations and interventions, including the United Nations Children's Fund's Basic Education Child Care Adolescent Development, the Joint United Nations Programme on HIV/AIDS, the Programme for Enhancing Adolescent Reproductive Lives, the Family Life Education Programme and the Delivery of Improved Services for Health, have provided services aimed at improving adolescents' use of reproductive health services in public health care facilities.

Chapter 2

Methodology

A national household survey on adolescent sexual and reproductive health was carried out with 12–19-year-old females and males between January and July 2004. Uganda Bureau of Statistics, in collaboration with ORC Macro, Makerere Institute of Social Research and the Guttmacher Institute, conducted the survey.

Questionnaire Design and Content

The survey used two instruments: a household screener and an adolescent questionnaire. The household screener was used to list all usual members and visitors in the selected household. The age, sex, relationship to head of household and education characteristics were collected for each person listed. The purpose of the form was both to identify eligible 12–19-year-olds for individual interviews and to collect information on the household's access to water and sanitation facilities, environmental conditions, land ownership and possessions. All 12–19-year-old *de facto* residents (i.e., those having spent the prior night in the household) in a household were eligible and invited to participate.

The adolescent questionnaire collected information about a wide range of aspects of adolescents' lives. A conceptual framework of adolescent sexual and reproductive health (Chart 2.1) guided the content of the survey questionnaire and ensured that data on the social environment, knowledge, attitudes and sexual and reproductive experiences and key behavioral outcomes (e.g., condom use, current sexual activity) were obtained. The adolescent survey questionnaire is comprised of the following sections:

- Respondent's background characteristics (education, work, religion)
- Family and social group information (contact with and characteristics of biological mother and father; existence of mother- and father-figures; membership and office-holding in social groups or clubs)
- Reproductive experiences (age at puberty, birth history, fertility preferences, abortion knowledge and experiences)
- Pregnancy knowledge and sex education (knowledge and misperceptions about how pregnancy happens, experiences with and content and format of sex education)
- Contraceptive method knowledge, use and information and service sources (includes detailed questions about correct use of male condoms and attitudes about male condoms and perceptions of different sources for contraceptive methods)
- Marriage and consensual union formation and sexual activity (12–14-year-olds were also asked questions about other kinds of sexual activities in addition to sexual intercourse)
- Sexual relationship history (characteristics and method use with the first sex partner and up to three sex partners in the 12 months prior to the survey interview, including questions about receiving money or materials goods in exchange for sex, and questions about reasons for abstaining from sex for those who never had sex or did not have sex in the 12 months prior to the survey interview)
- HIV knowledge, information sources, and voluntary counseling and testing knowledge and experiences
- Knowledge of, experiences of, and information and service sources for STIs other than HIV (includes questions about perceptions of different sources for STI treatment)
- Social and cultural practices (includes experiences and timing of initiation rites, circumcision, recent experiences with injections, communication with family and others about sex-related matters, and attitudes about sexual activity)
- Worries (including fear of having enough to eat, money to spend, and the risks of HIV and unwanted pregnancy), substance abuse and other issues during early childhood
- Physical and sexual abuse (including knowledge and experience of abuse), anal sex and other sexual practices

Because the last section of the interview was the most sensitive, its application was treated differently than the rest of the questionnaire. Extra precautions were taken to ensure the privacy and confidentiality of responses to this section. If there was only one eligible respondent, that respondent was given the complete survey, including the section on physical and sexual abuse. When there was more than one eligible 12–19-year-old in the household, a table at the end of the household screening form was used to randomly select one adolescent in the household to answer the section with sensitive questions. Only one adolescent per household was selected, so that respondents could be assured that other adolescents in the same household would not know that the respondent had been asked these questions. Interviewers also had to complete a separate filter check for privacy before administering this final section: If anyone over three years of age was within listening distance, the interviewer did not administer the questions.

The Guttmacher Institute, in collaboration with the University of Cape Coast (Ghana), Institut Supérieur des Sciences de la Population (Burkina Faso), Makerere Institute of Social Research (Uganda), Centre for Social Research (Malawi) and the African Population and Health Research Center (Kenya), designed the content of the survey instruments. The survey household screener and the adolescent questionnaire were developed with external input and pretested extensively. A review of 27 existing survey questionnaires used to measure different aspects of adolescent sexual and reproductive health was undertaken by Guttmacher Institute staff and most of the questionnaire items were drawn from these existing survey instruments. Questions for standard measures of household amenities, contraceptive knowledge and experience of sexual intercourse were drawn from recent Demographic and Health Surveys for the sake of comparability. Five questions about the correctness of condom use were based on items from Indiana University's Kinsey Institute for Research in Sex, Gender and Reproduction's Condom Use Errors Survey for Adolescent Males (August 26, 2001 version). All research partners from the six institutions above met in November 2002 to provide input into the content areas and specific measures that should be obtained from the national surveys of adolescents. ORC Macro provided a large amount of input into the structure of the survey instruments and also provided comments on the content.

A set of 15 mock interviews was conducted in March 2003 in New York to estimate a range for the du-

ration of an adolescent interview, and drafts of the survey instruments were sent to 19 external reviews for comment in April 2003. Further revisions were made in light of external reviewer input and low-priority items were identified given the mock interview timing estimates (ranging between 60 and 118 minutes).

Preliminary findings from 55 exploratory focus group discussions (FGDs) conducted with 14–19-year-olds from January through March 2003 in the four study countries were also used in revising the questionnaire. The FGDs indicated that young people in the four countries were generally comfortable talking about sexual activity and sexual relationships, with the exception of 14–16-year-old females in Burkina Faso (these questions were not asked of 12–14-year-olds). Because of this, in Burkina Faso only, 14–16-year-old females were asked the set of questions asked of 12–14-year-olds about awareness of specific sexual activities. Questions about personal experiences were asked only if the participant indicated an awareness of the relevant sexual activity. In general, the FGD findings helped in the development of detailed questions about sexual behaviors and partner characteristics. Findings from the Uganda and Malawi FGD analyses, in particular, resulted in very specific survey questions that defined “sexual activities,” since this phrase covered behaviors ranging from talking together to visiting with boyfriends or girlfriends to forced intercourse. Country-specific questions about how pregnancy occurs were also derived from the exploratory FGDs with adolescents.

A pretest of the survey instruments was conducted in September 2003 by the Institute of Statistical, Social and Economic Research in Legon, Ghana with 292 12–19-year-olds to obtain estimates of the average duration of the interview, examine the receptivity of 12–14-year-olds to sets of questions, and to check on instrument skip patterns and field protocols (including the random selection of one eligible adolescent per household for the last section of the questionnaire). Revisions to the instruments were based on feedback from the interviewers (this feedback was taped so that other colleagues could listen to the comments), frequency distributions of variables and the timing estimates. The majority of the survey content is comparable across all four countries. Both survey instruments were translated into six local languages which included Ateso, Luganda, Lugbara, Luo, Runyankole-Rukiga and Runyoro-Rutoro.

Sample Design and Field Procedures

The sample for the 2004 Uganda National Survey of Adolescents covered the population residing in private households in the country. A two-stage stratified sample design was used. The 2002 Uganda census served as the sampling frame. The census was chosen over the 2000–2001 Uganda Demographic and Health Survey (DHS) because all materials had been updated by the census for every enumeration area (EA). The self-weighting national sample was selected in two stages. The first stage made a systematic selection of 202 EAs with probability proportional to size. The second stage made a selection of 38 households per EA. During fieldwork, four districts in the Northern Region (Kitgum, Gulu, Pader and Lira) had to be dropped from the sample due to security concerns. Fourteen EAs were part of the four districts dropped from the sample. Thus, the survey sample for Uganda is representative of the whole country excluding four districts in the Northern Region. It is worth noting that the EAs that were dropped, which are predominantly inhabited by the Luo people, constituted less than 7% of the total number of EAs covered by the study. Given that the neighboring Luo-speaking districts of Nebbi and Apac were covered by the study, dropping these EAs is expected to have had only a minimal impact on the overall results.

A pretest of the household screener and adolescent questionnaire in each language for the 2004 Uganda National Survey of Adolescents was conducted from January 18–26, 2004 by the Uganda Bureau of Statistics. The lessons learned from the pretest were used to finalize the survey instruments, field protocols and translations.

Training of field personnel was conducted in Entebbe from February 9–21, 2004. A total of 32 male and female interviewers and 17 supervisors and field editors in eight teams participated in the 2004 survey. Training was extensive and was based on standard DHS training protocols for conducting an interview, making callbacks and completing survey questionnaires. The interviewer training manual was based on the core DHS Interviewer's Manual and included explanations of each question in the 2004 National Survey of Adolescents questionnaires. Interviewers were, in general, selected to be young (around 18–25 years old) and to have successfully completed the interviewer training.

Each field team had a field supervisor and field editor. Field supervisors were responsible for all field logistics, from obtaining all sample maps and household

listings to securing accommodation for the field team, and for managing the interviewer workload. Field editors were to observe at least one full interview every day (with the consent of the respondent); edit all completed questionnaires in the field; and conduct regular review sessions with each interviewer and advise them of any problems found in their questionnaires.

Field data collection started on February 27 and ended on July 6, 2004. All adolescents aged 12–19 who were de facto residents in the selected households were eligible for the interview. Interviewers made at least three attempts at contacting households and eligible adolescents for interview, with each visit to be made at a different time of day and on different days (i.e., it was not permitted to make all three visits on the same day). Interviewers were assigned to interview adolescents of their same sex because of the personal nature of the topics covered. Cases of interviewers conducting interviews with respondents of the opposite sex occurred mainly because an interviewer of the same sex and fluent in the specific language needed was not available to complete the interview.

Informed consent was sought from each eligible adolescent and, for adolescents younger than 18, consent from a parent or caretaker was obtained before the adolescent was approached to participate in the survey. Once the parent or caretaker gave consent, separate consent was still obtained from the eligible adolescent. Two different informed consent statements, one for the parent or caretaker and another for the eligible adolescent, were used.

Data entry and processing for the 2004 National Survey of Adolescents interviews began shortly after interviewing started and was carried out using the software package CSPro. CSPro is an interactive data entry system that can check for acceptable codes for questions, follow skips and filters in the questionnaire and check the consistency of data as they are entered. The questionnaires were entered by cluster, with each cluster being assigned to one data entry operator.

Consistency checks were developed and performed in two stages: Simpler consistency checks were handled at the data entry stage and the majority of the more complex consistency checks were carried out during a secondary stage of machine editing. Guidelines were also developed on how to resolve inconsistencies detected during data entry and in the editing process, as well as the action to take if the inconsistencies could not be resolved through an examination of the responses to other pertinent questions in the questionnaire.

Data entry during the field period allowed field-

check tables to be generated to examine data quality while interviews were still being conducted. Depending on the size of the sample and the speed of data entry, the tables were produced every 2–3 weeks to measure

- household and eligible adolescent response rates;
- age displacement (to determine whether interviewers were intentionally displacing the ages of young people from the eligible range (12 to 19 years) to an ineligible age (11 and under or 20 and older));
- knowledge of male and female condoms (to ensure that interviewers were distinguishing clearly between the two methods);
- awareness of sources for contraceptive methods and STI treatment (to check whether interviewers were intentionally coding respondents out of questions about service providers);
- having heard of sexual intercourse (among 12–14-year-old respondents) and having had sexual intercourse (among 15–19-year-old respondents); and
- presence of others within hearing distance before the last section of questions was to be administered (Some interviewers might have been tempted to skip this section because of the nature of the questions, and one way to do this was to check the box that others were present or listening.).

Senior survey staff worked together with the data processing chief, ORC Macro, Guttmacher Institute and Makerere Institute of Social Research staff to interpret the tables and identify problems. If data collection problems were discovered at the team level, tabulations were produced by interviewer to determine whether problems were team-wide or restricted to one or two team members. Immediate action was taken to address the problems.

Table 2.1 shows the length of interview, privacy of interview and how well the interviewer thought the respondent understood the survey questions in general. The duration of the interview can indicate the burden on the adolescent respondent in answering questions: The survey aimed for a 45 minute interview on average. However, the results show that on average, each interview took slightly over an hour. The length of interview did not vary much by age and sex of the respondent and it is considered not too long to have constituted an undue burden on the respondents.

Ensuring privacy of the interview was absolutely critical to fielding the survey, as the presence of partic-

ular people within hearing distance can influence the responses an adolescent is willing to give. Interviewers were trained to conduct interviews in places or ways that would assure privacy for adolescent respondents.. At times people may have wandered by or were within hearing distance as they went about their daily activities. Interviewers were instructed at the end of the interview to note who the people were within hearing distance during any point of the interview. Section 12, which contained especially sensitive questions, was not to be administered if anyone older than three years was within hearing distance of the interview. Separate information on the presence of others for this section was recorded by the interviewer. According to the results, absolute privacy was not achieved in one out of every 10 interviews conducted.

Finally, the interviewer's assessment of the respondent's level of understanding provides a general indication of adolescent comprehension of survey questions that focus mainly on sexual and reproductive health, whether there are big differences by age and sex, and especially the usefulness of information provided by the youngest adolescents (12–14-year-olds). According to the interviewers, most of the adolescents (95% of females and 89% of males) understood the survey questions very well or well. The 15–19-year-olds, as compared with the 12–14-year-olds (as was expected), as well as the female adolescents, exhibited higher levels of understanding the survey questions than their counterparts.

Sample Characteristics

Of the 6,659 adolescents aged 12–19 listed in the household screener, 852 were usual members of the household but did not spend the night in the household the evening before the household screener interview (i.e., they were *de jure* but not *de facto* household members). Among those absent, 57% were in boarding schools or at a university, 27% were staying in another household, 6% were on vacation, traveling or visiting and 10% were away for other reasons. Only *de facto* 12–19-year-olds were interviewed and included in the final sample.

Table 2.2 presents information on the number of households selected and interviewed and the number of eligible adolescents identified and interviewed by urban and rural residence and in total. It also provides the response rates for households and adolescents by urban and rural residence and in total. The household interview was completed for 87% of the selected households: The exercise was more successful in the

rural (88%) than the urban (82%) areas. The most common reason for not completing a household interview was that the dwelling was vacant, destroyed or not located. The proportion and pattern, by residence, of the interviews completed among the adolescents were quite similar to those reported above for the household. Overall, 88% of eligible adolescents were interviewed with the rural areas recording a higher success (89%) than the urban areas (81%). A fairly high percentage of urban adolescents (12% compared with 8% in the rural areas) were not interviewed because they were not at home. This occurred mainly among the 15–19-year-old urban males, 21% of whom could not be interviewed because they were not at home (not shown).

Table 2.3 presents information on the number of eligible adolescents identified and interviewed, the corresponding response rates and the specific reasons for interviews that were not completed by age-group and sex. Most of the eligible de facto adolescent females (90%) and males (86%) were successfully interviewed. These proportions did not differ remarkably by age of the respondents. Refusal to participate (or parent/caretaker's refusal to permit minor adolescents from participating) in the survey was not the main reason for survey nonresponse. Rather, even with multiple attempts, most of the eligible adolescents who could not be interviewed were reported as being not at home. It is re-assuring that the response rates for both female and male adolescents were very similar to those obtained in the 2000–2001 UDHS.²⁵

Comparisons of the 2004 data to external data sources are useful as a check on the ways that the 2004 survey sample population may differ from other surveys. Table 2.4 shows several key characteristics of 15–19-year-old females and males in the 2004 National Survey of Adolescents (NSA) and the most recent UDHS (2000–2001). One would expect some differences between the two surveys due to the time gap, different content of the survey questionnaire and interview and sampling error. Compared with the 2000–2001 UDHS, the rural adolescent population (both male and female) had a slightly higher representation in the 2004 NSA sample. However, the 2004 rural/urban sample composition is very similar to the 2001–2002 Uganda Population Census figures which show that 87% and 86% of the 15–19-year-old female and male adolescents respectively live in rural areas.

Table 2.4 also shows a much higher percentage of 15–19-year-old females who were ever in union in the 2000–2001 UDHS, compared with the 2004 NSA (32% versus 23%). The difference between surveys in

the percentage of 15–19-year-old females who ever had sexual intercourse was much smaller (52% in the 2000–2001 UDHS versus 48% in the 2004 NSA). The difference was in the opposite direction in the percentage of 15–9-year-old males who ever had sexual intercourse (38% and 49%). The wording of questions was the same in both surveys for the union status and sexual intercourse questions for 15–19-year-olds, although the content of the questionnaires was different (the NSA obtained much more detail on sexual activity and sexual and reproductive health related information, services, sources and knowledge). These differences notwithstanding, as a national survey on aspects of sexual and reproductive health, the 2004 NSA provides detailed information on sexual and reproductive health of adolescents, thus complementing results from the UDHS and the trends over time in behaviors that the UDHS documents.

TABLE 2.1 Percentage of adolescents by duration of interview and others present during interview, and percentage distribution of adolescents by interview characteristics, all according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=1275)	15-19 (N=1302)	Total (N=2577)	12-14 (N=1193)	15-19 (N=1294)	Total (N=2488)
Mean duration of interview (minutes)	63.8	63.8	63.8	65.3	65.1	65.2
Presence of other people within hearing range during interview*						
No person within hearing range	91.0	91.0	91.0	90.5	90.5	90.5
Spouse/partner	0.1	0.3	0.2	0.2	0.1	0.1
Mother	0.2	0.4	0.3	0.3	0.4	0.3
Father	0.1	0.1	0.1	0.0	0.3	0.2
Brother/sister	0.4	0.5	0.5	0.5	0.5	0.5
Other adolescents	1.6	2.5	2.0	3.1	3.9	3.6
Other children	1.4	1.9	1.6	3.3	2.8	3.0
Other adults	6.5	5.8	6.1	4.2	3.9	4.0
Interviewer rating of respondent's understanding of survey questions						
Very well	43.5	54.6	49.1	30.7	53.0	42.2
Well	49.0	42.3	45.6	53.6	40.1	46.6
Not very well	7.5	3.1	5.3	15.7	6.9	11.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 2.2 Percentage distribution, numbers and response rates of households and respondents, according to residence, 2004 National Survey of Adolescents

Result	Residence		Total
	Urban	Rural	
Selected households			
Completed (C)	81.6	87.7	87.0
Household present but no competent respondent at home (HP)	4.1	1.2	1.6
Refused (R)	0.6	0.2	0.2
Household absent (HA)	0.7	1.9	1.7
Dwelling vacant, destroyed or not found (DV)	12.0	8.5	9.0
Other (O)	1.0	0.4	0.5
Total	100.0	99.9	100.0
Number of sampled households	875	6,231	7,106
Household response rate (HRR)*	94.6	98.4	98.0
Eligible de facto adolescents			
Completed (EAC)	81.3	89.3	88.3
Not at home (EANH)	12.4	8.1	8.6
Postponed (EAP)	0.0	0.0	0.0
Respondent refused (EAR)	1.2	0.7	0.8
Parent/caretaker refused (PEAR)	1.3	0.1	0.2
Partly completed (EAPC)	0.4	0.2	0.2
Incapacitated (EAI)	1.8	1.2	1.3
Other (EAO)	1.6	0.3	0.5
Total	100.0	99.9	99.9
Number of adolescents	672	5,135	5,807
Eligible adolescent response rate (EARR)†	81.3	89.4	88.4
Overall response rate (ORR)‡	76.9	88.0	86.6

*The household response rate is calculated as: $HRR = (100 \times C) / (C + HP + R)$. †The eligible adolescent response rate is calculated as: $EARR = (100 \times EAC) / (EAC + EANH + EAP + EAR + PEAR + EAPC + EAI + EAO)$. ‡The overall response rate is calculated as: $ORR = (HRR \times EARR) / 100$.

TABLE 2.3 Percentage distribution of adolescents, by interview characteristics, according to sex and age, 2004 National Survey of Adolescents

Result	Female			Male		
	12–14	15–19	Total	12–14	15–19	Total
Eligible de facto adolescents						
Completed (EAC)	91.4	89.6	90.4	88.4	84.4	86.2
Not at home (EANH)	5.8	7.6	6.7	8.5	12.3	10.5
Postponed (EAP)	0.0	0.1	0.0	0.0	0.0	0.0
Parent/caretaker refused (PEAR)	0.1	0.4	0.3	0.3	0.1	0.2
Respondent refused (EAR)	0.3	0.7	0.5	0.6	1.5	1.1
Partly completed (EAPC)	0.4	0.2	0.3	0.1	0.1	0.1
Incapacitated (EAI)	1.8	1.2	1.5	1.3	1.0	1.1
Other (EAO)	0.1	0.3	0.2	0.9	0.6	0.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of adolescents	1379	1507	2886	1348	1573	2921
Eligible adolescent response rate (EARR)*	91.5	89.5	90.4	88.3	84.4	86.2

*The eligible adolescent response rate is calculated as: $EARR = (100 \times EAC) / (EAC + EANH + EAP + EAR + PEAR + EAPC + EAI + EAO)$.

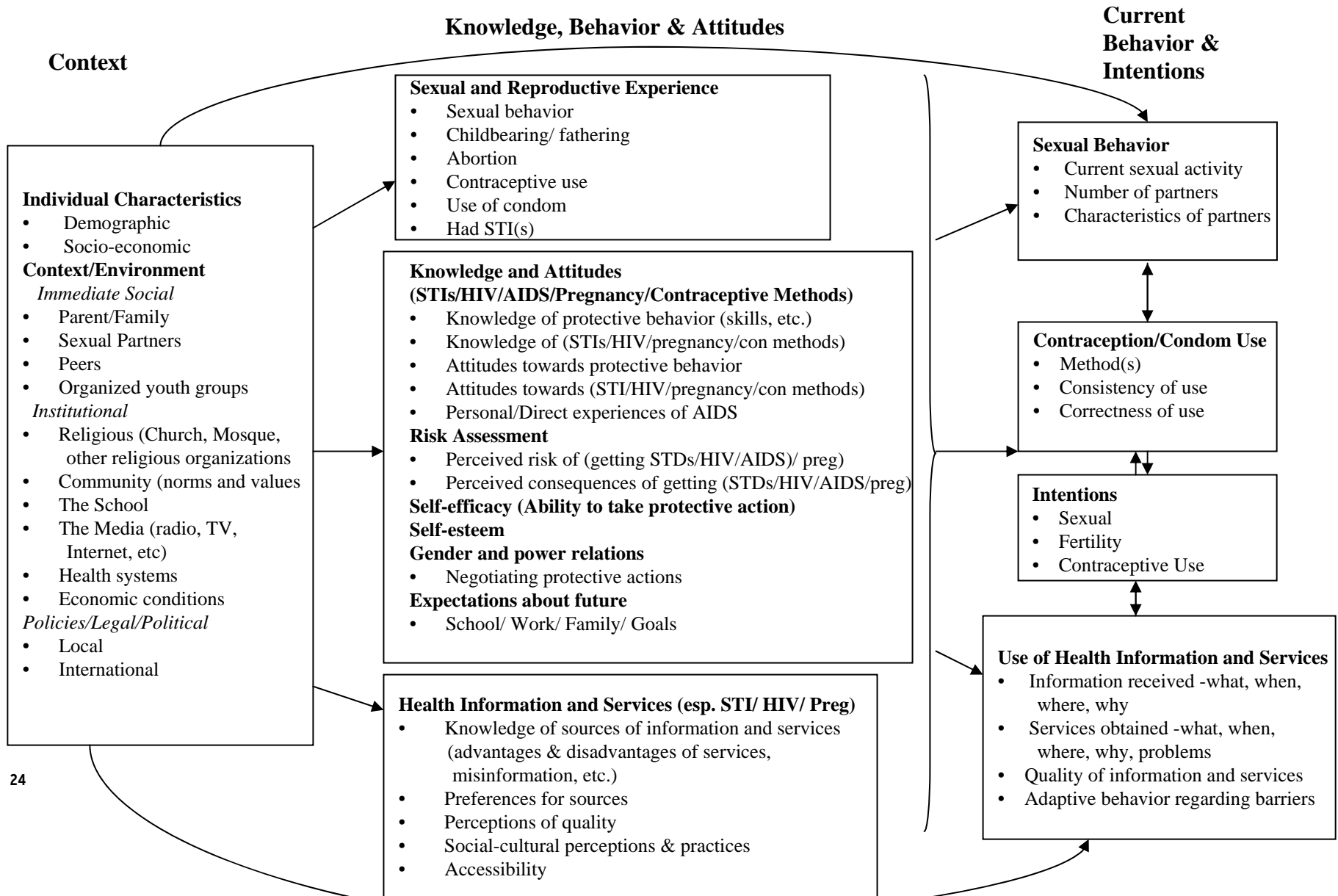
TABLE 2.4 Comparison of respondent characteristics of 15–19-year-olds across surveys: 2000–2001 Uganda Demographic and Health Survey (UDHS) and 2000–2001 and 2004 National Survey of Adolescents (NSA)

Characteristic	Female		Male	
	2000–2001 UDHS (N=1615)	2004 NSA (N=1315)	2000–2001 UDHS (N=441)	2004 NSA (N=1303)
Urban-rural residence				
Urban	19.4	14.5	18.3	11.1
Rural	80.6	85.5	81.7	88.9
Ever in a union				
No	67.7	77.5	93.5	96.5
Yes	32.3	22.5	6.5	3.5
Ever had sexual intercourse				
No	48.0	51.7	61.6	51.4
Yes	52.0	48.3	38.4	48.6
Ever had a child				
No	74.4	78.5	94.9	98.8
Yes	25.6	21.5	5.1	1.2

Note: Ns are weighted for the 2000–2001 UDHS and 2004 NSA.

Chart 2.1

Conceptual Framework of Adolescent Sexual and Reproductive Health



Chapter 3

Context of Adolescents' Lives

This chapter presents evidence on a range of important aspects of young people's lives—their education, work and family situations—to understand better the social and economic reasons for young people's vulnerability to HIV and unwanted pregnancy. Family, peers and other social aspects of adolescents' lives that have been shown to influence their protective and risk behaviors are also shown.

Characteristics of Survey Respondents

A description of the basic characteristics of the adolescents interviewed in the survey provides the background for interpreting findings on sexual and reproductive health presented later in the report.

Descriptive analysis of age and sex differentials in sexual and reproductive health indicators by further characteristics, such as region of residence or ethnic group, are somewhat limited due to the small numbers of cases for particular groups (as can be seen in Table 3.1).

One in 10 females aged 12–19 in Uganda are currently in union (i.e. married or living together with a man as if married). This proportion is even higher among older females, with almost 20% of the 15–19-year-old females currently in union in 2004. As expected, few young men were in union—fewer than 1% of the males aged 12–19 reported being in union, and this proportion is slightly less than 2% among the 15–19-year-olds.

The distribution of respondents by rural-urban residence is fairly similar for females and males, with 12% of female adolescents and 10% of their male counterparts residing in an urban area. The largest proportions of both female and male respondents (32% and 30%, respectively) live in the Central Region, while the Northern Region is the least populated area, with 16% of female and 17% of male adolescents. However, failure to include four districts in the Northern Region within the survey sample may contribute, in part, to the lower proportion of adolescents living in the Northern

Region relative to the other three regions. More than 10 ethnic groups are represented among the survey respondents, with similar proportions of males and females (20% each) identifying themselves as Muganda. About 11% were Munyankore, and another one in 10 belonged to an “Other Northerner” ethnic group.

Wealth quintiles were constructed using the protocol used in the DHS, based on analysis of household assets (wealth indicators).²⁶ As many logical indicators of household wealth as possible were used to distribute cases more finely across index scores. Factor analysis was then employed to obtain factor loadings for each indicator variable and the indicator values were multiplied by the factor loadings to obtain a wealth index value for each survey household with a completed screener. A weighted frequency of households' wealth index values was then produced with the weight being a product of the number of household members and the household sampling weight. Quintile cut-off points for the household wealth index were then set based on the weighted frequency. Table 3.1 shows that female and male adolescents are similarly distributed across the five wealth quintiles though slightly more 12–14-year-old adolescents live in households that are in the lowest wealth quintile compared with 15–19-year-olds.

Family Formation and Living Arrangements

The sexual and reproductive health issues facing adolescents who are in union or those who have already given birth to a child are often quite different than those facing adolescents who are not in union and have not yet begun childbearing. Table 3.2 shows the distribution of adolescents by these key family formation characteristics.

While the majority of young women aged 12–19 in Uganda are not in union and have not yet begun childbearing (86%), being in union and childbearing are not uncommon among older female adolescents. In 2004, 13% of females aged 15–19 were in union and had already had a child and nearly one in 10 female respon-

dents aged 15–19 was not in union and had had a child.

Fewer than half of adolescents in Uganda lived with both their biological parents (40% among females and 44% among males). Younger adolescents were more likely to report living with both biological parents than their older counterparts. A fairly high proportion of adolescents lived with only one biological parent: Fifteen percent of females and 18% of males lived with their biological mother only, while 8% of females and 10% of males lived with their biological father only. Nearly three in 10 adolescents in Uganda did not live with either of their biological parents nor were they in union.

The relationship of the adolescent to the household head indicates the type of living arrangement the adolescent has. It also suggests the adolescent's relative freedom in the household and has implications for her or his access to household resources. For example, some evidence indicates that orphans living in a household headed by an unrelated person are in a more disadvantaged position than those who are biologically related to the household head.²⁷ In 2004, the vast majority of adolescents aged 12–19 lived in households headed by a parent (60% of females and 69% of males). Younger adolescents aged 12–14 were more likely to report being the son or daughter of the household head, compared with older adolescents. For females, this difference can be partially explained by the fact that older females were more likely to be married and to have reported their relationship to the household head as wife/spouse. As for males, the difference may be due partly to the fact that older adolescents were more likely to be living away from home and hence to identify themselves as relatives (e.g., brother, cousin or nephew) of the household head, compared with their younger counterparts. Approximately 40% of the females surveyed and more than 30% of the males reported they were not the son or daughter of the head of their household. For example, one in 10 females and males reported his or her grandparent to be their household head. About 12% of young women and 9% of young men identified another relative as the head of their household.

Charts 3.1 and 3.2 summarize the frequency of contact between adolescents and their biological parents (among those with a living biological mother or father). Adolescents have relatively similar levels of contact with their biological mothers and fathers: 67% lived with mothers and 66% with fathers and another 8% visited their mother and 11% visited their father at least once a week.

Table 3.3 provides information on characteristics of orphanhood among adolescents aged 12–17. About one in five orphaned adolescents lost their mothers before age six, while about three in five females and more than half of males experienced this loss before they were 12 years old. Similarly, roughly one in four lost their fathers before age 6; three in five females and more than half of males did so before age 12. The percentage of adolescents with a deceased father is somewhat greater than the percentage of adolescents with a deceased mother. This may be partly due to the age differences in spouses (mothers are younger on average than fathers). Many adolescents who have at least one deceased biological parent report living with neither a biological parent nor someone they consider a parent-figure (40% of females and 39% of males).

Schooling Experiences and Expectations

Educational attainment and school enrollment are two of the most important characteristics pertaining to adolescents' sexual and reproductive behavior. Table 3.4 shows the educational attainment, enrollment and expectations for future educational attainment. In addition, information about any vocational training received is included, since this is also an important part of skills adolescents can acquire that have an impact on their future livelihood.

The data show slightly more adolescent males had ever gone to school than females (98% and 96%, respectively) and the gender difference was larger when looking at current attendance (81% of males reported current attendance compared with 72% of females). School attendance was, not surprisingly, higher among 12–14-year-olds than among those aged 15–19.

Marked differences exist between female and male youth in Uganda when it comes to expectations for future educational attainment. Whereas 20% of adolescent females in 2004 had no expectation for further schooling, only 8% of adolescent males did not have this expectation. The gap between the sexes was wider among 15–19-year-olds than among 12–14-year-olds. For example, 29% of females aged 15–19 expected to complete secondary school, compared with 41% of males. This reflects how entering a consensual union may change educational aspirations, since many of these 15–19-year-old females were in union. Among 12–14-year-olds, 42% of females and 48% of males expected to complete secondary education. Finally, approximately one in five young people had received vocational training (22% of females and 20% of males).

Table 3.5 shows the main reasons adolescents

stopped attending school. Of those who stopped attending school in Uganda, the main reason was that they could not afford to pay their school fees (53% of females and 60% of males). For 15–19-year-old females, 10% said they stopped going to school because of a pregnancy.

Table 3.6 shows when adolescents began their schooling and the background characteristics of their most recent school environment. Information is also included on whether adolescents who were enrolled in school at the time of the survey were repeating the same grade they were in the prior school year, which is a mark of performance in school. Of those who ever attended school in Uganda, a fairly large percentage started school before or at the age of 6, with girls more likely to begin school earlier than boys (45% of females and 35% of males) and younger adolescents more likely to do so than their older counterparts. Nearly one in five young people of both sexes did not start school until the age of nine or older.

The majority of adolescents in Uganda (55% of females and 58% of males) who have attended school go to a government-aided religious school. Government-run religious schools are not unusual in Uganda. During colonial times and the post-independent era, most schools were initiated and run by missionaries of various faiths, including Roman Catholic, Protestant and Islamic. While the government took over most of these schools, the religious groups retained some control of the management of the schools. Government-aided, nonreligious school is also a fairly common option for many young people, with almost three in 10 females and about a quarter of male adolescents having attended such schools in 2004. Older adolescents more commonly attended private schools than younger adolescents, a fact that is partly due to the fact that privatization began mainly in the secondary schools rather than the primary schools. However, there has been a recent increase in privately owned primary schools within Uganda.

Time Use and Work

Information about how adolescents spend their time, whether they earn income and what they do, where they work, and the degree to which they control that money is potentially helpful when thinking about the nature of programs to help adolescents meet their reproductive health needs. This information can also help us understand the broader context in which adolescents make decisions regarding their sexual and reproductive health.

Table 3.7 shows that most adolescents (94% of fe-

males and 78% of males) were involved in doing daily household chores. More males (55%) than females (34%) reported daily engagement in work on family business or farm. More young men than young women worked for pay. Many more young women are out of school and not working than their male counterparts (14% versus 4%) (see also Chart 3.4).

The vast majority of young people who worked were working at home, and this was more common among females than males (87% versus 71%) and older rather than younger adolescents. The majority of adolescents who worked also reported receiving no remuneration for their work, neither in cash nor in kind (72% of females and 60% of males). More adolescent males got paid either in cash or in kind for their work than did females (24% and 10%, respectively among males and 18% and 4%, respectively among females), and older adolescents of both sexes were more likely to be paid in cash compared with the younger adolescents.

One-third of the female respondents and about half of the male respondents reported that they worked or did something for money within the year prior to the survey. As expected, older adolescents were more likely to do so than younger adolescents. Of those earning money, many more males (50%) than females (33%) had the freedom to decide on how their money was to be spent. For 56% of the females and 46% of the males, their parents/guardians made the decisions on how the money was to be spent.

Social Ties

Connections to a religious faith or to social groups offer an additional source of advice and guidance to adolescents and can help encourage them to take fewer risks that might jeopardize their sexual and reproductive health. Table 3.8 shows the religious affiliations of adolescents and, for those who had a religious affiliation, how important they considered religion to be in their lives and how frequently they participated in religious services. This table also shows the percentage of adolescents who belonged to a social group or club and, for those who did belong, the types of clubs they belonged to and whether they held an office or position of leadership in the club.

Nearly all Ugandan adolescents identified with a religion. The distribution of male and female respondents by religion is similar, with the largest proportion of young people identifying as Catholic (43%), second largest as Protestant (33–34%), followed by Muslim (12–13%). The majority of adolescents who had a reli-

gious affiliation classified religion as being “very important” in their lives (86% of females and 88% of males) and went to religious services once a week (76% of females and 69% of males).

While the majority of adolescents did not belong to a group or club, about one in five young women in the country participated in such activities and one in six young men did so. Drama and choir clubs were the most popular among the female youth, more so among younger females than older females, and about one in five girls who belong to a club are members of a netball club. Among male adolescents who belonged to a social group, football clubs were the most popular. Approximately one quarter of females and 11% of males who belonged to some sort of social group or club belonged to a church or Muslim youth group. Other less common social groups were anti-AIDS groups, Boy and Girl Guides and the Youth Brigade.

An important role that parents can play in the sexual and reproductive health of their children is simply being aware of what their children are doing and who their friends are. Table 3.9 shows adolescents’ perceptions of how aware their parents or guardians were about where they went at night, what they did with their free time and who their friends were. For adolescents who were married at the time of the interview, the questions were asked with respect to before they were married, in order to better reflect the degree of involvement parents had when the adolescents were unmarried. The assumption is that the more “monitoring” parents do of their children’s lives, the better the outcomes are for their children.

Seventy-six percent of female adolescents and 57% of males reported that their parents/guardians always knew where they went at night. Adolescents felt similarly about their parents’ awareness of how they spent their free time: Some 67% of the females and 51% of the males reported that their parents/guardians always knew. Parents or guardians were considerably more likely to know their daughters’ friends (64%) than their sons’ friends (44%). As adolescents get older, the level of parental monitoring decreases. For example, 71% of 12–14-year-old males said that their parents always knew where they went out at night, compared with 45% among 15–19-year-old males. Similar patterns existed among females.

Adolescents who lived in rural areas more often reported that their parents/guardians knew who their friends were than adolescents in urban areas (data not shown). Female adolescents in rural areas also reported greater parent or guardian awareness of what they

did with their free time than those who lived in urban areas (69% vs. 58%, respectively). On the other hand, teachers were more likely to almost always keep their eyes on urban male adolescents to make sure they were not getting into trouble than their counterparts in rural areas (66% compared with 53%, respectively).

Friends often play an important role in adolescents’ lives in terms of the decisions they make and the risks they take. Another important aspect of friendship networks is whether friends are the same sex or include both males and females. Table 3.10 provides information on the number of adolescents’ close friends by the sex of the friends.

In Uganda in 2004, female adolescents had between three and four close same-sex friends, on average, while male adolescents had an average of six close same-sex friends. Females indicated they had one close male friend, on average, while males reported having an average of two close female friends.

Table 3.11 shows the percentage of adolescents reporting different types of people who had talked to them about sex-related matters. The degree to which parents, other family members, friends and teachers are involved helps us better understand who, if anyone, is approaching adolescents about these sensitive topics. In 2004, about 46% of female respondents and only 28% of male adolescents reported that a family member had talked to them about sex-related matters. More male than female adolescents had had nonfamily members talk to them about sex-related matters (51% compared with 43%, respectively). Evidence from this study shows that for female youth, their mother (31%), their aunt (19%), female friends (22%) as well as their teachers (22%) were the people who talked to them about sex-related matters. For males, their male friends (34%) and teachers (18%) were major sources of sex-related information.

Chart 3.5 highlights the degree to which mothers and fathers had spoken to their adolescent children about sex-related matters, regardless of the content of what was said. Most adolescents in Uganda simply had never been talked to by either of their parents about sex (67% of females and 81% of males). This was particularly true among younger adolescents.

Alcohol and Drug Use

The use of alcohol reduces inhibitions and can make people more willing to take risks, such as having sexual intercourse without using a condom or other contraceptive method. Table 3.12 shows the percentage of adolescents who had ever tried alcohol and, for those

who had tried alcohol, the age when they first tried it and whether they had gotten “drunk” in the 12 months prior to the survey. In Chapter 4, the level of condom use among adolescents is examined by whether alcohol was consumed at the last sexual intercourse. There is the possibility that alcohol or drug use might be underreported, given the sensitivity of questions about socially inappropriate substance use.

Twenty-eight percent of females and 38% of the male adolescents surveyed report having ever tried alcohol. Of these, one-third of females and males tried alcohol at age 11 or younger. Another third had their first alcoholic drink between the ages of 12 and 14 years. Among those who had ever tried alcohol, about one in three females and four in 10 males reported having gotten drunk within the 12 months prior to the survey.

Physical Abuse and Current Worries

Other studies have also shown that negative experiences in childhood, such as being physically abused by someone, can make risky behaviors more likely later in life. This national survey asked adolescents whether several such negative experiences happened to respondents before age 10. Adolescents were asked whether their household suffered because someone drank too much alcohol. One-third of female adolescents and one-fourth of male adolescents said their household suffered due to someone drinking too much alcohol (data not shown). Because of the special sensitivity of the experience, the question about physical abuse was asked only of one randomly-selected adolescent per household, so as to ensure the confidentiality of the information. This subgroup of adolescents was asked whether a parent or other adult living in their home ever hit them hard enough to leave marks or cause injury before they had reached age 10. About 16% of females and 23% of males asked this question said that someone in their household had hit them hard enough to leave a mark or cause injury. While 43% of males and females reported that such behavior did not occur very often, one in five females and one in six males indicated that it did.

Table 3.13 shows the level of worry that young people had about a number of important situations and needs facing adolescents. Understanding the major concerns of young people suggests other pathways through which programs and policies might channel prevention efforts. For example, if young people at risk of HIV are most concerned with getting money, HIV interventions might have a heightened impact if tied to livelihoods programs.

About half of those surveyed reported that they were somewhat or very worried about their health in general. A fairly substantial proportion of adolescents were also worried about getting enough to eat (43% of females and 42% of males) and getting money (60% of females and 64% of males reported being somewhat or very worried about this). Young women in Uganda reported being particularly worried about getting pregnant (53% of the females surveyed were very worried about this). Worrying about pregnancy is not exclusive to females: About one-third of males were very worried about getting a female pregnant and another one-fifth were somewhat worried about it.

Compared with other issues indicated above that may cause adolescents to worry, more adolescents in Uganda reported being very worried about getting HIV (69% of females and 52% of males). The issues asked about were preselected based on existing literature and read out to respondents (i.e., adolescents did not name what their major concerns were). Response categories were also read out to respondent. These questions were asked of adolescents toward the end of the interview, so high levels of worry about HIV could be partly attributable to the extensive questions asked about HIV earlier in the interview. Nevertheless, a sizable proportion, particularly among males, reported that they were not worried about getting virus (23% females and 35% of males).

Key Points for Programs and Policies

- Childbearing is common among young women between the ages of 15 and 19 years old in Uganda. Even among women within this age-group who are not in union, one in nine report having had a child. Consequently, integrating HIV prevention programs into maternal health services should continue because it serves a large portion of the population. However, with the majority of young people not in union and not yet having begun childbearing, messages addressing HIV prevention that target youth need to keep this profile in mind if they want to be most effective in the fight against HIV.
- Nearly half of female 15–19-year-olds and 7% of 12–14-year-olds in Uganda are not currently enrolled in school. Also, large gaps between the sexes exist when it comes to education expectations for future educational attainment. While 44% of males expect to go to secondary school, only 34% of females have such desires, and the gap widens as adolescents get older. With this in mind, sexual and reproductive health programs need

to target not only adolescents in school but should also address the needs of those young people who stop attending, particularly young women. More importantly, a greater effort should be made in bridging the gap between the sexes when it comes to education.

- The demand for education far outstrips the supply and the ability to afford education. School fees are a major barrier for many adolescents in advancing their education—the main reason cited by more than half of those who stopped attending school. To ensure access for all young people, programs on HIV education and prevention targeted to youth should be free and accessible to youth in school and out of school. National policymakers should be aware and consider the implications of young people dropping out of school because of their (or their family's) financial circumstances. Because many adolescents stop attending school for financial reasons, provisions for universal secondary education should be supported without compromising the investment in, and quality of universal primary education. It is currently one of the issues in President Museveni's Manifesto, and the Ministries of Education and Finance Planning and Economic Development, as well as other stakeholders, are trying to determine its feasibility and how it can be implemented.
- Because most young people do not engage in paid economic activities, the cost of contraceptive methods and VCT should be affordable to youth. Such costs place a bigger burden on female youth than on males because they are less likely to get paid for their labor and are also less likely to have control over how they spend their money.
- Nearly all young people identify with a religion and, for most, religion is very important, with the majority attending religious services at least once a week. Therefore, it is important to educate religious leaders on the reproductive and sexual behavior patterns of youth and involve them in developing effective strategies and programs for preventing HIV and unintended pregnancy among youth in Uganda.
- Promoting sexual and reproductive health education among popular social groups and clubs, such as drama or choir groups among females and football clubs among males, is another venue to reach some young people.
- Programs that encourage parents to engage in their children's lives may be beneficial to the sexual and reproductive health outcomes of their children. More than half of male adolescents and one third of female adolescents said that their parents/guardians do not always know who their friends are. An individual's friends greatly influence the behavior of that individual. It is critical that parents get involved in their children's lives and know with whom their children are associating.
- For female youth, mothers, aunts, female friends and teachers are the people who are most likely to talk to them about sex-related issues. For males, the picture is somewhat different: Male friends and teachers are the major sources of sex-related information. It is important that those who develop policies and programs addressing the sexual and reproductive health needs of young people gain an understanding of who talks to adolescents about sex. The ability of youth in Uganda to speak openly to family and friends about HIV is unique and such sources provide a major untapped avenue for behavior change.
- By age 14, one in four females and nearly one in three males in Uganda have tried alcohol. Because alcohol can compromise the judgment of an individual when it comes to having sex and using protection, understanding the context and reasons adolescents use alcohol should be a priority. Such information can inform public health policy that aims to reduce alcohol use among young people and will have positive effects on adolescents having safer sex.
- While adolescents in Uganda are mainly very worried about becoming infected with HIV, young women, in particular, are also very concerned about getting pregnant. Given this, there may be a number of benefits to combining HIV interventions with family planning services and counseling.

TABLE 3.1 Percentage distribution of adolescents, by basic sociodemographic characteristics, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1281)	15–19 (N=1311)	Total (N=2592)	12–14 (N=1202)	15–19 (N=1301)	Total (N=2503)
Current union status						
Not in union	100.0	81.2	90.5	100.0	98.4	99.2
In union	0.0	18.8	9.5	0.0	1.6	0.8
Residence						
Urban	9.0	14.5	11.8	8.1	11.1	9.6
Rural	91.0	85.5	88.2	91.9	88.9	90.4
Region						
Central	31.3	31.9	31.6	29.9	29.4	29.7
East	24.5	22.3	23.4	25.9	21.9	23.8
North	16.6	15.8	16.2	17.7	16.3	17.0
West	27.6	30.0	28.8	26.5	32.4	29.5
Ethnic Group						
Muganda	22.1	21.3	21.7	21.3	16.7	18.9
Munyankore	10.2	12.5	11.3	10.3	12.5	11.5
Mukiga	6.0	6.6	6.3	4.5	5.8	5.1
Musoga	6.7	6.8	6.7	8.4	5.7	7.0
Munyoro	4.3	4.7	4.5	3.5	3.4	3.4
Mutoro	3.3	3.1	3.2	3.5	4.9	4.2
Mugishu	4.0	3.6	3.8	3.1	5.1	4.2
Acholi	0.5	0.6	0.5	0.7	1.2	1.0
Langi	6.6	5.9	6.3	8.0	6.2	7.1
Itesot	6.6	4.9	5.7	6.8	5.1	5.9
Other westerner	5.2	5.9	5.6	5.6	7.0	6.3
Other easterner	9.5	8.9	9.2	9.3	8.7	9.0
Other northerner	12.5	12.2	12.4	11.4	13.0	12.2
Other Ugandans	0.7	1.2	1.0	1.5	1.7	1.6
Non-Ugandans	1.8	1.7	1.8	2.1	3.0	2.5
Household wealth quintile						
Lowest	22.4	17.0	19.7	23.3	18.1	20.6
Second	20.9	18.1	19.5	20.8	21.6	21.3
Third	18.3	18.5	18.4	19.5	20.9	20.2
Fourth	19.9	21.5	20.7	20.4	19.5	19.9
Highest	18.4	24.9	21.7	15.9	19.9	18.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 3.2 Percentage distribution of adolescents, by union status, childbearing status and living arrangements, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1281)	15–19 (N=1311)	Total (N=2592)	12–14 (N=1202)	15–19 (N=1301)	Total (N=2503)
Union and childbearing status						
In union, ever had child	0.0	13.0	6.6	0.0	0.6	0.3
In union, never had a child	0.0	5.7	2.9	0.0	1.0	0.5
Not in union, ever had child	0.0	8.5	4.3	0.0	0.5	0.3
Not in union, never had a child	100.0	72.7	86.2	100.0	97.8	98.9
Lives with spouse/partner*						
No	--	6.9	6.9	--	--	--
Yes	--	93.1	93.1	--	--	--
Coresidence with biological parents						
Lives with both biological parents	46.9	32.8	39.8	47.4	40.6	43.9
Mother only	15.9	14.3	15.1	18.0	17.8	17.9
Father only	7.6	7.3	7.5	10.4	9.9	10.1
Neither biological parent, respondent in a union	0.0	17.9	9.0	0.0	0.8	0.4
Neither biological parent, respondent not in union	29.6	27.7	28.6	24.2	30.9	27.7
Relationship to head of household						
Head	0.0	1.2	0.6	0.0	3.3	1.7
Spouse	0.1	13.5	6.9	0.0	0.1	0.0
Son/daughter	68.7	51.3	59.9	73.3	65.4	69.2
Son- or daughter-in-law	0.2	5.2	2.7	0.2	0.8	0.5
Grandchild	12.2	8.9	10.5	13.1	9.5	11.3
Parent-in-law	0.0	0.0	0.0	0.1	0.0	0.0
Brother/sister	2.9	4.8	3.8	2.9	6.4	4.7
Other relative	12.5	10.8	11.6	7.9	9.8	8.9
Adopted	0.3	0.0	0.2	0.0	0.2	0.1
Fostered	0.9	0.2	0.5	0.9	0.6	0.8
Stepchild	1.1	0.9	1.0	1.2	1.4	1.3
Househelp	0.7	2.4	1.5	0.2	1.8	1.0
Not related	0.4	0.8	0.6	0.3	0.8	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who are currently in union. Sample sizes: females 12–14 (N=0); females 15–19 (N=246); males 12–14 (N=0); males 15–19 (N=21). Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 3.3 Percentage distributions of adolescents aged 12–17, by orphanhood characteristics, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1284)	15–17 (N=826)	Total (N=2110)	12–14 (N=1210)	15–17 (N=865)	Total (N=2075)
Orphan status						
Both biological parents alive	72.6	71.3	72.1	72.6	68.7	70.9
Mother died, father alive	5.5	6.2	5.7	5.0	6.2	5.5
Father died, mother alive	14.3	15.7	14.8	15.8	17.6	16.5
Both biological parents died	7.7	6.8	7.3	6.6	7.5	7.0
Respondent's age when mother died*						
≤5	24.3	19.6	22.5	17.7	18.2	17.9
6–8	16.6	18.7	17.4	15.6	8.3	12.2
9–11	27.8	15.9	23.2	27.0	20.7	24.0
12–14	16.0	24.3	19.2	12.1	26.4	18.7
15–17	na	4.7	1.8	na	12.4	5.7
Don't know	15.4	16.8	15.9	27.7	14.0	21.4
Respondent's age when father died†						
≤5	28.4	25.5	27.2	22.2	23.9	23.0
6–8	13.5	17.6	15.1	17.8	11.9	15.2
9–11	23.8	14.4	20.0	18.5	17.4	18.0
12–14	13.1	18.6	15.3	11.1	19.7	15.0
15–17	na	6.4	2.6	na	7.8	3.5
Don't know	21.3	17.6	19.8	30.4	19.3	25.4
Coresidence with parent figures among adolescents with a deceased biological parent‡						
Lives with two parent figures	10.2	3.8	7.6	7.2	5.8	6.6
Mother figure only	7.1	7.6	7.3	5.4	5.8	5.6
Father figure only	4.0	2.9	3.5	1.5	2.2	1.8
Lives with biological mother	32.2	30.7	31.6	34.8	35.0	34.9
Lives with biological father	9.0	10.5	9.6	11.7	12.8	12.2
Lives with no biological parents or parent-figures	37.6	44.5	40.4	39.3	38.3	38.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to adolescents whose mother died. Sample sizes: females 12–14 (N=169); females 15–17 (N=107); males 12–14 (N=141); males 15–17 (N=121). †Limited to adolescents whose father died. Sample sizes: females 12–14 (N=282); females 15–17 (N=188); males 12–14 (N=270); males 15–17 (N=218). ‡Limited to adolescents with a deceased biological parent. Sample sizes: females 12–14 (N=354); females 15–17 (N=238); males 12–14 (N=333); males 15–17 (N=274). *Note:* Ns are weighted.

TABLE 3.4 Percentage distributions of adolescents, by schooling characteristics, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1284)	15–19 (N=1315)	Total (N=2599)	12–14 (N=1209)	15–19 (N=1303)	Total (N=2512)
Ever attended school						
No	2.1	6.4	4.3	1.5	2.9	2.2
Yes	97.9	93.6	95.7	98.5	97.1	97.8
Currently attending school						
No	6.9	49.4	28.4	4.3	32.8	19.1
Yes	93.1	50.6	71.6	95.7	67.2	80.9
Schooling completed (years)						
None	2.6	6.8	4.7	2.2	2.9	2.6
1–3	33.0	10.1	21.4	37.2	10.1	23.1
4–5	46.7	25.9	36.1	44.8	27.7	35.9
6	11.6	19.0	15.4	9.8	18.3	14.2
7	4.2	13.9	9.1	3.9	15.7	10.0
8	1.7	6.9	4.3	1.6	7.5	4.7
9+ years	0.2	17.4	8.9	0.5	17.8	9.5
Highest level of school attended						
None	2.1	6.4	4.3	1.5	2.9	2.2
Primary	93.9	67.0	80.3	94.5	68.5	81.0
Secondary	4.0	26.4	15.3	4.0	28.4	16.7
Higher	0.0	0.2	0.1	0.0	0.2	0.1
Expectations for highest level of schooling						
No expectation of further schooling	4.4	35.2	20.0	1.7	14.7	8.4
Primary	15.6	6.6	11.1	15.4	8.7	11.9
Secondary	41.5	28.5	34.9	48.2	40.8	44.4
Higher	38.4	29.6	34.0	34.7	35.8	35.3
Ever received vocational training						
No	80.9	75.5	78.1	81.6	78.4	80.0
Yes	19.1	24.5	21.9	18.4	21.6	20.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 3.5 Percentage distribution of adolescents who have stopped schooling, by main reason for stopping, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=61)	15–19 (N=561)	Total (N=622)	12–14 (N=34)	15–19 (N=386)	Total (N=420)
Main reason for leaving school						
Could not pay school fees	41.0	54.0	52.7	[50.0]	60.9	60.0
Lack of school materials	9.8	6.1	6.4	[8.8]	6.0	6.2
Completed schooling/had enough	0.0	1.4	1.3	[0.0]	2.6	2.4
Pregnant/made someone pregnant	1.6	10.3	9.5	na	na	na
Got married	0.0	1.8	1.6	[0.0]	0.5	0.5
Illness	18.0	4.6	5.9	[14.7]	7.0	7.6
Work at home	8.2	6.2	6.4	[5.9]	7.0	6.9
Not interested	1.6	4.8	4.5	[8.8]	4.1	4.5
Not a good student	1.6	5.3	5.0	[5.9]	3.9	4.0
Got a job	0.0	0.0	0.0	[0.0]	0.3	0.2
Vacation/holidays	0.0	1.1	1.0	[0.0]	2.6	2.4
Other reason	18.0	3.9	5.3	[5.9]	5.2	5.2
Don't know	0.0	0.4	0.3	[0.0]	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted. [] = N is 25–49.

TABLE 3.6 Percentage distribution of adolescents who ever attended school, by schooling characteristics, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1257)	15–19 (N=1233)	Total (N=2490)	12–14 (N=1192)	15–19 (N=1262)	Total (N=2454)
Age first attended school						
≤6	48.5	40.4	44.5	39.3	30.3	34.7
7	17.8	18.0	17.9	22.8	21.8	22.3
8	12.0	11.9	12.0	11.4	13.2	12.3
≥9	14.9	22.2	18.5	13.7	23.6	18.8
Don't know	6.8	7.5	7.1	12.8	11.0	11.9
Repeated last grade*						
No	90.3	93.4	91.4	88.8	90.3	89.4
Yes	9.7	6.6	8.6	11.2	9.7	10.6
Current or last school was coed						
No	0.6	3.6	2.1	0.4	1.3	0.9
Yes	99.4	96.4	97.9	99.6	98.7	99.1
Current or last school type						
Government-aided, not religious	31.0	27.0	29.0	26.2	24.5	25.3
Government-aided, religious	58.3	52.3	55.3	61.7	54.7	58.1
Private, not religious	4.4	8.4	6.4	4.5	8.4	6.5
Private, religious	6.3	12.3	9.2	7.6	12.3	10.0
Living arrangement at current or last school						
Day student	98.4	91.8	95.1	97.5	93.1	95.2
Boarder	1.6	8.2	4.9	2.5	6.9	4.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those currently attending school. Samples size: females 12–14 (N=1196); females 15–19 (N=664); males 12–14 (N=1158); males 15–19 (N=876). Note: Ns are weighted.

TABLE 3.7 Percentage distribution of adolescents, by time use and work characteristics, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1283)	15–19 (N=1314)	Total (N=2597)	12–14 (N=1210)	15–19 (N=1303)	Total (N=2513)
Usual daily activities (outside of school)*						
Studying	42.1	28.1	35.0	40.0	33.5	36.6
Household chores	94.2	92.9	93.6	85.4	71.1	78.0
Work on family business/farm	30.0	37.4	33.7	51.7	57.3	54.6
Work to get money	3.4	10.8	7.1	6.2	26.5	16.7
Playing with friends	41.0	22.6	31.7	41.1	31.2	36.0
Idling	14.9	19.9	17.4	10.8	10.3	10.5
Other	0.3	0.9	0.6	2.1	4.3	3.3
Work and school status						
In school, working	30.4	17.3	23.8	51.0	41.0	45.8
In school, not working	62.7	33.2	47.8	44.7	26.2	35.2
Not in school, working	2.2	26.8	14.6	2.7	26.8	15.2
Not in school, not working	4.7	22.7	13.8	1.5	6.0	3.8
Place of work†						
Home	92.4	83.3	87.0	81.2	63.9	71.2
Away from home	7.6	16.7	13.0	18.8	36.1	28.8
Remuneration‡						
Cash only	8.9	24.5	18.2	9.9	33.8	23.7
Cash and kind	4.1	6.1	5.3	3.9	9.2	7.0
In kind only	4.1	4.4	4.3	9.3	9.8	9.6
Not paid	83.0	65.0	72.3	76.9	47.3	59.8
Did anything for money in past 12 months						
No	74.9	60.5	67.6	56.9	37.9	47.1
Yes	25.1	39.5	32.4	43.1	62.1	52.9
Who decides how money will be spent‡						
Respondent	21.8	40.6	33.4	34.1	60.2	50.0
Spouse/partner	0.3	8.1	5.1	0.6	0.7	0.7
Respondent and spouse/partner jointly	1.9	5.0	3.8	0.8	1.7	1.4
Parents/guardians	75.7	44.2	56.2	62.6	34.8	45.7
Sibling	0.3	1.3	1.0	1.5	1.9	1.7
Someone else	0.0	0.8	0.5	0.4	0.6	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. †Limited to those who are working or helping with family business/farm. Sample sizes: females 12–14 (N=394); females 15–19 (N=570); males 12–14 (N=643); males 15–19 (N=881). ‡Includes those who work for money or reported doing something for money in past 12 months. Sample sizes: females 12–14 (N=321); females 15–19 (N=520); males 12–14 (N=519); males 15–19 (N=807). Note: Ns are weighted.

TABLE 3.8 Percentage distributions of adolescents, by religious and social group participation, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1282)	15–19 (N=1314)	Total (N=2596)	12–14 (N=1209)	15–19 (N=1303)	Total (N=2512)
Religion						
Catholic	43.1	42.0	42.5	43.4	43.2	43.3
Protestant	35.2	33.2	34.2	32.0	34.5	33.3
Pentecostal/Charismatic	8.0	9.5	8.7	6.3	5.3	5.8
Other Christian	2.3	2.1	2.2	2.7	1.8	2.3
Muslim	10.9	12.4	11.7	13.8	12.9	13.3
Traditional Religion	0.1	0.0	0.0	0.0	0.2	0.1
No religion	0.5	0.2	0.3	0.6	1.3	1.0
Other	0.1	0.6	0.3	1.2	0.8	1.0
Importance of religion*						
Very important	85.7	86.7	86.2	85.9	89.4	87.7
Somewhat important	13.9	12.3	13.1	12.6	9.7	11.1
Not important	0.4	1.1	0.7	1.6	0.9	1.2
Frequency of religious service attendance*						
More than once a week	15.9	17.0	16.4	16.9	21.9	19.5
Once a week	76.7	74.4	75.5	72.2	66.7	69.4
At least once a month	6.5	6.8	6.6	9.6	9.2	9.4
Less than once a month	0.5	0.9	0.7	0.7	1.2	1.0
Not at all	0.4	0.9	0.7	0.5	1.0	0.8
Belongs to any social group or club						
No	79.7	78.4	79.0	85.9	81.8	83.8
Yes	20.3	21.6	21.0	14.1	18.2	16.2
Holds an office or leadership position in club†						
No	82.6	70.5	76.3	82.4	67.9	74.0
Yes	17.4	29.5	23.7	17.6	32.1	26.0
Type of social club or group†						
Church/Muslim youth	22.3	27.7	25.1	8.8	12.2	10.8
Football/netball	19.6	23.3	21.5	55.0	49.8	52.0
Drama/choir	51.5	32.6	41.7	12.4	18.6	16.0
Anti-AIDS	3.5	6.7	5.2	1.8	5.1	3.7
Red Cross	1.5	1.4	1.5	1.2	1.3	1.2
Girl/Boy Guide	2.7	2.1	2.4	11.8	5.5	8.1
Wildlife Society	0.8	1.4	1.1	1.8	2.1	2.0
Youth Brigade	3.1	5.3	4.2	1.2	3.0	2.2
Other	13.5	22.3	18.0	15.3	18.1	17.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who have a religious affiliation. Sample sizes: females 12–14 (N=1277); females 15–19 (N=1312); males 12–14 (N=1203); males 15–19 (N=1287). †Limited to those in social groups or clubs. Sample sizes: females 12–14 (N=259); females 15–19 (N=281); males 12–14 (N=170); males 15–19 (N=234). Note: Ns are weighted.

TABLE 3.9 Percentage distribution of adolescents, by parent and teacher monitoring, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1282)	15–19 (N=1313)	Total (N=2595)	12–14 (N=1206)	15–19 (N=1301)	Total (N=2507)
Parents/guardians know where respondent goes out at night*						
Do not know	7.5	13.6	10.6	13.3	24.8	19.3
Sometimes know	9.8	18.0	13.9	16.2	30.2	23.5
Always know	82.7	68.4	75.5	70.6	45.0	57.3
Parents/guardians know what respondent does with free time*						
Do not know	8.2	13.4	10.8	14.0	19.3	16.7
Sometimes know	18.4	25.2	21.8	25.2	38.0	31.8
Always know	73.4	61.4	67.3	60.8	42.7	51.4
Parents/guardians know who respondent's friends are*						
Do not know	12.3	17.5	15.0	14.2	18.1	16.2
Sometimes know	17.6	24.1	20.9	37.5	41.8	39.7
Always know	70.0	58.4	64.1	48.3	40.0	44.0
Teachers keep eye on students to make sure they are not getting into trouble†						
Almost always	47.9	46.6	47.3	55.0	53.0	53.9
Sometimes	39.5	39.8	39.7	34.9	36.0	35.5
Almost never	11.1	12.3	11.7	9.1	10.2	9.7
Don't know	1.4	1.3	1.4	1.0	0.8	0.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

*For married adolescents, the question refers to parental knowledge before respondent got married. †Limited to those who ever attended school. Sample sizes: females 12–14 (N=1257); females 15–19 (N=1229); males 12–14 (N=1188); males 15–19 (N=1261). *Note:* Ns are weighted.

TABLE 3.10 Percentage distribution of adolescents, by characteristics of friendship networks, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=1282)	15-19 (N=1310)	Total (N=2592)	12-14 (N=1204)	15-19 (N=1302)	Total (N=2506)
Number of close female friends						
0	1.6	3.8	2.7	51.3	27.2	38.8
1	11.7	13.1	12.4	10.4	17.0	13.8
2	28.1	23.5	25.8	16.0	18.4	17.2
3	21.1	22.4	21.8	8.4	11.8	10.2
4	14.6	12.3	13.4	4.6	8.0	6.3
5+	22.5	24.4	23.5	8.6	17.1	13.0
Don't know	0.3	0.5	0.4	0.7	0.5	0.6
Average number of close female friends	3.5	3.7	3.6	1.5	2.7	2.2
Number of close male friends						
0	65.7	38.8	52.1	0.9	1.0	1.0
1	11.1	20.6	15.9	7.9	5.5	6.7
2	10.0	16.6	13.3	19.3	13.3	16.2
3	5.9	9.0	7.5	18.6	14.2	16.3
4	3.4	5.1	4.2	12.4	11.2	11.8
5+	3.9	9.9	7.0	40.3	54.2	47.5
Don't know	0.0	0.0	0.0	0.6	0.5	0.6
Average number of close male friends	0.9	1.8	1.3	4.9	6.4	5.7
Sex composition of friendship networks						
No close friends	1.9	3.7	2.8	2.2	1.9	2.0
Only male	0.2	1.0	0.6	50.1	26.1	37.7
Only female	63.9	35.4	49.5	0.2	0.2	0.2
Both male and female	33.9	59.9	47.1	47.5	71.8	60.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 3.11 Percentage of adolescents, by types of people who talked about sex-related matters with adolescents, according to sex and age, 2004 National Survey of Adolescents*

Characteristic	Female			Male		
	12–14 (N=1282)	15–19 (N=1314)	Total (N=2596)	12–14 (N=1206)	15–19 (N=1300)	Total (N=2506)
Persons who have ever talked to respondent about sex-related matters						
Any family member	39.2	52.0	45.6	25.2	30.6	28.0
Any nonfamily member	33.8	51.8	42.9	40.6	59.8	50.6
Spouse/cohabiting partner	0.5	3.7	2.2	0.1	0.4	0.2
Mother	28.1	34.6	31.4	12.8	13.8	13.3
Father	6.3	8.3	7.3	13.3	13.8	13.6
Brother	2.0	3.9	3.0	6.4	12.5	9.5
Sister	10.5	15.4	12.9	1.8	2.7	2.3
Aunt	15.4	21.5	18.5	1.5	2.8	2.2
Uncle	1.2	1.6	1.4	2.7	5.5	4.2
Cousin	1.3	1.7	1.5	0.8	0.9	0.9
Grandmother	8.0	8.8	8.4	1.7	1.2	1.4
Grandfather	0.5	0.8	0.7	1.7	1.0	1.3
Other family member	0.2	1.0	0.6	0.1	0.5	0.3
Girlfriend	1.6	5.6	3.6	1.7	6.7	4.3
Boyfriend	0.4	4.6	2.5	5.1	10.5	7.9
Male friend	2.3	5.5	3.9	26.6	40.4	33.7
Female friend	13.7	29.3	21.6	2.7	7.0	4.9
Teacher	20.3	23.5	21.9	14.4	21.0	17.8
Health care provider	2.1	4.6	3.4	1.7	5.1	3.5
Religious/church leader	2.0	3.0	2.5	1.4	1.7	1.6
Other nonfamily member	0.6	1.8	1.2	1.6	1.6	1.6

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 3.12 Percentage distribution of adolescents, by alcohol and drug use, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=1282)	15-19 (N=1314)	Total (N=2596)	12-14 (N=1206)	15-19 (N=1301)	Total (N=2507)
Ever tried alcohol						
No	74.1	69.5	71.8	68.5	56.8	62.4
Yes	25.9	30.5	28.2	31.4	43.2	37.5
Refused to answer	0.0	0.0	0.0	0.1	0.0	0.0
Age when had first alcoholic drink*						
≤11	45.8	23.2	33.4	48.5	21.1	32.2
12-14	38.3	30.2	33.8	32.7	26.8	29.2
15-19	na	36.7	20.1	na	39.5	23.5
Don't know age	4.8	2.2	3.4	12.9	9.1	10.6
Refused to answer	11.1	7.7	9.3	5.8	3.6	4.5
Has gotten "drunk" in last 12 months*						
No	65.0	65.7	65.4	71.0	51.4	59.3
Yes	35.0	34.3	34.6	29.0	48.6	40.7
Ever tried any other type of drug						
No	96.3	97.0	96.7	97.9	96.8	97.3
Yes	3.7	2.7	3.2	1.9	3.2	2.6
Refused to answer	0.0	0.3	0.2	0.2	0.0	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who ever had an alcoholic drink. Sample sizes: females 12-14 (N=332); females 15-19 (N=401); males 12-14 (N=379); males 15-19 (N=560). *Note:* Ns are weighted.

TABLE 3.13 Percentage distribution of adolescents, by levels of worry about different issues, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1282)	15–19 (N=1314)	Total (N=2596)	12–14 (N=1206)	15–19 (N=1302)	Total (N=2508)
Worry about own health						
Very worried	28.7	28.8	28.7	20.5	22.1	21.3
Somewhat worried	20.3	19.8	20.0	23.5	28.6	26.1
Not worried	50.4	51.2	50.8	54.2	48.4	51.2
Don't know	0.6	0.2	0.4	1.8	0.9	1.4
Worry about getting enough to eat						
Very worried	21.8	20.0	20.9	12.7	15.6	14.2
Somewhat worried	23.8	20.6	22.2	28.0	28.1	28.1
Not worried	53.9	59.2	56.6	58.2	55.9	57.0
Don't know	0.5	0.2	0.3	1.1	0.4	0.7
Worry about getting money						
Very worried	30.9	38.2	34.6	28.3	39.7	34.2
Somewhat worried	26.3	25.1	25.7	29.4	29.1	29.3
Not worried	42.6	36.4	39.5	41.5	30.4	35.8
Don't know	0.2	0.2	0.2	0.8	0.8	0.8
Worry about getting (someone) pregnant						
Very worried	51.4	54.1	52.8	31.4	38.6	35.2
Somewhat worried	14.4	13.1	13.7	12.6	18.4	15.6
Not worried	33.2	32.4	32.8	53.6	42.0	47.6
Don't know	1.1	0.4	0.7	2.3	0.9	1.6
Worry about getting HIV/AIDS						
Very worried	65.4	72.1	68.8	47.3	55.4	51.5
Somewhat worried	6.9	7.7	7.3	9.8	13.6	11.8
Not worried	26.9	20.0	23.4	40.8	30.4	35.4
Don't know	0.9	0.2	0.5	2.1	0.6	1.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

Chart 3.1 Frequency of contact with biological mother among adolescents with a living biological mother, 2004 National Survey of Adolescents

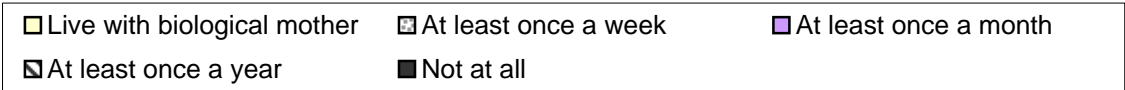
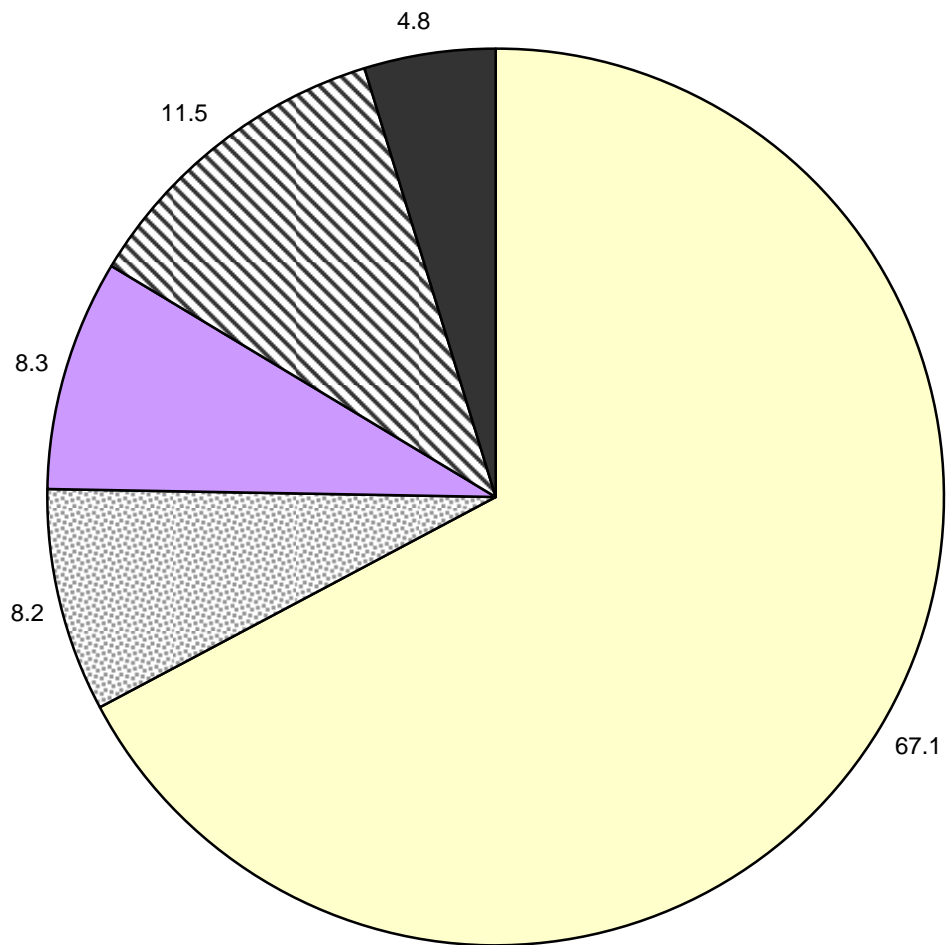


Chart 3.2 Frequency of contact with biological father among adolescents with a living biological father, 2004 National Survey of Adolescents

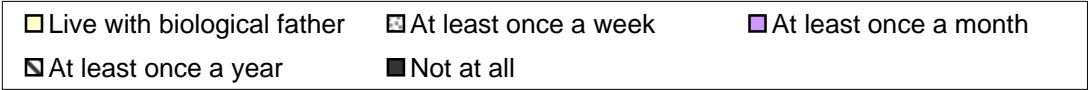
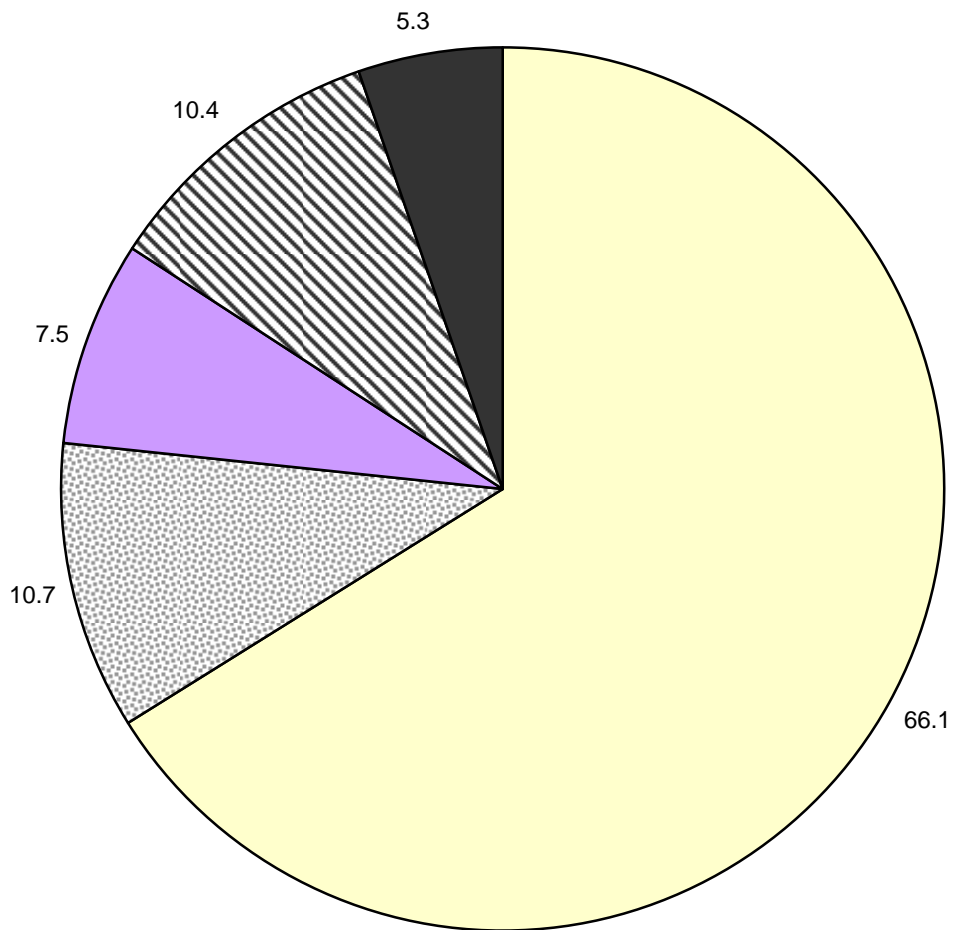


Chart 3.3 Percentage of adolescents attending school among those who ever attended school, according to current age and sex, 2004 National Survey of Adolescents

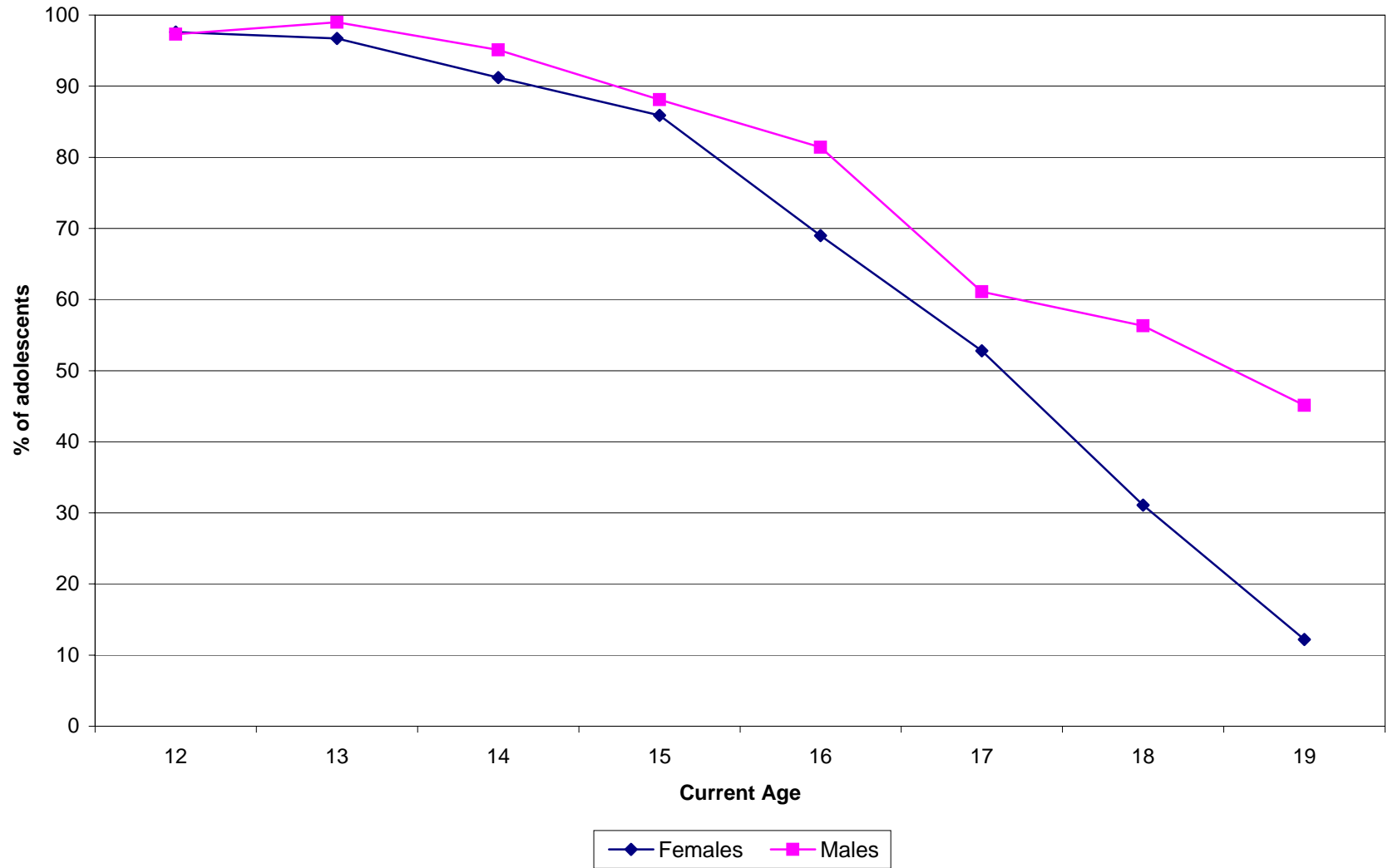


Chart 3.4 Work and school status of adolescents, according to sex, 2004 National Survey of Adolescents

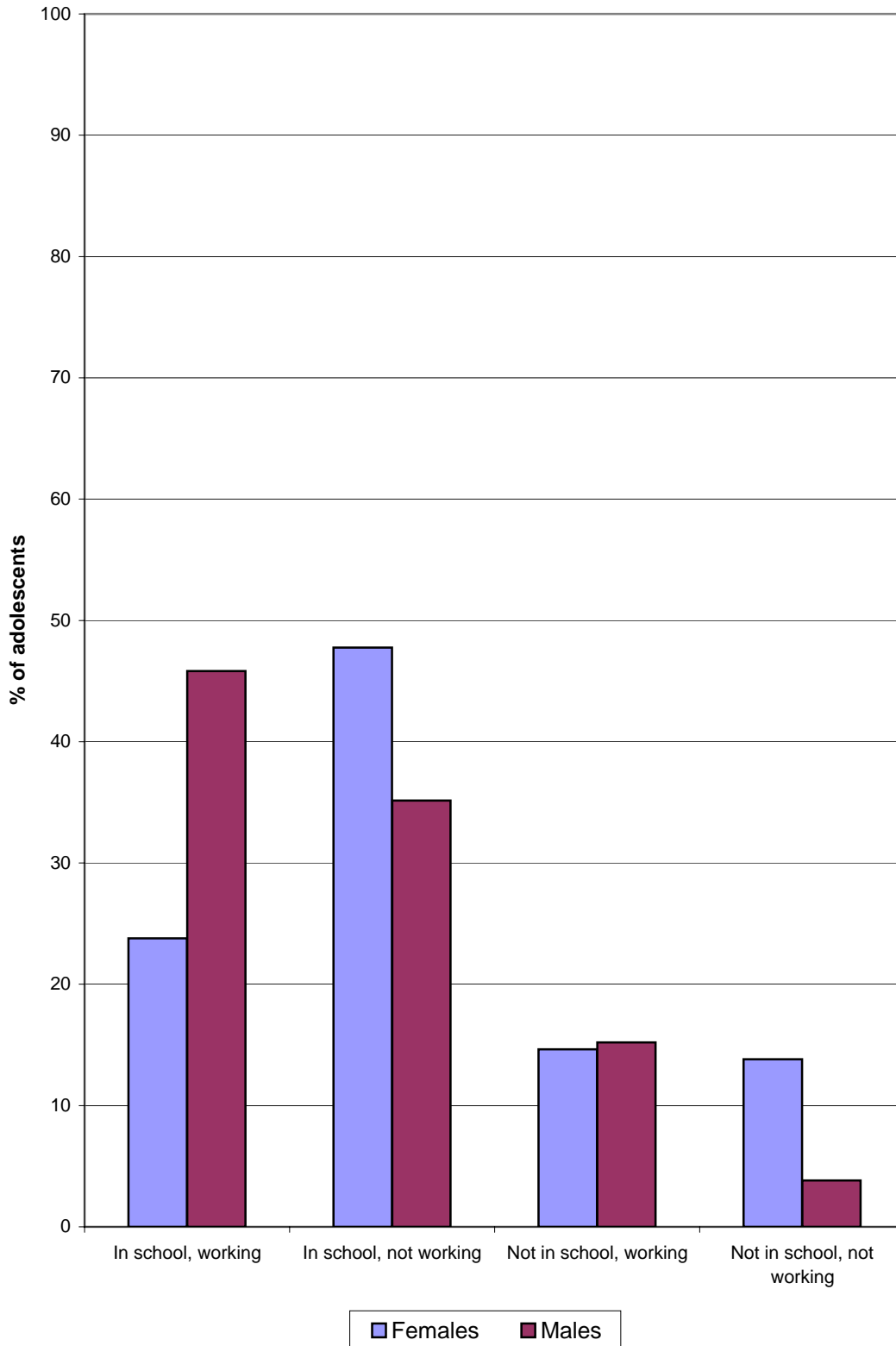
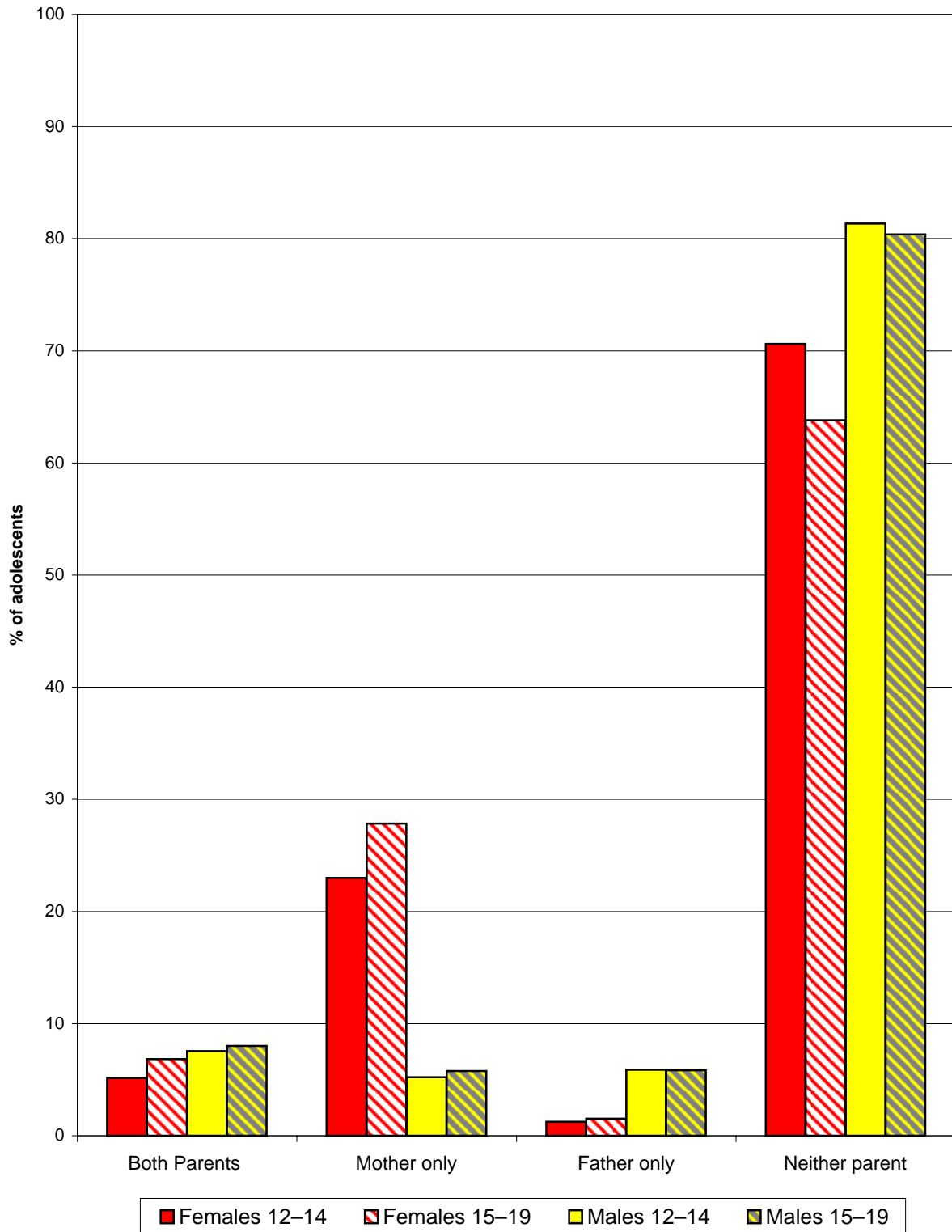


Chart 3.5 Communication with parents about sex-related matters among adolescents, according to sex and age, 2004 National Survey of Adolescents



Chapter 4

Sexual Activity and Relationships

This chapter presents information about adolescents' sexual maturation, sexual activity and intimate relationships. Adolescents' experience and timing of the first major sign of puberty (for girls this is menstruation and for boys this is growing pubic hair, deepening of the voice or having a "wet dream"), initiation rites and circumcision are described. Evidence is then presented on adolescents' awareness and experience of a range of the sexual activities and relationships, including the timing of first sexual intercourse, characteristics of the first and most recent sex partners, and number of sex partners. Survey data also provide nationally representative estimates of sex in exchange for money or other goods and experiences of sexual abuse and coercive sexual intercourse among female and male adolescents.

Puberty and Initiation Rites

Table 4.1 shows the experience and timing of key developmental events, such as first menstruation for girls and first signs of puberty for boys. The question wording for boys was "As boys grow into men, certain changes happen to their bodies, such as growing pubic hair, voices get deeper, or sometimes they have 'wet dreams.' At what age did you first notice any of these changes happening in your body, or have none happened yet?"

Median age at first pubertal change is calculated using a life table method, a superior method to calculating the median, since it includes years of exposure to the event (puberty) from those who have not yet experienced the event (puberty).²⁸

Of those surveyed, approximately 60% of the respondents indicated that they had experienced puberty. The median age of experiencing first puberty changes for both boys and girls in Uganda was 15.

About 80% of male youth in the country had not been circumcised. Among those who had, half had the procedure before or at the age of one and about one-fifth reported having been circumcised between the

ages of six and 11. Experience of circumcision was not asked among females because it is not widespread in the country.

Although the majority of adolescents in Uganda have not experienced an initiation rite, such rituals do occur, particularly among older females. About one in five females between ages 15 and 19 had experienced an initiation rite. Initiation rites for females differ across ethnicity; however, one of the more common rites is "visiting the bush," mainly practiced among the Bantus of Central and Western Uganda. In this rite, young girls before menstruation go in the bush with their peers and pull their labia. Paternal aunts are expected to teach these girls how to do it. Female genital cutting is also practiced among the Sebei within the Kapchorwa district. Whereas females are more likely to experience such an event around the age of 12, males tend to have their initiation rite at age 10 or younger.

Sexual Activity and Awareness

Becoming sexually active and entering a union mark important transitions in the lives of adolescents. These transitions affect their exposure to the risk of pregnancy and STIs, including HIV, as well as their immediate need for information and services to protect their sexual health. Entering a consensual union has especially broad effects on the lives of young women, as it shapes the extent to which they can independently make decisions, including those involving childbearing and planning pregnancies. Questions were asked to adolescents who had not initiated sexual activity nor entered a union regarding whether they had ever had a boyfriend or girlfriend, as this is an indicator of the proportion who are likely to soon become sexually active.

To increase our understanding of the level of sexual development and awareness of young adolescents who are mostly sexually inexperienced, a separate battery of questions were asked of 12–14-year-olds (almost all of whom were not in union) about whether they had ever heard of specific behaviors (kissing,

fondling and sexual intercourse), whether they knew of any close friends who had engaged in these behaviors and whether they had ever engaged in the behaviors. If the respondent had never heard of the sexual activity, she or he was not asked the two follow-up questions about experiences of that sexual activity. The question wording for awareness of each sexual activity was as follows:

- “Now I am going to ask you some questions about what young people might do together. Have you ever heard of kissing?”
- “Have you ever heard of fondling? By this I mean someone’s private parts, breasts or other parts of the body being touched in a sexual way.”
- “Have you ever heard of sexual intercourse? By this I mean a penis in a vagina.”

Ever had intercourse

Overall, approximately 30% of young people between the ages of 12 and 19 had had sexual intercourse (Table 4.2). Among younger adolescents, males were twice as likely to be sexually experienced as females, with 15% of males 12–14 having had sex compared with 8% of their female counterparts. Among older adolescents, both sexes were equally likely to engage in sexual intercourse. In fact, among 15–19 year-olds, nearly half of females and males in the country had had sex.

Ever in union

About one in 10 females aged 12–19 in Uganda had entered a union. As expected, few young men (2% of those surveyed) were in this situation. However, it is not uncommon for adolescents, particularly males, to have had sex and not be in union. Whereas one in six females had never been in union and had had sexual intercourse, the proportion of males who had not been in union but had had sex was three in ten. Among older adolescents (aged 15–19), this proportion was higher, with 26% of females and 45% of males having had sex while never having been in union.

While the majority of adolescents had never been in union and had never had sex, some were in a situation where sexual activity was likely to occur soon. For instance, 8% of female and 12% of male virgins reported having had a boyfriend or girlfriend.

Sexual behavior and awareness among younger adolescents

Although most young adolescents (aged 12–14) who are not in union have not engaged in sexual intercourse,

most have heard of sex (85% of females and 89% of males reported having heard of sexual intercourse). A large percentage of had also heard of other physical behaviors, such as kissing and fondling. Interestingly enough, young adolescents are more likely to have heard of sexual intercourse than these behaviors.

Compared with males aged 12–14, females of the same age-group are more likely to have heard of fondling, have known a close friend who has engaged in the activity and have actually done it themselves. About one-third of young female respondents who knew about fondling reported having engaged in the activity. Kissing was also a more common behavior among young females than young males.

While equal proportions of younger adolescents have heard of sex and have known a friend who has had sex, males were more likely than females to have actually had sex. Many younger adolescents (18% females and 6% of males) who had not had sexual intercourse or a boyfriend or girlfriend had nevertheless engaged in sexual behaviors such as kissing or fondling.

Reasons for never having been sexually active

The reason most often cited by adolescents for not having had sex—reported by 69% of females and 72% of males—was to avoid STIs, including AIDS (Table 4.3). A higher proportion of older than younger adolescents reported this concern. Another common reason, cited by 64% of females who have never had sex and 34% of such males, was the fear of getting pregnant or getting someone pregnant. Reasons provided were spontaneous (i.e., responses were not read out loud).

A large proportion of females (56%) reported having felt pressure, whether a little or a great deal, from others not to have sexual intercourse. Males (47%) also reported having felt pressure to abstain from sex. Two-thirds of females and nearly half of males that felt some pressure identified their mother as someone who pressured them not to have sex. Females also felt pressure from other female family members, their father, teachers and female friends. Males indicated they also felt pressure from their father, male friends and teachers not to have sex.

Recent sexual activity

One in five adolescents reported having had sexual intercourse in the 12 months prior to the survey (Table 4.4). Males aged 12–14 were twice as likely to have had sex in the past year as their female counterparts (8% vs. 4%). A higher proportion of females aged 15–19, including those in union and not, had had sex in

the past three months, compared with their male counterparts. Some young people had had sex but not in the past year—7% of females and 12% of males were in this situation.

No longer sexually active and underlying reasons

The main reasons for not having had sex in the past year among those who had ever had sex were similar to the reasons adolescents gave for never having had sex (Table 4.4). For instance, a large percentage indicated that they wanted to avoid STIs, including AIDS (73% of females and 81% of males). Fear of pregnancy was another common reason, though more so for females (69%) than males (43%). Approximately 26% of females who have had sex but not in the last 12 months and 14% of these males indicated that they stopped having sex because they wanted to wait until marriage to have sex again. Reasons provided were spontaneous (i.e. responses were not read out loud).

Attitudes about sexual activity

The adolescents surveyed held similar attitudes towards sexual activity, regardless of whether or not they had had sex (Table 4.5). About four in five adolescents agreed that young women and men should remain virgins until they marry and this attitude did not differ according to sexual experience.

First Sexual Intercourse

The timing of first intercourse is an important indicator of the onset and duration of exposure to risk for both unplanned pregnancy and STIs. Younger female adolescents have higher biological risks both for complications of pregnancy and delivery and of STI infection. Younger male and female teens are more exposed to the risk of sexual coercion. Age is also very likely to be related to knowledge of risks and means of protection, as well as to the ability to seek and obtain information and services: Older adolescents are likely to be better equipped in all respects.

Timing of first intercourse

Chart 4.1 shows age at first sexual intercourse. Similar to the median age at first puberty in Table 4.1, median age at first sex is also calculated using a life table method, which includes years of exposure to the event (first sex) from those who have not yet experienced their first sexual intercourse. Differences begin to emerge around age 13 when the proportion of the males experiencing first sex increases, reaching almost 30% at age 15, and increasing afterwards to 67% by

age 19. For the females, the proportion experiencing sex increases gradually at younger ages and accelerates at older ages, reaching 71% by age 19.

Relationship with first sexual partner and main reason for first intercourse

Most adolescents in Uganda (75%) had their first sexual experience with a boyfriend or girlfriend (Table 4.6). One in nine female adolescents who had had sex had their first sexual intercourse with their spouse. Eighteen percent of sexually experienced males reported that their first time was with a casual partner. Having a casual partner as a first sex partner was not uncommon among younger males—28% of males aged 12–14 reported that the first time they had sex was with a casual acquaintance. Also, one in nine females aged 12–14 reported having sex for the first time with a casual acquaintance.

The main reason for having sexual intercourse reported by half of sexually experienced females and more than three-quarters of males was because they felt like it. One in 10 females had sex with their first sexual partner because they were married and one in 10 reported they had sex because they expected gifts.

It is not uncommon that the first sexual experience for female youth, particularly younger girls is coercive. One in 10 sexually experienced females 12–14 years of age reported that their first sexual intercourse was forced, and one in 11 indicated that they had had sex because their partner insisted.

Nearly 20% of females aged 12–14 who had had sex, did so for the first time because they expected gifts or money from their partner. Young females were more likely than males to report that they were influenced by friends to have sex for the first time (23% and 13%, respectively).

Characteristics of first sexual experience

Male adolescents were more likely to have had their first sexual experience with someone who was either their age or younger (68%) than were females, who were more likely to have their first sexual experience with someone who is older (85%) (Table 4.7). About 42% of these sexually experienced young women reported their first sex partner was 1–4 years older and 24% reported he was 5–9 years older. Female adolescents aged 15–19 who were in union were more likely than those not in union to experience their first sexual intercourse with someone at least five years older than themselves, while those not in union were more likely to have had their first sexual encounter with someone

who was 1–4 years older. Almost 7% of young girls aged 12–14 who had had sex, had their first sexual encounter with someone who was 10 or more years older, and approximately 12% had their first sexual intercourse with someone who was 5–9 years older.

More than half of female adolescents who had had sex reported they had not been very willing to have sex during their first sexual encounter, with 23% reporting that they had not been willing at all. Among females aged 12–14, more than one-fourth reported that they had not been willing at all.

The majority of young people did not use any method of family planning during their first sexual encounter. Adolescent males were more likely not to have used a method than their female counterparts. Also, older adolescents were more likely to have used family planning compared with younger adolescents. Among those who relied on a method at first sex, the most common method used was the male condom. More than 40% of older female youth who were not in union and about one-third of older males reported having used a condom with their first sex partner.

Sex Partners

The number of sexual partners an individual has over the period of a year is used as an indicator of level of risk of STIs, including HIV. The number of partners over an individual's lifetime is also an indicator, and is relevant for adolescents who have spent relatively few years since becoming sexually active. Table 4.8 presents results on both of these measures. In addition, the type of relationship adolescents have with partners, the age differences between partners, the duration of relationships, the exchange of money or gifts, and the consumption of alcohol at the time of intercourse are all factors that also influence risks of unintended pregnancy and STIs.

In 2004, the majority of young people who had had sex had done so in the past year, with 74% of females and 62% of males reporting at least one sexual partner during this time. Most sexually experienced adolescents had had only one partner in the past year (70% of females and 51% of males) and few had had two or more partners. Young men were more likely to have had two or more partners than young women in the past 12 months (11% and 4%, respectively).

Characteristics of last sexual relationship

Table 4.9 presents information on the characteristics of adolescents' last sex partner in the 12 months prior to being interviewed. For 80% of male adolescents who

had had sex in the last 12 months, the last sexual encounter was with a girlfriend. Among females who had had sex in the past year, 44% indicated their last sexual partner was a boyfriend, 35% reported their spouse and 14% reported a live-in partner. The majority of younger adolescents reported that their last sex partner was their boyfriend or girlfriend (78% females and 71% of males). Nearly one in four males aged 12–14 who had had sex in the last 12 months reported that their last sexual partner was a casual acquaintance. Among sexually active women age 15–19 who were not in union, 9% reported that their last sexual experience was with a casual acquaintance.

Males more commonly reported having been in a short-term relationship with their last sex partner than did females, while females in union and not were more likely than males to have had longer relationships with this partner. Whereas 27% of sexually active young men reported that the duration of their last sexual relationship was less than three months, 43% of young women reported their relationship with this partner was for two years or more.

Although the majority of young people reported that no alcohol was consumed by either themselves or their partner during their last sexual encounter, 10% of young women surveyed reported their partner drank alcohol at their last sexual intercourse. For males, about 8% reported that alcohol was used by one or both partners at their last sexual encounter.

Sex in Exchange for Money or Gifts

Questions about sex with a partner in exchange for money or gifts were asked of respondents for up to three nonmarital sex partners in the last 12 months. The question wording was “Have you received anything from this person, such as money, gifts or something else, so you would have sexual intercourse with (him/her)?” If yes, “What did you receive?”

The reported level of transactional sex was quite high in the surveyed population. Three-fourths of adolescent women not in union received gifts or money in exchange for sex from their last sexual partner (Table 4.9). Receiving gifts or money in exchange for sex was also not an uncommon experience among young men. One-third of adolescent males reported having received gifts or money for sex from their last sexual partner within the past year. These proportions are similar when respondents were asked about transactional sex with *any* partner in the last 12 months (Table 4.10). The reported prevalence of the behavior, particularly among females, seems extremely high. A study on

transactional sex in 12 Sub-Saharan African countries (but not including Uganda) found much lower proportions of women reporting this behavior in all of the countries over the same period of time (past 12 months). For example, 27% of young women aged 15–19 reported exchanging sex for money or other gifts in Zambia. This proportion is much lower in the other countries, ranging from 2% in Niger to 14% in Benin and Kenya.²⁹ It is not known how adolescents in Uganda interpret the question and whether females and males interpret it similarly. One conclusion that one can draw from the findings is that exchange of gifts, particularly from boys to girls, is common among young sexual partners in Uganda. However, any attempt to draw a causal relationship between sex and this practice must be done with caution.

Among females who engaged in transactional sex with a noncohabiting partner, nearly all reported receiving money for sex. More than half received clothes, one-fourth reported receiving jewelry or cosmetics, and one-tenth indicated that they were given food in exchange for sex. Almost half of males who engaged in transactional sex reported receiving money, one-fourth reported receiving food, one-fourth received clothes and one-fifth indicated receiving jewelry in exchange for sex. Although the responses to these questions were spontaneous and the categories were not read out loud, the high proportion of adolescent males reporting to have received jewelry in exchange for sex highlights the possibility that the question may have been interpreted by males as giving gifts and not receiving gifts.

Sexual Abuse and Coercion

Recent evidence has pointed to the relatively widespread occurrence of sexual coercion and its negative sexual and reproductive health consequences.³⁰ In the 2004 survey, questions were asked about how willing adolescents were at their first sexual intercourse and, for one randomly-selected eligible adolescent per household, whether they had ever experienced sexual abuse or sexual coercion. The question wording for sexual abuse was “Sometimes people do things to us we do not want. Has anyone ever touched you in an unwanted sexual way, such as touching, kissing, grabbing or fondling?” The question wording for coercive sex was “Has anyone physically forced, hurt or threatened you into having sexual intercourse?”

Evidence on the willingness of first sex was presented earlier in Tables 4.6 and 4.7, which show that more than half of female adolescents who had sex re-

ported they had not been very willing during their first sexual experience (31% indicated they were somewhat willing and 23% reported they were not willing at all).

Table 4.11 shows that more than one-third of females surveyed reported being touched, kissed, grabbed or fondled in an unwanted sexual way. As young women get older they are more likely to experience such sexual abuse: Nearly half of older adolescent females aged 15–19 reported having been touched in an unwanted sexual way. Sexual abuse is also not uncommon among males in Uganda, particularly older males: Approximately 20% of adolescent males age 15–19 reported having been touched in an unwanted sexual way.

A substantial percentage (17%) of young women in Uganda reported they had experienced some type of sexual coercion. This was more prevalent among older than younger females—one in four females aged 15–19 reported that someone physically forced, hurt or threatened them into having sexual intercourse. Among older males, one in 11 reported having experienced sexual coercion.

The perpetrators of sexual abuse among female youth tended to be individuals that the adolescent did not know well. For instance, one in three young women who experienced sexual coercion indicated that their perpetrator was a stranger and nearly one-fourth reported that the person was an acquaintance. Other common perpetrators of sexual abuse reported by females included boyfriends (22%) and schoolmates (18%). Whereas younger females were more likely than older females to have been sexually coerced by a family member other than their parents, older females were more likely than younger females to have been forced into sex by their boyfriends. For adolescent males, the perpetrators of sexual coercion were likely to have been a schoolmate, friend, girlfriend or stranger, in that order.

Other Sexual Practices

While sexual intercourse remains one of the most important experiences to understand, given its direct link to unwanted pregnancy and STI transmission, several other sexual behaviors are linked to STI transmission as well. Some have argued (based on anecdotal evidence) that young women use anal sex as a substitute for vaginal sexual intercourse in order to avoid the risk of pregnancy and/or to preserve their virginity. Survey questions about anal sex were especially sensitive and were asked only of one, randomly-chosen eligible adolescent per household and if no one over three years of

age was within listening distance. Three questions were asked about anal sex: whether respondents had ever heard of anal sex, whether they knew of any close friends who had experienced anal sex, and then whether they had ever experienced anal sex. If the respondent had never heard of anal sex, she or he was not asked the two follow-up questions. The question wording for awareness of anal sex was “Young people sometimes have sex in different ways. Have you ever heard of anal intercourse? By this I mean where a man puts his penis in his partner’s anus.”

More than half of young men and more than one-third of young women in Uganda had heard of anal sex. Although young women were less likely to have heard of anal intercourse compared with young men, among those who had, females were more likely than males to have known a friend who had engaged in this type of sexual behavior (23% vs. 10%, respectively) (data not shown). Few adolescents report having engaged in anal intercourse, however: Only about 2% of adolescents who had heard of anal sex reported having experienced it.

Key Points for Programs and Policies

- Although most 12–14-year-olds are not sexually active, many have engaged in sexual behaviors such as kissing and fondling. This group of young people will soon be sexually active. Consequently, targeting such youth with safer sex messages should be a high priority. In addition, study findings show that the rate of exposure to sex for females increases after the age of 14, reconfirming that sex education needs to be targeted to a young audience. Moreover, the observed age difference between adolescent females and their sexual partners is likely to influence their risk to HIV infection.
- The first sexual experience for many girls is at least somewhat coercive, with over half who have had sex not reporting that they were very willing to have sex during their first sexual encounter. Study findings also show sexual coercion is not so uncommon among males. For females, the perpetrators of coercive sex are strangers, acquaintances, boyfriends and schoolmates. For males the perpetrators are mainly schoolmates, friends and girlfriends. Such findings emphasize the need for educating adolescents about respecting each other’s bodies, boundaries and rights. Gender sensitivity training should be incorporated as a part of sex education programs in schools.
- The most-cited reason for not having sex is to avoid STIs, including HIV. However, avoiding pregnancy is also a common reason reported by many. While the emphasis on avoiding STIs is not misplaced in many programs, such programs need to also address the additional concerns of adolescents such as pregnancy prevention.
- Lastly, education is one of the most powerful predictors of delayed sexual debut. Therefore, promoting education among all young people would have positive effects on their sexual and reproductive lives.

TABLE 4.1 Percentage distribution of adolescents, by experiences of and age at first menstruation or other pubertal changes, circumcision and initiation rites, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1284)	15–19 (N=1315)	Total (N=2599)	12–14 (N=1209)	15–19 (N=1303)	Total (N=2512)
Experienced menstruation/male puberty changes						
No	73.8	7.1	40.0	67.9	8.4	37.0
Yes	26.2	92.9	60.0	32.1	91.6	63.0
Median age (in years) at first menstruation/male puberty changes						
	na	na	14.6	na	na	14.8
Age first experienced menstruation/male puberty changes*						
≤10	4.7	0.5	1.4	3.9	0.8	1.5
11	3.8	1.1	1.7	7.5	0.8	2.5
12	23.7	8.7	11.9	27.6	8.1	12.9
13	46.2	21.0	26.5	42.3	14.5	21.3
14	20.7	34.1	31.2	16.2	31.3	27.6
15	na	24.5	19.2	na	30.7	23.1
16	na	7.4	5.8	na	9.6	7.3
17+	na	1.6	1.2	na	3.1	2.3
Don't know	0.9	1.1	1.0	2.6	1.0	1.4
Experienced circumcision						
No	na	na	na	81.9	77.6	79.7
Yes	na	na	na	18.1	22.4	20.3
Age first experienced circumcision†						
≤1	na	na	na	59.2	43.9	50.5
2–5	na	na	na	11.9	10.4	11.0
6–11	na	na	na	20.2	21.1	20.7
12–14	na	na	na	5.5	12.1	9.3
15–19	na	na	na	na	9.7	5.5
Don't know	na	na	na	3.2	2.8	3.0
Experienced initiation rites						
Yes	13.2	22.5	17.9	8.1	13.0	10.6
No	83.5	75.1	79.2	83.9	81.1	82.5
Don't know	3.4	2.4	2.9	8.0	5.9	6.9
Age first experienced initiation rites‡						
≤10	30.9	14.8	20.6	37.5	27.0	30.9
11	20.0	7.2	11.8	6.3	1.8	3.5
12	34.5	24.1	27.9	10.4	4.3	6.6
13	9.7	18.2	15.1	5.2	4.9	5.0
14	3.6	16.8	12.1	7.3	10.4	9.3
15	na	10.0	6.4	na	11.0	6.9
16	na	6.2	3.9	na	9.8	6.2
17+	na	2.1	1.3	na	10.4	6.6
Don't know	1.2	0.7	0.9	33.3	20.2	25.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who have experienced the event. Sample sizes: females 12–14 (N=338); females 15–19 (N=1223); males 12–14 (N=388); males 15–19 (N=1193). †Limited to those who have been circumcised. Sample sizes: males 12–14 (N=218); males 15–19 (N=289). ‡Limited to those who have experienced initiation rite. Sample sizes: females 12–14 (N=165); females 15–19 (N=291); males 12–14 (N=96); males 15–19 (N=163). Note: Ns are weighted.

TABLE 4.2 Percentage distribution of adolescents, by relationship status and sexual activity among adolescents, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1284)	15–19 (N=1307)	Total (N=2591)	12–14 (N=1210)	15–19 (N=1290)	Total (N=2500)
Ever had sexual intercourse						
No	92.4	51.7	71.9	85.1	51.4	67.7
Yes	7.6	48.3	28.1	14.9	48.6	32.3
Relationship status						
Ever in union	0.1	22.6	11.4	0.0	3.5	1.8
Never in union, ever had sex	7.5	25.6	16.7	15.0	45.2	30.6
Never in union, never had sex:						
Ever had a boyfriend/girlfriend	6.3	10.2	8.3	10.2	13.8	12.1
Never had a boyfriend/girlfriend	86.1	41.6	63.6	74.8	37.5	55.5
Sexual activity*						
Kissing:						
Heard of it	57.2	na	57.2	53.7	na	53.7
Know close friends who have done it†	46.8	na	46.8	35.8	na	35.8
Have done it†	21.9	na	21.9	10.0	na	10.0
Fondling:						
Heard of it	65.4	na	65.4	56.4	na	56.4
Know close friends who have done it†	62.3	na	62.3	48.5	na	48.5
Have done it†	35.3	na	35.3	21.0	na	21.0
Sexual intercourse:						
Heard of it	84.9	na	84.9	89.0	na	89.0
Know close friends who have done it†	49.6	na	49.6	47.9	na	47.9
Have done it†	8.8	na	8.8	16.8	na	16.8
Relationship status and sexual activity among 12–14-year-olds						
Ever had sex	7.5	na	7.5	14.9	na	14.9
Never had sex, but had boyfriend/girlfriend	6.3	na	6.3	10.1	na	10.1
Never had sex and never had boyfriend/girlfriend, but have (been) kissed or fondled	17.7	na	17.7	5.7	na	5.7
Never had sex, never had boyfriend/girlfriend, never (been) kissed or fondled	68.5	na	68.5	69.3	na	69.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Only unmarried 12–14-year-olds were asked these sexual activity questions. Sample size is (N=1280). †Limited to those who have heard of the specific sexual activity. Notes: Ns are weighted.

TABLE 4.3 Percentage distribution of adolescents who never had sexual intercourse, by reasons for never having had sexual intercourse and encouragement received, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=990)	15–19 (N=671)	Total (N=1661)	12–14 (N=893)	15–19 (N=661)	Total (N=1554)
Reasons for never having had sexual intercourse*						
Don't have a partner	19.2	11.9	16.3	12.0	13.5	12.6
Waiting until marriage	23.0	20.6	22.0	12.4	14.2	13.2
Afraid to get pregnant/make someone pregnant	59.3	70.9	64.0	26.7	48.5	35.9
Avoid STIs/AIDS	67.0	73.0	69.4	67.2	77.5	71.6
Too young	13.0	6.6	10.4	20.7	8.3	15.5
Schooling reasons	2.5	2.5	2.5	4.0	3.9	4.0
Religious reasons	0.4	1.0	0.7	1.3	1.1	1.2
Because of parents	2.3	1.6	2.0	2.1	1.2	1.7
Not interested	1.3	1.8	1.5	3.0	4.1	3.5
No reason	0.7	0.4	0.6	0.6	0.0	0.3
Sex is bad/feel ashamed	0.0	0.3	0.1	0.0	0.0	0.0
Fear arrest/jailing	0.0	0.0	0.0	1.6	0.8	1.2
Other	2.7	3.6	3.1	10.0	7.9	9.1
Don't know	2.3	1.2	1.9	3.4	2.0	2.8
Felt pressure from others not to have sex						
A great deal	35.5	46.2	39.8	33.8	33.1	33.5
A little	15.5	17.4	16.3	12.8	13.5	13.1
None	48.7	36.4	43.7	52.6	53.3	52.9
Don't know	0.4	0.0	0.2	0.8	0.2	0.5
From whom received the pressure						
Girlfriend/boyfriend	4.6	2.3	3.6	1.4	2.9	2.1
Mother	65.4	58.7	62.3	49.2	45.6	47.6
Father	23.7	18.3	21.2	46.0	38.4	42.8
Brother	7.2	6.3	6.8	11.6	17.3	14.0
Sister	15.9	14.3	15.2	3.6	3.6	3.6
Other female family member	36.8	37.2	37.0	12.3	9.1	10.9
Other male family member	7.2	6.6	6.9	13.5	11.7	12.7
Female friends	17.1	25.1	20.8	2.7	7.5	4.7
Male friends	5.2	8.9	6.9	24.3	33.2	28.1
Teacher	20.1	22.1	21.0	23.2	31.9	26.9
Church/mosque	0.8	3.1	1.8	6.3	13.0	9.2
Other	1.0	2.6	1.7	3.9	4.5	4.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. †Limited to those who receive any encouragement from others not to have sexual intercourse. Sample sizes: females 12–14 (N=503); females 15–19 (N=426); males 12–14 (N=415); males 15–19 (N=307). Note: Ns are weighted.

TABLE 4.4 Percentage distribution of adolescents, by sexual activity status and reasons for not having had sex in the last 12 months, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1284)	15–19 (N=1307)	Total (N=2591)	12–14 (N=1210)	15–19 (N=1290)	Total (N=2500)
Sexual activity status						
Never had sex	92.4	51.7	71.9	85.1	51.4	67.7
Ever had sex, no sex in last 12 months	3.9	10.6	7.3	7.3	17.1	12.3
Had sex in last 12 months, not in last 3 months	1.6	10.9	6.3	2.6	10.6	6.8
Had sex in last 3 months	2.0	26.7	14.5	5.0	20.9	13.2
Reasons for not having had sex in last 12 months*						
Don't have a partner	[16.7]	16.4	16.5	22.9	12.5	15.4
Waiting until marriage	[39.6]	20.3	25.6	15.7	13.9	14.4
Afraid to get pregnant/make someone pregnant	[81.3]	64.3	68.9	20.5	51.9	43.1
Avoid STIs/AIDS	[81.3]	70.3	73.3	77.1	82.3	80.9
Too young	[0.0]	0.0	0.0	4.8	1.9	2.7
Schooling reasons	[2.1]	3.1	2.8	1.2	4.2	3.3
Religious reasons	[0.0]	1.6	1.1	1.2	0.5	0.7
Because of parents	[4.2]	0.0	1.1	4.8	0.5	1.7
Not interested	[2.1]	3.9	3.4	9.6	2.3	4.3
No reason	[0.0]	0.8	0.6	1.2	0.0	0.3
Sex is bad/feel ashamed	na	na	na	na	na	na
Fear arrest/jail	[0.0]	0.0	0.0	0.0	1.4	1.0
Other	[2.1]	7.0	5.7	3.6	10.6	8.7
Don't know	[0.0]	0.8	0.6	1.2	0.9	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. Limited to those who ever had sex but not in the last 12 months. Sample sizes: females 12–14 (N=48); females 15–19 (N=129); males 12–14 (N=83); males 15–19 (N=216). Notes: Ns are weighted. [] = N is 25–49.

TABLE 4.5 Percentage distribution of adolescents, by attitudes about sexual activity, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1283)	15–19 (N=1312)	Total (N=2595)	12–14 (N=1206)	15–19 (N=1300)	Total (N=2506)
Young women should remain virgins until they marry						
Agree	89.2	90.5	89.9	80.8	82.8	81.8
Disagree	8.1	8.0	8.1	14.4	15.6	15.0
Don't know	2.7	1.5	2.1	4.7	1.6	3.1
Young men should remain virgins until they marry						
Agree	83.8	82.8	83.3	79.9	81.9	80.9
Disagree	11.1	13.9	12.5	14.9	16.7	15.8
Don't know	5.2	3.4	4.2	5.2	1.5	3.3
Usually people do not plan to have sex, it just happens						
Agree	25.3	40.1	32.8	31.5	43.2	37.6
Disagree	29.4	37.1	33.3	37.7	45.7	41.8
Don't know	45.2	22.8	33.9	30.9	11.0	20.6
Young women should remain virgins until they marry*						
Agree	90.6	88.0	88.3	75.0	78.9	78.0
Disagree	9.4	10.6	10.5	22.8	20.5	21.0
Don't know	0.0	1.4	1.2	2.2	0.6	1.0
Young men should remain virgins until they marry*						
Agree	81.3	79.5	79.7	71.1	76.8	75.6
Disagree	16.7	18.6	18.3	26.7	22.7	23.6
Don't know	2.1	1.9	1.9	2.2	0.5	0.9
Usually people do not plan to have sex, it just happens*						
Agree	33.3	50.4	48.1	30.0	41.4	38.9
Disagree	50.0	43.2	44.1	51.1	53.5	52.9
Don't know	16.7	6.4	7.8	18.9	5.1	8.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who ever had sex. Sample sizes: females 12–14 (N=96); females 15–19 (N=631); males 12–14 (N=180); males 15–19 (N=625). *Note:* Ns are weighted.

TABLE 4.6 Percentage distribution of adolescents who ever had sexual intercourse, by relationship with first sex partner and main reason for having sex, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=97)	15–19 (N=633)	Total (N=730)	12–14 (N=180)	15–19 (N=633)	Total (N=813)
Relationship with first sex partner at time of first sex						
Spouse	0.0	12.6	11.0	0.0	1.7	1.4
Live-in partner	3.1	5.7	5.3	0.0	0.6	0.5
Boyfriend/girlfriend	81.4	73.0	74.1	64.4	80.3	76.8
Casual acquaintance	11.3	6.6	7.3	27.8	14.5	17.5
Commercial sex worker	0.0	0.0	0.0	0.0	0.2	0.1
Other	4.1	2.1	2.3	7.8	2.7	3.8
Main reason for sex with first partner						
Married	1.0	12.5	10.9	0.0	0.9	0.7
Felt like it	35.1	52.8	50.5	66.7	81.7	78.4
Partner insisted	9.3	9.3	9.3	6.1	4.3	4.7
Influence from friends	22.7	3.6	6.2	13.3	8.2	9.3
Expectation of gifts/money	19.6	9.5	10.8	0.0	0.5	0.4
Wanted to get pregnant	0.0	1.9	1.6	0.6	0.5	0.5
Was forced	10.3	7.4	7.8	0.6	0.3	0.4
Other	2.1	1.4	1.5	6.7	2.5	3.4
Don't know	0.0	1.6	1.4	6.1	1.1	2.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 4.7 Percentage distribution of adolescents who ever had sexual intercourse, by characteristics of first sex, according to sex, age and union status, 2004 National Survey of Adolescents

Characteristic	Female				Male		
	12–14 (N=93)	15–19 Not in union (N=514)	15–19 In union (N=116)	Total (N=723)	12–14 (N=170)	15–19 (N=624)	Total (N=794)
Age difference with first sex partner							
Partner is 10+ years older	6.5	8.2	14.7	9.0	0.0	0.5	0.4
Partner is 5–9 years older	11.8	24.0	31.9	23.7	2.4	1.3	1.5
Partner is 1–4 years older	37.6	44.6	31.0	41.6	25.9	25.6	25.7
Partner is older, don't know specific age	26.9	8.4	5.2	10.2	4.1	1.8	2.3
Partner is same age or younger	8.6	8.4	6.0	8.0	64.7	68.6	67.8
Don't know	8.6	6.4	11.2	7.5	2.9	2.2	2.4
Respondent's willingness to have first sex							
Very willing	25.8	44.8	67.2	45.9	65.6	74.0	72.1
Somewhat willing	47.4	30.9	15.5	30.8	27.2	23.0	23.9
Not willing at all	26.8	24.3	17.2	23.2	7.2	3.0	4.0
Contraceptive methods used at first sex							
Condom only	16.1	40.5	8.5	32.4	8.4	30.3	25.4
Condom and other method	2.2	2.1	0.9	1.9	0.0	2.9	2.2
Other method only	1.1	3.7	3.4	3.2	0.0	2.1	1.6
No method	80.6	53.6	87.2	62.4	91.6	64.7	70.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 4.8 Percentage distribution of adolescents who ever had sexual intercourse, by the number of lifetime and recent sex partners, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=95)	15–19 (N=632)	Total (N=727)	12–14 (N=180)	15–19 (N=629)	Total (N=809)
Number of lifetime sex partners						
1	74.7	61.7	63.4	66.7	53.1	56.1
2	22.1	28.5	27.6	22.2	20.3	20.8
3	2.1	7.3	6.6	5.0	11.6	10.1
4+	1.1	2.5	2.3	6.1	14.9	13.0
Number of sex partners in last 12 months						
0	51.0	22.0	25.9	48.9	35.1	38.2
1	45.9	73.4	69.7	41.7	53.9	51.2
2	3.1	4.1	4.0	8.3	8.8	8.7
3	0.0	0.2	0.1	0.6	1.1	1.0
4+	0.0	0.3	0.3	0.6	1.1	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 4.9 Percentage distribution of adolescents who had sexual intercourse in the last 12 months, by characteristics of last sex partner, according to sex, age and union status, 2004 National Survey of Adolescents

Characteristic	Females				Males		
	12–14 (N=46)	15–19 Not in union (N=227)	In union (N=258)	Total (N=531)	12–14 (N=92)	15–19 (N=406)	Total (N=498)
Relationship to last sex partner in last 12 months							
Spouse	[0.0]	na	72.9	35.4	0.0	3.4	2.8
Live-in partner	[4.3]	na	27.1	13.6	1.1	2.2	2.0
Boyfriend/girlfriend	[78.3]	86.8	na	43.9	70.7	82.0	79.9
Casual acquaintance	[15.2]	8.8	na	5.1	23.9	10.8	13.3
Commercial sex worker	[0.0]	0.0	na	0.0	0.0	0.2	0.2
Other	[2.2]	4.4	na	2.1	4.3	1.2	1.8
Age difference with last sex partner in last 12 months							
Partner is 10+ years older	[2.2]	9.3	12.5	10.1	0.0	0.0	0.0
Partner is 1–4 years older	[56.5]	48.7	32.4	41.3	16.5	14.0	14.5
Partner is 5–9 years older	[8.7]	19.9	39.5	28.9	1.1	0.0	0.2
Partner is older, don't know specific age	[19.6]	8.0	3.5	6.7	2.2	1.5	1.6
Partner is same age or younger	[2.2]	10.6	4.7	6.9	79.1	83.0	82.3
Don't know	[10.9]	3.5	7.4	6.1	1.1	1.5	1.4
Duration of relationship							
Had sex one time only	[32.6]	15.8	0.8	10.0	31.9	18.3	20.8
3 months or less	[19.6]	17.1	6.2	12.0	27.5	27.2	27.2
4–11 months	[15.2]	14.5	15.5	15.0	15.4	19.5	18.8
1 year	[13.0]	18.0	22.1	19.5	11.0	15.1	14.3
2 years	[13.0]	21.9	22.5	21.4	12.1	11.4	11.5
More than 2 years	[6.5]	12.7	32.9	22.0	2.2	8.6	7.5
Gifts or money received for sex from last sex partner in last 12 months*							
Received gifts or money	[65.5]	76.5	na	75.0	33.3	32.2	32.4
No gifts or money	[34.5]	23.5	na	25.0	66.7	67.8	67.6
Alcohol use at last sex in last 12 months†							
Respondent drank alcohol at last sex	[3.2]	1.0	0.8	1.0	3.2	2.5	2.6
Partner drank alcohol at last sex	[3.2]	7.2	12.8	9.9	1.6	2.5	2.4
Both respondent and partner drank alcohol at last sex	[3.2]	1.0	0.4	0.8	0.0	3.7	3.1
No alcohol at last sex	[90.3]	90.7	86.0	88.3	95.2	91.2	91.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

*Question not asked if most recent partner was the first sex partner ever and had sex only one time or if partner was a spouse or cohabiting partner. Sample sizes: females 12–14 (N=29); females 15–19, not in union (N=187); males 12–14 (N=66); males 15–19 (N=323). †Question not asked if most recent partner was the first sex partner ever and had sex only one time. Sample sizes: females 12–14 (N=31); females 15–19 not in union (N=194); females 15–19 in union (N=257); males 12–14 (N=63); males 15–19 (N=353). Notes: Ns are weighted. [] = N is 25–49.

TABLE 4.10 Percentage distribution of adolescents who had sexual intercourse with partners who were not spouses or cohabiting partners in the last 12 months, by experiences of sex in exchange for money or other items, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Females	Males
	12–19 (N=221)	12–19 (N=396)
Money or other items received in exchange for sex with any partner in last 12 months*		
No gifts or money	24.4	65.9
Received gifts or money	75.6	34.1
Money or other items received in exchange for sex†		
Money	92.2	46.7
Food	9.6	25.7
School fees	2.4	0.0
Drugs (including glue)	0.6	0.0
Alcohol	2.4	0.0
Shelter/rent	2.4	0.0
Clothes	54.5	23.0
Transportation	3.6	0.0
Jewelry/cosmetics	25.7	21.5
Entertainment (e.g., video games)	4.2	1.5
Other	5.4	30.4
Total	100.0	100.0

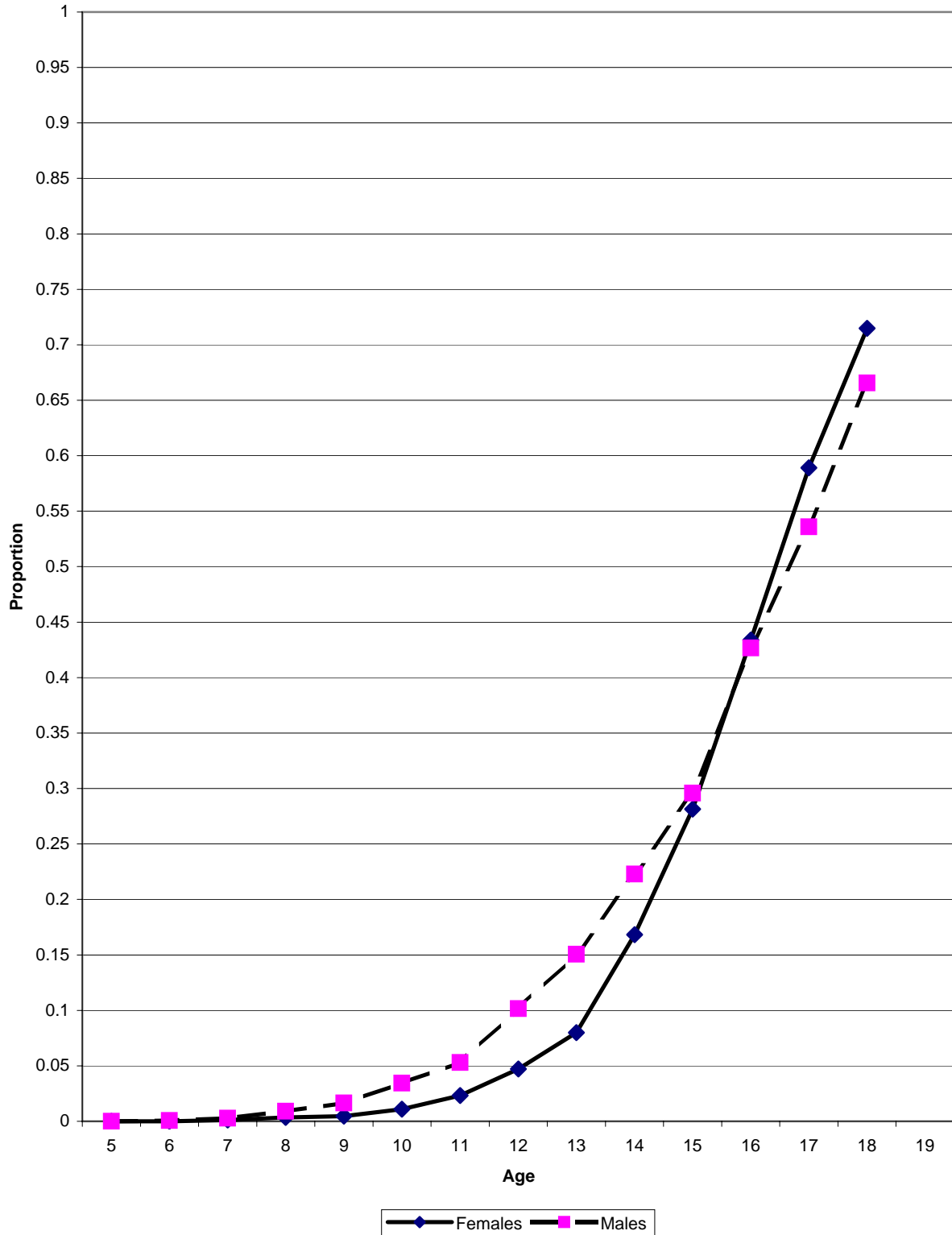
*Question not asked if most recent partner was the first sex partner ever and had sex only one time or if partner was a spouse or cohabiting partner. †Totals may exceed 100 because multiple responses are possible. Question asked only of those who received something in exchange for sex and responses are for up to three recent partners in the last 12 months. Sample sizes: females 12–19 (N=167); males 12–19 (N=135). *Note:* Ns are weighted.

TABLE 4.11 Percentage distribution of adolescents, by experiences of sexual abuse and coercion, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=593)	15–19 (N=593)	Total (N=1186)	12–14 (N=574)	15–19 (N=638)	Total (N=1212)
Ever been touched, kissed, grabbed or fondled in an unwanted sexual way*						
Yes	18.9	48.7	33.8	10.1	19.9	15.3
No	80.3	50.8	65.5	89.7	80.1	84.7
Refused to answer	0.5	0.0	0.3	0.2	0.0	0.1
Don't know	0.2	0.2	0.2	0.0	0.0	0.0
Missing	0.2	0.3	0.3	0.0	0.0	0.0
Ever been physically forced, hurt or threatened into having sexual intercourse*						
Yes	9.3	25.5	17.4	4.2	8.9	6.7
No	90.2	74.0	82.1	95.8	90.6	93.1
Refused to answer	0.2	0.5	0.3	0.0	0.5	0.2
Don't know	0.2	0.0	0.1	0.0	0.0	0.0
Relationship of person(s) to respondent, among those forced into having sex†						
Spouse or live-in partner	0.0	2.0	1.5	--	0.0	0.0
Boyfriend/girlfriend	3.8	28.9	22.4	--	18.5	20.0
Friend	13.2	11.9	12.3	--	23.2	21.3
Parent	0.0	0.7	0.5	--	0.0	0.0
Sibling	0.0	1.3	1.0	--	1.8	3.7
Uncle/aunt	5.7	5.3	5.4	--	1.8	3.8
Other family	14.8	5.3	7.8	--	3.6	2.5
Schoolmate	14.8	19.2	18.0	--	26.8	27.8
Acquaintance	27.8	23.0	24.3	--	7.0	4.9
Teacher	3.7	0.7	1.5	--	0.0	0.0
Stranger	34.0	31.8	32.4	--	23.2	20.0
Neighbor	0.0	0.0	0.0	--	0.0	0.0
Other	3.7	1.3	1.9	--	10.7	7.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Questions asked of only one eligible adolescent per household and only if no one over the age of three was present or within hearing range. †Multiple responses possible and sample limited to those who said they had ever been forced into having sexual intercourse. Sample sizes: females 12–14 (N=54); females 15–19 (N=151); males 12–14 (N=24); males 15–19 (N=57). Notes: Ns are weighted. "--" = N is 24 or fewer.

Chart 4.1. Proportion of adolescents who have had their first sexual experience (life table estimates) by age and gender, Uganda, National Adolescent Survey, 2004



Chapter 5

Contraception

This chapter describes young people's knowledge and use of contraceptive methods and characteristics of their contraceptive use at last sex. Knowledge of these methods is relevant for all young people—those who are already sexually active, as well as those who are not. Such knowledge is essential preparation for those who are not yet sexually active to be able to protect themselves when they do begin to have sex. Use of contraceptives is measured among those who have initiated sexual activity as the relevant group who have used a method. In addition, current contraceptive use and recent use is discussed with regard to those adolescents who are sexually active in the past three months and the past year. Results on sources of contraceptive information and services are presented in Chapter 9.

Contraceptive Method Knowledge

Table 5.1 shows the proportion of adolescents who knew any method, the proportion who knew each contraceptive method (including the male and female condom) and the average number of methods known. Respondents were first asked to spontaneously name ways males and females delay or avoid a pregnancy. When the respondent failed to name a particular method spontaneously, the interviewer described the method and asked whether the respondent recognized it.

Knowledge of any contraceptive method was very high among adolescents—92% of females and 96% of males knew at least one method. More importantly, almost all adolescents who knew of a method knew of at least one *modern* method. As expected, older adolescents were more likely than their younger counterparts to have heard of contraceptive methods. In fact, knowledge of at least one method among older adolescents aged 15–19 was almost universal, with 97% of females and 99% of males having known at least one method.

Proportionately more males knew of male methods, such as male condoms, male sterilization and withdrawal, while more females knew about female meth-

ods, like the pill, IUD or coil, injectables and implants. Interestingly, more males than females also knew about female sterilization, the female condom and emergency contraception. Adolescents had heard of approximately four methods of contraception on average and there were no substantial gender differences. The most commonly known methods were the male condom, the pill and injectables, which were known by more than half of all female and male adolescents.

Knowledge of the Fertile Period and the Withdrawal Method

Table 5.2 shows adolescents' knowledge of the fertile period among those who had ever used the rhythm method and those who had not used the method, in order to determine whether those who had used the method had correct knowledge of the fertile period (i.e., that a woman is most likely to conceive halfway between two menstrual periods).

Eighty-eight percent of females and 70% of males who were sexually experienced recognized that there are certain days when a woman is more likely to get pregnant. However, only 16% of these females and 10% of these males correctly identified when a woman's fertile period occurs in her cycle. Many adolescents believe that a woman's fertile period is right after her period has ended (52% of sexually experienced females and 34% of sexually experienced males). Interestingly, only 16% of sexually experienced females who had ever used the rhythm method and knew that a woman has a fertile period correctly identified the fertile period.

The majority of adolescents think that a female cannot get pregnant if the male withdraws before ejaculating (Table 5.3). Fewer than one-third of females and 16% of males indicated that there is a risk of pregnancy when using withdrawal and those who had never used the method were more likely to indicate this risk, compared with those who had used withdrawal.

Attitudes About the Impact of Contraception on Sexual Behavior

Some arguments against making contraceptive information available to young adolescents are based on the assumption that making comprehensive sex education available encourages adolescents to have sex. When adolescents who had heard of any contraceptive methods were asked whether they thought that having family planning methods available encourages young people to have sexual intercourse, they were mixed in their views. Although a large proportion of adolescents (48% of females and 43% of males) in Uganda believe that making family planning methods available to young people encourages young people to have sex, a similarly large proportion of adolescents disagreed (40% of females and 46% of males) (data not shown). Older adolescents were more likely to believe that the availability of contraception encourages sex, compared with younger adolescents.

Ever-Use of Contraceptives

Contraceptive method use is an important protective behavior for adolescents. Table 5.4 shows the percentage of adolescents who have ever used a contraceptive method either for pregnancy prevention or to prevent STIs, including HIV, among those who had ever had sexual intercourse. Information on method use (ever-use and current use) is based on combining information from questions about current use of contraceptive methods to prevent pregnancy and separate questions about method use asked per partner for up to three sex partners in the 12 months prior to the survey.

It was more common for females in the 2004 survey to have ever used a contraceptive method than for males, regardless of age. Whereas, 47% of sexually experienced male adolescents reported having ever used a method, 57% of sexually experienced female adolescents reported having used a method. As expected, the level of ever-use among adolescents increased with age.

A large proportion of adolescents who were using a contraceptive method were using a modern one. Approximately 86% of sexually experienced females who had ever used a method (or 49% of all sexually experienced females) had ever used a modern method. This proportion was higher among males, reaching 95% of those who had ever used a method (or 45% of all sexually experienced males). The male condom was the most common method used among adolescents in Uganda, with 44% of sexually experienced females and males having used it. The rhythm method was the most common traditional method ever used among fe-

males (18%), followed by withdrawal (14%). Among males, fewer than 10% had ever used either method. For both sexes, use of other traditional methods was negligible.

Current Use of Contraceptives

Table 5.5 shows current contraceptive use for adolescents who were currently sexually active (i.e., they had had sexual intercourse in the three months prior to the survey interview). Current use is defined as either having used a method with a sex partner in the three months prior to the survey (for pregnancy or STI prevention or both) or reporting current use of a method for pregnancy prevention (irrespective of a specific partner).

Among adolescents who had had sex in the last three months, 42% of females and 56% of males reported currently relying on a method. Sixty-one percent of sexually active females aged 15–19 who were not in union were currently using a method, compared with 30% of their counterparts who were in union.

The majority of current users were relying on a modern method and the most common method was the male condom (26% of sexually active females and 49% of males). More 15–19-year-old females in union reported current use of injectables, rhythm method or periodic abstinence compared with those not in union.

Contraceptive Use at Last Intercourse

Table 5.6 shows differences in contraceptive use at last sex among adolescents who had had sex in the 12 months prior to the survey, according to a range of relationship characteristics. One of the questions this table addresses is: In what kinds of sexual relationships are adolescents practicing contraception?

Female adolescents whose last sex partner was their boyfriend were more likely to have used a method at their last sexual intercourse than those whose partner was their spouse or live-in partner. Interestingly, male adolescents were more likely to have used a contraceptive method at their last sexual encounter if their partner was a girlfriend compared with a casual acquaintance.

More females used a method in short-term relationships (e.g., of three months or less) than in longer relationships of one or two years. For females, longer relationships most likely signify being in union, which in turn is associated with lower levels of contraceptive use. In the opposite direction, proportionately more males used a contraceptive method in longer relationships than in shorter relationships: For example, 43%

of males used a method at last sex in relationships lasting three months or less, compared with 58% of males whose relationships spanned one or more years.

Adolescents also used contraceptive methods more often if they talked about contraceptives with their partner, compared with relationships where they did not talk about contraceptives. Nearly 80% of males and 55% percent of females who talked with their partner about contraceptive methods used a contraceptive method at their last sexual intercourse.

Two in five females and more than half of males who used a condom at their last sex indicated that they suggested the use of a condom themselves (Table 5.7). More females than males said this was a joint decision (31% vs. 14%, respectively).

Forty-seven percent of young women and 39% of young men used the male condom to prevent pregnancy only. In contrast, 16% of young women and 39% of young men used condoms to prevent STIs, including HIV, only. Use of male condoms for dual protection was cited more commonly among females (33%) than males (22%).

Key Points for Programs and Policies

- Most adolescents in Uganda have heard of at least one method of contraception and among older adolescents, knowledge is almost universal. More importantly, knowledge of at least one modern method is high among young people in the country. It is important to note, however, that one in eight female adolescents between the ages of 12 and 14 report not knowing a method.
- Targeting the attitudes of adolescents about contraception is important, since a fairly high percentage of adolescents believe that making contraception available encourages sex.
- Although awareness of contraception is high among Ugandan youth, a large proportion of sexually experienced adolescents have never used a method (43% of females and 53% of males). Improving use of contraceptive methods is an important protective behavior for sexually active adolescents to adopt in efforts to reduce the risk of unintended pregnancy and infection with HIV and other STIs.
- Most adolescents who have used a method have used a modern one. Promotion of modern method use should continue to be encouraged among youth in Uganda, particularly among married adolescents and

those in union, since they are least likely to use contraception.

- The male condom is the most popular method among both male and female youth in Uganda. While one in four currently sexually active young women relies on the male condom, nearly half of sexually active males are currently using this method. Promoting and ensuring a supply of condoms need to continue in Uganda, especially for sexually active adolescents.

TABLE 5.1 Percentage distribution of adolescents, by knowledge of contraceptive methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=1284)	15-19 (N=1315)	Total (N=2599)	12-14 (N=1209)	15-19 (N=1304)	Total (N=2513)
Knowledge of any method						
No	12.1	3.3	7.7	7.4	1.5	4.3
Yes	87.9	96.7	92.3	92.6	98.5	95.7
Knowledge of any modern method*	87.6	96.2	92.0	92.4	98.5	95.5
Female sterilization	33.7	51.0	42.5	29.4	53.4	41.9
Male sterilization	11.9	25.6	18.8	14.8	39.6	27.6
Pill	60.3	82.7	71.6	53.8	77.0	65.8
IUD/Coil	8.9	21.2	15.1	4.0	13.7	9.0
Injectables	60.8	80.6	70.8	44.8	71.5	58.6
Implants	7.7	22.1	15.0	5.1	14.3	9.9
Male condom	81.1	94.5	87.9	90.8	97.8	94.4
Female condom	27.0	55.0	41.2	33.3	61.4	47.9
Foam/Jelly	5.5	13.5	9.5	3.6	9.1	6.5
Emergency contraception	5.4	18.9	12.2	8.5	24.2	16.7
Mean number of modern methods known	3.0	4.7	3.8	2.9	4.6	3.8
Knowledge of any traditional method*	22.3	54.2	38.4	23.1	54.3	39.3
Rhythm	14.5	44.6	29.7	10.7	33.1	22.3
Withdrawal	7.9	35.7	22.0	15.1	40.1	28.1
Abstinence	0.2	0.2	0.2	1.0	1.8	1.4
Herbs	na	na	na	na	na	na
Other	6.0	8.1	7.0	5.2	7.8	6.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 5.2 Percentage distribution of sexually experienced 12–19-year-olds, by knowledge of fertile period, according to ever-use of rhythm method and sex, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	Never used rhythm (N=594)	Ever used rhythm (N=134)	Total (N=728)	Never used (N=739)	Ever used rhythm (N=68)	Total (N=807)
Knows there are certain days when a woman is more likely to get pregnant						
Yes	85.7	98.5	88.0	68.2	89.7	70.0
No	5.2	0.0	4.3	10.4	2.9	9.8
Don't know	9.1	1.5	7.7	21.4	7.4	20.2
Time when woman more likely to get pregnant*						
Just before period begins	22.2	17.6	21.3	22.9	16.4	22.2
During period	7.7	6.1	7.3	29.8	18.0	28.5
Right after period has ended	49.7	58.8	51.6	32.0	54.1	34.4
Half way between periods	15.7	16.0	15.8	10.3	8.2	10.1
Other	0.4	0.0	0.3	0.0	0.0	0.0
Don't know	4.3	1.5	3.8	5.0	3.3	4.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who said there are certain days when a woman is more likely to get pregnant. Sample sizes: female, never used (N=509); female, ever used (N=131); male, never used (N=503); male, ever used (N=61). *Notes:* Ns are weighted.

TABLE 5.3 Percentage distribution of sexually experienced 12–19-year-olds, by knowledge of pregnancy prevention, according to ever-use of withdrawal method and sex, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	Never used withdrawal (N=626)	Ever used withdrawal (N=103)	Total (N=729)	Never used withdrawal (N=760)	Ever used withdrawal (N=46)	Total (N=806)
A girl can get pregnant if a boy withdraws before ejaculating						
Yes	31.8	10.7	28.8	16.3	[10.9]	16.0
No	53.4	80.6	57.2	72.4	[87.0]	73.2
Don't know	14.9	8.7	14.0	11.3	[2.2]	10.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted. [] = N is 25–49.

TABLE 5.4 Percentage of adolescents who ever had sexual intercourse, by ever-use of contraceptive methods for any reason, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=97)	15–19 (N=631)	Total (N=728)	12–14 (N=180)	15–19 (N=627)	Total (N=807)
Ever-use of any method						
Yes	25.8	61.6	56.9	13.9	56.8	47.2
No	74.2	38.4	43.1	86.1	43.2	52.8
Any modern methods*	23.7	53.0	49.1	12.8	53.9	44.7
Female sterilization	0.0	0.0	0.0	0.0	0.0	0.0
Male sterilization	0.0	0.0	0.0	0.0	0.0	0.0
Pill	4.1	9.0	8.4	0.6	5.3	4.2
IUD/coil	0.0	0.0	0.0	0.0	0.3	0.2
Injectables	2.0	8.4	7.5	0.0	2.7	2.1
Implants	0.0	0.0	0.0	0.0	0.3	0.2
Male condom	23.7	47.5	44.3	12.8	53.0	44.0
Female condom	2.1	1.4	1.5	0.0	2.6	2.0
Foam	0.0	2.4	2.1	0.6	0.3	0.4
Emergency contraception	0.0	1.3	1.1	0.6	1.4	1.2
Any traditional methods*	7.2	26.9	24.3	3.3	15.8	13.0
Rhythm	4.1	20.6	18.4	1.1	10.5	8.4
Withdrawal	2.1	16.0	14.1	0.6	7.2	5.7
Other	1.0	0.6	0.7	1.7	2.2	2.1

*Multiple responses are possible. *Note:* Ns are weighted.

TABLE 5.5 Percentage of adolescents who had sex in the last three months, by current use of contraceptive methods for any reason, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female				Male		
	12–14	15–19		Total	12–14	15–19	Total
	(N=26)	Not in union (N=136)	In union (N=213)	(N=375)	(N=60)	(N=269)	(N=329)
Current use of any method							
Yes	[46.2]	61.0	30.0	42.4	13.3	65.8	56.2
No	[53.8]	39.0	70.0	57.6	86.7	34.2	43.8
Current use modern method*	[46.2]	59.6	24.4	38.7	13.3	63.0	53.9
Not using any method	[53.8]	39.0	70.6	57.7	86.7	34.1	43.6
Female sterilization	[0.0]	0.0	0.0	0.0	0.0	0.0	0.0
Male sterilization	[0.0]	0.0	0.0	0.0	0.0	0.0	0.0
Pill	[7.7]	8.1	5.6	6.6	0.0	3.7	3.0
IUD	[0.0]	0.0	0.0	0.0	0.0	0.0	0.0
Injectables	[0.0]	4.4	7.0	5.6	0.0	1.1	0.9
Implants	[0.0]	0.0	0.0	0.0	0.0	0.0	0.0
Male condom	[38.5]	46.3	11.2	26.1	13.3	57.4	49.4
Female condom	[0.0]	0.7	0.0	0.3	0.0	0.4	0.3
Emergency contraception	[0.0]	0.0	0.0	0.0	0.0	0.4	0.3
Current use traditional method*	[0.0]	5.1	6.1	5.3	1.7	3.3	3.0
Rhythm or periodic abstinence	[0.0]	1.5	5.1	3.5	0.0	2.6	2.1
Withdrawal	[0.0]	0.0	0.0	0.0	0.0	0.0	0.0
Other	[0.0]	0.0	0.5	0.3	0.0	0.4	0.3

*Multiple responses are possible. Notes: Ns are weighted. [] = N is 25–49.

TABLE 5.6 Percentage of adolescents who had sexual intercourse in the last 12 months and used any contraceptive method at last sex, by relationship characteristic, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=46)	15–19 (N=485)	Total (N=531)	12–14 (N=90)	15–19 (N=406)	Total (N=496)
Relationship to last sex partner						
Spouse	--	17.6	17.6	--	--	--
Live-in partner	--	27.5	26.8	--	--	--
Boyfriend/girlfriend	[30.6]	53.0	49.6	12.5	60.1	52.5
Casual acquaintance	--	--	[44.4]	--	[31.8]	25.8
Commercial sex worker	--	--	--	--	--	--
Other	--	--	--	--	--	--
Duration of sexual relationship						
Had sex one time only	--	[34.2]	26.4	[6.9]	39.2	30.1
3 months or less	--	58.2	57.8	[16.0]	49.1	43.0
4–6 months	--	[35.9]	[31.8]	--	60.0	50.8
7–11 months	--	[20.6]	[18.9]	--	[53.3]	[50.0]
1 year	--	34.7	34.6	--	62.3	57.7
2 years	--	33.6	35.1	--	[68.9]	57.1
More than 2 years	--	29.6	29.9	--	[65.7]	[62.2]
Ever talked with partner about contraceptive methods						
Had sex one time only (not asked question)	--	[32.4]	25.0	4.0	43.3	31.8
Yes	--	54.0	55.1	--	79.4	78.2
No	--	20.0	20.0	10.7	31.3	26.1
Don't know	--	--	--	--	--	--

Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 5.7 Percentage distribution of adolescents who had sexual intercourse in the last 12 months and used a male condom, by characteristics of condom use at last sex, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=11)	15-19 (N=131)	Total (N=142)	12-14 (N=11)	15-19 (N=206)	Total (N=217)
Who suggested use of male condom						
Had sex one time only	--	8.4	8.5	--	12.6	12.4
Participant	--	38.9	40.1	--	58.3	57.1
Partner	--	19.1	19.0	--	15.0	16.6
Joint decision	--	32.8	31.0	--	14.1	13.8
Refused to respond	--	0.8	1.4	--	0.0	0.0
Reason for using male condom						
Prevent pregnancy	--	44.3	46.5	--	39.3	38.7
Prevent HIV and other STIs	--	16.0	16.2	--	37.4	39.2
Prevent both pregnancy and STIs	--	35.1	33.1	--	22.8	21.7
Other	--	2.3	2.1	--	0.5	0.5
Don't know	--	2.3	2.1	--	0.0	0.0
Total	--	100.0	100.0	--	100.0	100.0

Notes: Ns are weighted. "--" = N is 24 or fewer.

Chapter 6

Pregnancy and Childbearing

Early pregnancy or childbirth can be dangerous to the mother and to her child. This is because very young females may not be physiologically mature enough to give birth. In some cases, physiological immaturity may be compounded by poor nutrition, especially among the poor, and these risks occur regardless of marital status. In addition, pregnancy, especially among the unmarried, may be unplanned and this may lead to the withdrawal of social support and further complicate a woman's situation. In such cases, young women may turn to unsafe abortion with its attendant problems. This chapter presents key findings on a number of issues related to adolescent pregnancy and childbearing, including the extent of knowledge and perceptions about how pregnancy occurs, the level of early childbearing, preferences regarding the timing of recent and future births, knowledge about abortion and personal experiences of abortion.

Perceptions of How Pregnancy Happens

Table 6.1 presents information on some common misperceptions about how pregnancy may or may not occur, as well as awareness among all adolescents of the fertile period during the menstrual cycle. The assumption is that knowledge about how pregnancy occurs can influence the use of contraceptives to prevent pregnancy.

Older adolescents (15–19 years) were more likely to have known that a girl can get pregnant the very first time she has sexual intercourse compared with younger adolescents (12–14 years of age): 61% of older females and 69% of older males knew that a girl can get pregnant the very first time she has sexual intercourse, compared with 49% of younger females and 54% of younger males. It is important to note that many adolescents thought that a girl could not get pregnant at her first sex (one in four males and females believed this) and many did not know if she could (one in eight females and one in five males reported this). Knowledge that a girl can get pregnant at first intercourse increased

with level of education. About three in four females with a secondary education believed a girl can get pregnant at first intercourse, compared with about a half of those with no education and those with primary education (data not shown).

Forty-three percent of females and 55% of males 15–19 years old thought that a girl could get pregnant if she had sex standing up. About two-thirds of 12–14-year-olds (68% of females and 65% of males) believed a girl cannot get pregnant or did not know that she could if she has sex standing up. Knowledge that a girl can get pregnant while standing up increased with level of education (e.g., more than half of females with secondary education knew this, compared with 35% with primary education and 21% with no education (data not shown)).

The majority of male 15–19-year-olds (70%) thought that if a boy withdraws before ejaculation the girl cannot get pregnant, compared with only 48% of female 15–19-year-olds. Forty-four percent of females and 39% of males aged 12–14 years said they did not know. As indicated in Chapter 5, among those who had ever used withdrawal, few were aware that this method carried some risk of pregnancy.

Respondents were also asked whether a girl can get pregnant if she washes herself thoroughly immediately after sex. As with other measures of knowledge, older adolescents were more knowledgeable than younger adolescents: Some 52% of females and 63% of males aged 15–19 years thought a girl could still become pregnant, compared with 42% of females and 41% of males aged 12–14. Knowledge that a girl can get pregnant if she washes herself thoroughly immediately after sex increased with level of education (data not shown).

While two-thirds of females and half of males indicated they knew there are certain days when a woman is more likely to get pregnant, few actually reported the correct time in a woman's cycle as half way between periods (15% of females and 12% of males). As expected, correct knowledge of a woman's fertile period

increased with age. Forty-six percent of females and 31% of males who knew there are certain days when a woman is more likely to get pregnant thought those days were right after a woman's period has ended. It is important to note that the majority of 12–14-year-olds did not know of or believed there were *not* certain days when a woman is more likely to get pregnant.

Pregnancy and Childbearing Experiences

This section examines adolescents' childbearing experiences and, given the very low levels of pregnancy and childbearing among 12–14-year-olds, focuses on adolescents aged 15–19. The level of adolescent childbearing, the extent to which childbearing occurs before marriage and the level of very early childbearing (before age 15) are examined for adolescent women. The proportion of adolescent men who report having ever made someone pregnant or fathered a child is extremely low. A summary of this information is displayed in Table 6.2.

About one in four female 15–19-year-olds reported ever being pregnant. As expected, the majority of females in union (88%) had been pregnant compared with 13% of those not in union. Furthermore, 70% of females in union and 11% not in union had ever given birth. About 16% of females in union and 3% not in union had had a birth by age 15. No male adolescent said he had fathered a child by age 15. Finally, 29% of females in union were pregnant at the time of the survey.

Desired Timing of Pregnancy or Birth

The timing of pregnancy or birth among adolescents vis-à-vis the time it is wanted reveals the level of unintended pregnancy or childbearing among adolescents. Ensuring that adolescents begin childbearing when they want to is important in adolescent sexual and reproductive health, and preventing unwanted childbearing is a key focus of current programs and policies. This section examines issues associated with the timing of pregnancy and childbearing among adolescents.

Table 6.2 (last two panels) shows that 39% of 15–19-year-old females in union wanted to have their current pregnancy then, 41% wanted it later and about 19% did not want their pregnancy at all. There were too few cases among currently pregnant females not in union to examine. Among those who ever had a birth, 20% of females not in union and 23% in union wanted their last birth later and 50% of those not in union and 22% in union did not want the last birth at all.

Table 6.3 shows adolescents' desired timing of the first or next birth. More than half of older females in

union wanted to wait for 1–2 years and about one in five wanted to wait 3–4 years before having a (or another) child. Among those not in union, approximately one in four wanted to wait at least 9 or more years to have a (or another) child. A similar pattern existed among older males. Only 10% of older females not in union and 10% of older males wanted to “wait until marriage.” Very few adolescents (4% or fewer) said the timing of childbearing is left up to what God decides. The desired length of time before the next birth also increases with level of education. For example, only 6% of female 12–19-year-olds with no education wanted to wait for 9 or more years compared with about 40% with secondary school education (data not shown).

Abortion

Abortion is only permitted in Uganda to save the life of the mother, and accessible abortion methods are unsafe and thus can result in negative health consequences, including death. Nationally, about one in five pregnancies end in induced abortion in Uganda.³¹ This section shows the percentage of adolescents who know of any ways to terminate a pregnancy and what methods they are aware of (responses to the question were spontaneous – categories were not read out). Thirty-seven percent of female and 40% of male 15–19-year-olds did not know of any method for aborting a pregnancy and the lack of knowledge among 12–14-year-olds was even higher (Table 6.4). The most commonly known way to terminate pregnancy was the use of an herbal drink (36% of female and 35% of male 12–19-year-olds), followed by tablets or pills (26% of females and 31% of males). The level of knowledge of one of the safest abortion methods was very low: Surgical abortion was mentioned by only 14% of female and 15% of male adolescents. There were no major differences by residence for most ways of abortion known (data not shown).

Fewer than 2% of the adolescents 15–19 years of age reported having ever tried to end a pregnancy or having had any involvement in ending a pregnancy (this percentage is for all 15–19-year-olds, though the question was only asked of those who had ever been pregnant or made someone pregnant). Among the few cases of female adolescents who had tried to end pregnancy, the methods used were tablets/pills, herbal drink or insertion of herbs and antimalarial medications (12%, data not shown). A range of places or people were visited to end the pregnancy: traditional/spiritual healer, drug shop/pharmacy, private clinic/hospital/doctor, government clinic/hospital and private nurse/

midwife (data not shown).

The prevalence of abortion among adolescents is likely to be grossly underreported, since abortion is a very sensitive and stigmatized experience. Because of the likely underreporting of personal experiences, the percentage of adolescents who say they have had close friends who tried to end a pregnancy may be a proxy for how common abortion is among adolescents. Overall, 26% of females and 22% of males had a close friend or friends who ever tried to end a pregnancy. More of the 15–19-year-old adolescents—33% of females and about 27% of males—had had at least one close friend who ever tried to end a pregnancy, compared with about 19% of females and 17% of males aged 12–14.

Key Points for Programs and Policies

- Many young people have general misperceptions about how pregnancy occurs. The majority of males and females do not know or do not believe a girl can get pregnant if she had sex standing up. A larger proportion do not know or do not think a girl can get pregnant if a boy withdraws before ejaculating. Furthermore, belief that there is no risk of pregnancy the very first time a girl has sex or if she washes herself thoroughly after sex still exists among a large proportion of Ugandan youth. These data suggest that there is a clear need for including more detailed information of how pregnancy occurs within sex education. In addition, pregnancy prevention messages need to highlight which behaviors that adolescents engage in put them at high risk for having an unintended pregnancy.
- Although most adolescents know that there are certain days in a woman's cycle when she is more likely to get pregnant, few adolescents can correctly identify this period. Education on the female reproductive cycle and knowledge of when a woman's fertile period occurs needs to be improved, particularly among male adolescents.
- Adolescent pregnancy and childbearing is common among 15–19-year-old females in a union, with nearly nine in ten having been pregnant and seven in ten having given birth. Although pregnancy among young women not in union is less common, it does occur, with one in eight of these young women having ever been pregnant and one in nine having given birth. Moreover, the level of very early childbearing among females 15–19 who are in union is not small, with one out of six having had a birth before the age of 15. Strategies for delaying pregnancy, such as abstinence and condom use, should be promoted.
- More than half of 15–19-year-old females in union want to wait 1–2 years before having a (or another) child, and an additional one in five want to wait 3–4 years. Young men want to wait even longer. About half of male 15–19-year-olds want to wait at least seven years before having a (or another) child. In order to meet the desires and needs of young people, pregnancy prevention efforts need to be targeted to these youth.
- Young people in Uganda are having abortions. While few adolescents indicate a personal experience with abortion, about one in four know a close friend who has tried to end a pregnancy. Among 15–19-year-old females, one in three report that a close friend has attempted an abortion. In addition, knowledge of safe abortion methods, such as surgical abortion, is low. The restrictions on access to safe abortion and the stigma associated with abortion suggests the need to educate young people about the consequences of unsafe abortion, improve their access to family planning and provide them with detailed information on how to prevent pregnancy.

TABLE 6.1 Percentage distribution of adolescents, by perceptions of how pregnancy occurs, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1285)	15–19 (N=1314)	Total (N=2599)	12–14 (N=1209)	15–19 (N=1302)	Total (N=2511)
Can a girl get pregnant the very first time she has sexual intercourse?						
Yes	48.6	61.1	54.9	54.3	68.7	61.7
No	26.8	23.2	25.0	27.0	23.1	25.0
Don't know	24.6	15.7	20.1	18.8	8.2	13.3
Can a girl get pregnant if she has sex standing up?						
Yes	32.1	42.6	37.4	35.2	55.4	45.7
No	36.7	30.1	33.3	34.7	26.7	30.6
Don't know	31.2	27.3	29.3	30.1	17.9	23.8
Can a girl get pregnant if she washes herself thoroughly immediately after sex?						
Yes	41.6	52.4	47.1	40.7	62.5	52.0
No	26.6	23.1	24.8	21.8	19.8	20.8
Don't know	31.9	24.5	28.1	37.5	17.7	27.3
Can a girl get pregnant if a boy withdraws before ejaculating or coming?						
Yes	28.0	24.2	26.0	16.0	16.1	16.1
No	28.5	47.9	38.3	45.0	70.1	58.0
Don't know	43.5	27.9	35.6	38.9	13.7	25.9
Are certain days when a woman is more likely to get pregnant?						
Yes	43.4	80.4	62.1	29.4	64.2	47.5
No	8.3	5.2	6.7	20.6	13.7	17.0
Don't know	48.4	14.5	31.2	50.0	22.1	35.5
Time when woman more likely to get pregnant*						
Just before period begins	24.8	21.1	22.4	16.1	22.1	20.3
During period	12.2	7.9	9.4	33.9	27.4	29.3
Right after period has ended	40.5	49.0	46.0	28.5	32.5	31.3
Half way between periods	13.8	16.1	15.3	9.6	12.7	11.8
Other	0.2	0.1	0.1	0.0	0.0	0.0
Don't know	8.5	5.9	6.8	11.9	5.4	7.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who say there are certain days when a woman is more likely to get pregnant. Sample sizes: females 12–14 (N=556); females 15–19 (N=1056); males 12–14 (N=354); males 15–19 (N=837). Note: Ns are weighted.

TABLE 6.2 Percentage distribution of older adolescents, by pregnancy and childbearing status, according to sex and union status, 2004 National Survey of Adolescents

Characteristic	Female 15-19			Male 15-19
	Not in union (N=1063)	In union (N=246)	Total (N=1309)	Total (N=1302)
Ever been pregnant/made someone pregnant				
No	87.4	12.2	73.3	97.4
Yes	12.6	87.8	26.7	2.6
Ever had a birth/fathered a child				
No	89.5	30.5	78.4	98.8
Yes	10.5	69.5	21.6	1.2
Ever had a premarital birth among those who ever gave birth*				
No	28.6	89.5	65.4	na
Yes	71.4	10.5	34.6	na
Ever had a birth by age 15				
No	96.8	84.1	94.4	na
Yes	3.2	15.9	5.6	na
Currently pregnant				
No	97.7	71.1	92.7	na
Yes	2.3	28.9	7.3	na
Wantedness of current pregnancy†				
Then	--	39.1	34.5	na
Later	--	40.6	39.1	na
Not at all	--	18.8	25.3	na
Don't know	--	1.6	1.1	na
Wantedness of last birth*				
Then	28.6	54.0	44.0	na
Later	20.0	22.7	21.6	na
Not at all	50.5	22.1	33.2	na
Don't know	1.0	1.2	1.1	na
Total	100.0	100.0	100.0	100.0

*Limited to those who ever had a birth. Sample sizes: females in union (N=163); females not in union (N=105). †Limited to those who are currently pregnant. Sample sizes: females not in union (N=23); females in union (N=64). Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 6.3 Percentage distribution of adolescents, by desired timing of next birth, according to sex, age and union status, 2004 National Survey of Adolescents

Characteristic	Female			Total	Male		
	12-14 (N=1284)	15-19 Not in union (N=244)	15-19 In union (N=1061)		12-14 (N=1210)	15-19 (N=1302)	Total (N=2512)
Desired time to wait before having a(another) child							
1-2 years	0.8	9.4	54.9	9.4	0.3	8.8	4.7
3-4 years	3.0	14.7	21.3	9.5	1.9	12.9	7.6
5-6 years	12.7	15.0	9.0	13.3	9.1	14.1	11.7
7-8 years	14.1	10.5	0.8	11.4	13.3	12.7	13.0
9 or more years	37.6	26.8	2.0	29.8	46.2	33.8	39.8
What God decides	4.8	3.7	4.1	4.2	4.1	2.9	3.5
Wait until marriage	11.8	10.4	0.0	10.1	12.7	10.1	11.4
Don't want a(another) child	1.6	2.1	1.6	1.8	1.0	0.6	0.8
Don't know	13.7	7.5	6.1	10.5	11.3	4.1	7.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 6.4 Percentage distribution of adolescents, by knowledge and experience of abortion, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1258)	15–19 (N=1315)	Total (N=2600)	12–14 (N=1210)	15–19 (N=1302)	Total (N=2512)
Knowledge of ways to abort pregnancy*						
Don't know any way	56.7	36.7	46.6	61.7	40.0	50.4
Surgical abortion	11.1	16.2	13.7	9.3	19.2	14.5
Herbal drink	27.7	44.6	36.3	27.2	42.5	35.2
Use of sharp objects	2.7	6.5	4.6	2.2	2.8	2.5
Tablet or pills	17.1	34.1	25.7	21.2	39.1	30.5
Insert herbs	6.3	9.4	7.9	2.8	4.5	3.7
Taking washing detergent	1.8	3.2	2.5	1.0	4.4	2.7
Antimalarial medication	1.6	4.0	2.8	1.2	1.5	1.4
Injections	1.5	3.4	2.5	0.2	0.6	0.4
Other method	0.6	0.9	0.8	0.9	1.0	1.0
Have any close friends who ever tried to end a pregnancy						
Yes	18.9	32.9	26.0	17.0	27.0	22.2
No	80.4	66.9	73.6	82.4	72.9	77.5
Refuse to answer	0.1	0.0	0.0	0.0	0.1	0.0
Don't know	0.6	0.2	0.4	0.6	0.0	0.3
Ever tried to end a pregnancy/been involved in ending a pregnancy						
No	99.8	98.2	99.0	100.0	99.3	99.6
Yes	0.2	1.8	1.0	0.0	0.7	0.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

Chapter 7

HIV and Other STIs

HIV and other STIs are critical health problems facing adolescents in Uganda. This chapter presents information on adolescents' awareness of and knowledge about HIV and other STIs and their experiences with STI symptoms.

Knowledge About AIDS and HIV Transmission and Prevention

AIDS awareness among adolescents has been shown to be high in other surveys, such as the Demographic and Health Surveys. Table 7.1 presents new information for those aged 12–14 that indicates that there is a very high level of awareness of AIDS, even among younger adolescents.

While awareness of AIDS is important, understanding how HIV can be transmitted and knowing effective ways of preventing transmission are even more important for adolescents to be able to take action to protect themselves. Responses shown in Table 7.1 are a combination of responses to prompted questions about modes of transmission and prevention, plus responses to a spontaneous question asked afterward if there was “anything (else) a person can do to avoid or reduce their chances of getting AIDS?” Prompted questions were used in the survey in order to construct standardized knowledge indicators that are comparable across interviews.

Among adolescents who were aware of AIDS, nearly all knew that HIV can be transmitted by having sex with a person or persons infected with the virus. It was also common knowledge among both female and male adolescents that HIV can be transmitted by sharing razors or sharp objects, or by getting injections with a needle used by someone else. Other modes of transmission commonly cited by those surveyed included mother-to-child transmission during pregnancy, delivery and breastfeeding. Females were more likely to report these ways of transmission than males.

Incorrect perceptions of how HIV can be transmitted also characterized substantial proportions of Ugan-

dan adolescents. More than 40% of female and male adolescents who were aware of AIDS thought that HIV could be transmitted via a mosquito bite and 21% of females and 16% of males thought that HIV could be transmitted by sharing food with an infected person. Rural residents were more likely to mention these modes of transmission, compared with those living in urban areas (data not shown). Furthermore, one in nine adolescents aware of AIDS believed that a young man infected with HIV can be cured if he has sex with a virgin.

The majority of adolescents who are aware of AIDS know that the transmission of HIV can be reduced by not having sex at all (92–93%); having just one partner who is not infected and who has no other partners (89%); using a condom correctly at every sexual intercourse (86–91%); and avoiding sharing needles (88–91%). Of course, these data only apply to each separate way of preventing transmission and do not convey how comprehensive adolescents' knowledge is.

Personal Ties to and Attitudes About People with HIV/AIDS

Personal ties to people with HIV/AIDS make the AIDS epidemic a real part of adolescents' lives. Having a personal tie to someone with HIV/AIDS could also make adolescents more cautious in their own risk and protective behaviors. Many young people in Uganda have personal ties to someone who has HIV or has died of AIDS.³² Table 7.2 shows that 70% of females and 63% of males who had heard of AIDS reported personally knowing someone who had HIV, and an even larger percentage knew someone who had died from AIDS (88% of females and 85% of males). As adolescents get older, they are more likely to have known someone with HIV or who has died from AIDS.

Holding negative attitudes towards people with HIV can influence one's own willingness to acknowledge risk and to get tested for HIV. Several indicators of HIV/AIDS stigma were measured concerning teachers,

vendors of unprepared food and family members. The question about school teachers was phrased (based on findings from a prior study) in terms of a female teacher in order to prevent respondents from thinking about the separate issue of male teachers and sexual relationships with students.³³ Approximately two out of three adolescents in Uganda who were aware of AIDS believed that a female teacher with HIV should not be allowed to teach in school. Roughly the same proportion reported they would not want to buy fresh vegetables from a shopkeeper or food seller with HIV.

Although many youth reported that they would want it to be a secret if a family member became infected with HIV, nearly three in four adolescents who were aware of AIDS said they would be willing to care for this family member. In general, as adolescents got older, fewer held negative attitudes about people with HIV, perhaps because older adolescents were more aware of the stigma associated with HIV/AIDS in their communities compared with younger adolescents.

Knowledge of STIs

Table 7.3 shows the proportion of adolescents who have heard of STIs other than HIV. Among those who have heard of other STIs, questions were asked about the types of STI symptoms they have heard of (an open-ended question) and about whether they had experienced an STI or STI-related symptoms.

Slightly more than half of 12–19-year-olds in Uganda had heard of STIs other than HIV, with very little difference between females and males (54% versus 56%, respectively). Older adolescents were almost twice as likely as younger adolescents to have heard of STIs other than HIV (about 70% of 15–19-year-olds versus 38% of 12–14-year-olds).

The level of knowledge of specific STI symptoms among young people is much smaller than their general knowledge. Fewer than half of adolescents who had heard of STIs could spontaneously identify an STI symptom. The symptom most commonly known by both males and females was an ulcer or sore on private parts (48% of females and 42% of males who had heard of other STIs reported this). Other symptoms identified by at least a third of females and a quarter of males included genital discharge and itching in private parts. Equal proportions of males and females (37%) reported burning pain in urination. In short, adolescents in Uganda were much more aware of HIV than they were of other STIs.

Experience of STIs

Given the fact that a number of STIs do not commonly manifest with noticeable symptoms, self-reporting of STIs is a much less valid indicator of prevalence than clinical tests. Self-reporting, therefore, captures perceptions of STI experiences and should be interpreted as a rough estimate of the prevalence among the study population. In the 2004 survey, adolescents who had heard of STIs were asked whether they had ever had an STI, and also whether they had ever experienced two common symptoms (bad-smelling, abnormal discharge or a genital sore or ulcer). Based on the fact that it is those who have ever had sex who are at risk of STIs, the proportions reporting any of these symptoms among those who had ever had sex are also indicated in Table 7.3 (last panel).

About 8% of females and 2% of males who had heard of STIs reported having had one (“yes” to a direct question). Similar proportions stated that they had experienced symptoms such as a bad-smelling, abnormal discharge. Slightly more reported having a genital sore or ulcer (9% of females and 3% of males). When the three measures of STI experience and symptoms are combined, the proportion of adolescents who have likely had an STI increases to 14% of females and 5% of males. For those who had ever had sex, 26% of females and 6% of males reported ever having an STI or one of two common symptoms of an STI.

Key Points for Programs and Policies

- Nearly all young people in Uganda have heard of AIDS. More importantly, a large percentage of Ugandan youth (92–98%) know that HIV can be transmitted by having sex with a person who is infected with the virus, by sharing razors or sharp objects, or by getting injections with a needle used by someone else. However, the survey data also show that many believe HIV can be transmitted via a mosquito bite (40% of males and females). Misconceptions of how HIV is transmitted still exist among some adolescents in the country, particularly those residing in rural areas. For instance, one in five young women in rural areas and one in six young men in rural areas believe HIV can be transmitted by sharing food.
- The majority of adolescents in Uganda know of at least one effective way of preventing HIV transmission. More than 85% of the males and females surveyed know that not having sex at all, having just one partner who is not infected and who has no other partners, using a condom correctly at every sexual inter-

course, and avoiding sharing needles are ways to avoid HIV. Adolescents living in urban areas are more likely to report these ways compared with their rural counterparts. Data suggest that education efforts on how HIV is transmitted and prevented need to be targeted towards youth, particularly in rural areas.

- While knowledge of AIDS is almost universal among young people in Uganda, nearly half have never heard of any STIs other than HIV. However, as adolescents get older, they are more likely to hear of other STIs. Specific knowledge of STI symptoms is low among Ugandan youth: Fewer than half of those who had heard of an STI could spontaneously identify a symptom. Adolescents in Uganda need to be educated about other STIs in addition to HIV.
- With one in four sexually experienced female adolescents reporting having an STI or an STI symptom, it is of crucial importance to improve education on STIs and how to avoid their transmission among both male and female youth.

TABLE 7.1 Percentage distribution of adolescents, by awareness and knowledge of HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1284)	15–19 (N=1315)	Total (N=2599)	12–14 (N=1209)	15–19 (N=1302)	Total (N=2511)
Ever heard of AIDS						
Yes	97.9	99.1	98.5	98.6	99.4	99.0
No	1.9	0.6	1.2	1.2	0.5	0.8
Don't know	0.2	0.3	0.3	0.2	0.1	0.2
The AIDS virus can be transmitted by:*†						
Having sex with persons who are infected with the virus	95.2	98.2	96.7	96.6	99.1	97.9
A mother to child during pregnancy	73.7	80.9	77.4	64.5	68.5	66.6
A mother to child during delivery	62.2	75.1	68.8	57.7	76.5	67.5
A mother to child during breastfeeding	58.5	67.5	63.1	49.2	57.1	53.3
Sharing razors or other sharp objects	91.0	93.5	92.3	92.1	96.3	94.3
Getting injections with a needle used by someone else	93.1	96.2	94.6	93.9	97.6	95.8
Having a blood transfusion	72.2	81.5	76.9	68.1	78.9	73.7
Sharing food	25.4	17.5	21.4	20.9	10.8	15.7
Mosquito bites	39.9	43.5	41.7	45.7	39.3	42.4
Witchcraft or supernatural means	16.0	11.0	13.5	15.8	7.2	11.3
Transmission of the AIDS virus can be reduced by:*†						
Not having sex at all	90.5	94.2	92.4	89.5	95.4	92.6
Having just one partner who is not infected and who has no other partners	84.8	92.5	88.7	85.8	92.3	89.2
Using a condom correctly at every sexual intercourse	80.4	91.0	85.8	86.4	95.1	90.9
Avoiding sharing needles	89.4	93.1	91.3	84.0	92.0	88.2
Can a man infected with the AIDS virus be cured if he has sex with a virgin?*						
Yes	12.7	10.6	11.6	10.9	11.4	11.2
No	73.4	81.6	77.6	74.8	84.5	79.8
Don't know	13.8	7.8	10.7	14.3	4.1	9.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who have heard of the AIDS virus. Sample sizes: females 12–14 (N=1254); females 15–19 (N=1302); males 12–14 (N=1185); males 15–19 (N=1293). †Totals may exceed 100 because multiple responses are possible.

Note: Ns are weighted.

TABLE 7.2 Percentage distribution of adolescents who have heard of AIDS, by personal ties to and attitudes about persons with HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=1257)	15-19 (N=1303)	Total (N=2560)	12-14 (N=1191)	15-19 (N=1292)	Total (N=2483)
Personally knows someone who has the virus that causes AIDS						
Yes	65.3	75.1	70.3	55.8	70.3	63.3
No	34.3	24.6	29.3	42.7	29.4	35.8
Don't know	0.4	0.4	0.4	1.5	0.3	0.9
Personally knows someone who has died from AIDS or who people said died of AIDS						
Yes	84.5	90.9	87.7	80.6	89.8	85.4
No	15.4	8.7	12.0	18.2	9.7	13.8
Don't know	0.2	0.5	0.3	1.2	0.5	0.8
If a female teacher has the AIDS virus, she should be allowed to teach in school						
Yes	31.7	36.8	34.3	28.4	43.7	36.4
No	66.0	61.1	63.5	69.5	55.0	62.0
Don't know	2.2	2.1	2.2	2.1	1.3	1.7
If knew shopkeeper or food seller had AIDS virus, would buy fresh vegetables from him/her						
Yes	28.1	35.7	32.0	26.0	47.1	37.0
No	71.5	63.6	67.5	73.6	52.6	62.7
Don't know	0.4	0.8	0.6	0.4	0.2	0.3
If a family member became infected with AIDS virus, would want it to be a secret						
Yes	66.9	68.6	67.8	55.7	60.0	57.9
No	31.8	30.9	31.3	43.7	39.6	41.5
Don't know	1.3	0.5	0.9	0.7	0.4	0.5
If a family member became infected with AIDS virus, would be willing to care for him or her						
Yes	68.6	82.3	75.6	65.9	80.4	73.5
No	30.6	17.5	23.9	33.1	19.1	25.8
Don't know	0.9	0.2	0.5	0.9	0.5	0.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 7.3 Percentage of adolescents, by awareness of and knowledge about STIs and symptoms experienced, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1282)	15–19 (N=1315)	Total (N=2597)	12–14 (N=1206)	15–19 (N=1301)	Total (N=2507)
Ever heard of STIs other than HIV/AIDS						
Yes	37.5	71.0	54.4	37.7	73.0	56.0
No	62.5	29.0	45.6	62.3	27.0	44.0
Symptoms of STIs*						
Ulcer/sore on private parts	42.8	50.4	47.8	31.2	47.7	42.3
Genital discharge	35.6	38.9	37.8	15.4	34.1	28.0
Itching in private parts	34.9	39.5	37.9	17.2	28.6	24.9
Lower abdominal tenderness/pain	20.6	13.7	16.0	9.0	11.5	10.7
Warts or growths on private parts	17.7	18.2	18.0	5.9	12.5	10.3
Burning pain in urination	29.5	40.3	36.6	22.4	43.2	36.5
Other	3.5	4.3	4.0	8.1	5.7	6.5
Don't know	17.7	15.6	16.3	38.0	19.3	25.4
Ever had:*						
An STI ('yes' to direct question)	4.8	10.0	8.2	1.3	3.0	2.4
A bad-smelling, abnormal discharge	5.0	10.0	8.3	0.4	3.1	2.2
A genital sore or ulcer	5.4	11.3	9.3	2.4	3.1	2.9
An STI ('yes' to direct question or experienced a specific symptom)	7.1	17.5	13.9	3.1	5.7	4.9
Ever had an STI ('yes' to direct question or experienced a specific symptom)†	[30.0]	25.7	26.1	3.7	6.3	5.9

*Limited to those who have heard of STIs. Totals may exceed 100 because multiple responses are possible. Sample sizes: females 12–14 (N=481); females 15–19 (N=930); males 12–14 (N=455); males 15–19 (N=948). †Limited to those who have ever had sex. Sample sizes: females 12–14 (N=40); females 15–19 (N=478); males 12–14 (N=82); males 15–19 (N=495). Note: Ns are weighted.

Chapter 8

Risk and Protective Behaviors

This chapter provides an overview of the level of risk and protection among all adolescents by synthesizing information on indicators of the current status of adolescents' sexual behavior and condom use. In addition, information on the consistency of condom use, knowledge about correctness of condom use and attitudes about condoms is presented in this chapter. Information about the context of adolescent sexual behavior, such as alcohol use and the receipt of money or gifts for sex, is also shown.

Self-Perceived Risk of HIV

Self-perceived risk of HIV can serve as a motivation for adolescents to change the behaviors that place them at risk of HIV. The question asked was: "Do you think your chances of getting HIV/AIDS are great, moderate, small or you have no chance at all?" Chart 8.1 shows the percentage distribution of adolescents' perceptions of their own risk of HIV by age and sex. Chart 8.2 shows self-perceived risk for 15–19-year-old females by union status.

Overall, at least 40% of adolescents perceived themselves to be at great risk of contracting HIV. The proportion is higher for females than for males among both 15–19-year-olds (54% versus 48%) and 12–14-year-olds (46% versus 39%). Among both young women and men, the proportion is also higher for adolescents aged 15–19 than for their younger counterparts. About three in four adolescents reported they were at high risk, and for both women and men, this proportion does not differ substantially by age.

About one in five of all female and male adolescents thought they were not at all at risk of HIV, but this differs across age-groups. Among young women, 25% of those aged 12–14 (as compared with 14% of their older counterparts) reported not being at risk. Similarly, 23% of 12–14-year-old males (compared with 15% of those aged 15–19) indicated that they were not at all at risk of HIV infection. This large difference by age in the proportion of adolescents reporting not being at risk of

HIV is understandable given that fewer 12–14-year-olds than 15–19-year-olds were sexually experienced.

Fewer adolescent women aged 15–19 who were in union considered themselves at no risk than those who are single (9% vs. 15%); however, the number of adolescents who felt this way for both of these groups was still relatively small (Chart 8.2).

Adolescent Sexual Behavior and Condom Use

We present two types of profiles of adolescents by age, each highlighting different perspectives on exposure to the risk of HIV and other STIs. The first profile (Charts 8.3 and 8.4) addresses risk for all adolescents and details changing patterns of risk and protection according to whether young women and men were in cohabiting or noncohabiting relationships. The second profile (Charts 8.5 and 8.6) focuses on those adolescents who were sexually active in the past 12 months and portrays risk and protection in terms of number of partners within the past 12 months.

Charts 8.3 and 8.4 present results on the first profile of adolescents' exposure to the risk of HIV and other STIs for females and males respectively. This profile incorporates sexual behavior (never had sex, ever had sex but not in the last 12 months, and among those who were sexually active in the past 12 months, type of partner—cohabiting or noncohabiting) and condom use over the past 12 months, all according to single years of age. The changes in sexual behavior and condom use by single-year age-groups depict the many changes adolescents go through during adolescence, from beginning sexual activity to entering a consensual union, between 12 and 19 years of age. Categories are defined to be mutually exclusive and are based on standard behavioral indicators developed by UNAIDS and other organizations to guide monitoring and evaluation of national AIDS prevention programs for young people. These categories are: never had sex, had sex but not in the last 12 months, had sex in the last 12 months with a cohabiting partner (includes spouse) and used a male condom,

had sex in the last 12 months with a cohabiting partner (includes spouse) and did not use a condom, had sex in the last 12 months with a noncohabiting partner and used a condom, and had sex in the last 12 months with a noncohabiting partner and did not use a condom.

At age 12, most adolescent women in Uganda (95%) were not sexually experienced (Chart 8.3). This proportion remained almost the same for young women aged 13 and declined steeply thereafter. Thus, by 16 and 18 years of age, 68% and 31% respectively of adolescent women had not initiated intercourse. The proportion of young women who had had sex but not in the last 12 months was generally small but showed a positive association with age. It increased from only 2% among the 12-year-olds to 8–10% among the 15–17-year-olds, and to 15% among the 19-year-olds.

Although cohabiting or being in union does not necessarily imply safety with respect to STI and HIV prevention, unprotected sexual activity with noncohabiting partners is often regarded as an indicator of risky sexual behavior. Eight to 12% of all young women aged 15–19 had had their last intercourse with a noncohabiting partner without using condoms. At each age (15–19), condom use was less prevalent with cohabiting than with noncohabiting partners: Some 1–4% of all young women in these ages had had their last intercourse with cohabiting partners and used condoms, compared with 4–10% who had had intercourse with noncohabiting partners and used condoms.

Given that few adolescent men are in union, it is not surprising that most of the sexually experienced young men had their last intercourse with noncohabiting partners (Chart 8.4). This proportion ranged from 5% among all young people aged 12 to 41% among the oldest adolescents (aged 19). Condom use at last intercourse was moderately high among older adolescents, especially those aged 18 and 19 (26–28%). Overall, the proportion of all young men who had had intercourse with a noncohabiting partner and used a condom ranged from fewer than 1% among the 12–13-year-olds, to 5% among the 15-year-olds, 17% among the 17-year-olds and 26–27% among the 18- and 19-year-olds.

Having intercourse with two or more partners is another measure often considered as an indicator of risky sexual behavior. Findings presented in Charts 8.5 and 8.6, show condom use at last sex by number of recent sex partners for adolescents who had had sexual intercourse in the last 12 months.

Overall, 94% of adolescent women aged 12–19 who were sexually active had had intercourse with only one partner in the past 12 months. This proportion consist-

ed of 23% who had used a condom at last intercourse and 72% who had not. The remaining 6% had had intercourse with two or more partners in the last 12 months, and the vast majority (75% of those with two or more partners) had used a condom at last sex. Although a small proportion of all sexually active young women had had intercourse with more than one partner, it appears that these women were aware of their relatively high risk of contracting or transmitting HIV or other STI and were trying to protect themselves or their partners by using condoms.

Among adolescent men aged 12–19 who were sexually active, 83% had had sexual intercourse with one partner in the last 12 months. Of these, 44% (or 36% of all sexually active adolescent men) used condoms at last intercourse, while the remaining 56% (or 47% of all sexually active young men) did not use the method. Altogether, 17% of sexually active young men had had intercourse with two or more partners in the past year. Slightly more than half of them (10% of all sexually active adolescent men) used the condom, while the remainder (or 8% of sexually active young men) did not.

Condom Use at Last Intercourse

Condom use often depends on the nature of the relationship (e.g., whether the partner is a boyfriend/girlfriend or a more casual partner), the relative power that the adolescent has in the relationship (e.g., whether the partner is significantly older or has given the adolescent money or gifts in exchange for sex) and whether alcohol was consumed around the time of sexual intercourse. Table 8.1 shows the percentage of adolescents who used a condom at last sex by different characteristics of the sexual relationship. Questions about money and gifts in exchange for sex and alcohol use at last sex were asked only for sex partners in the 12 months prior to the interview (if an adolescent had sex only one time in the last 12 months with their first ever sex partner, questions about alcohol use and sex in exchange for money or gifts were not asked).

Proportionately, more young women whose last sexual partner was a boyfriend used condoms at last intercourse (44%) than either those whose partner was a live-in partner (15%) or a spouse (9%). Thus, young women who had their last intercourse with their husbands were the least likely to have used the method. Among young women who were in union, there was little or no difference in the proportion who used condoms at last sex between women who were married (8%) and those who had live-in partners (11%).

Among young men, almost one-half of those whose

last intercourse was with a girlfriend reported condom use, compared with 26% of their counterparts whose last sex was with a casual acquaintance. The pattern reflects the findings among adolescents aged 15–19. Most 12–14-year-olds who were sexually active had their last intercourse with a girlfriend and 13% of them reported that they used condoms.

The age difference between partners is often regarded as an indicator of people's (especially women's) ability to negotiate condom use. Women who have intercourse with partners who are much older than them are assumed to be less likely to request or insist on condom use than those who are in relationship with someone their own age. Without controlling for the influence of other factors, this claim seems to be supported by evidence from the bivariate relationship examined in Table 8.1. Among all young women, those whose partners were slightly older (1–4 years age difference) and those whose partners were same age or younger were more likely to use condoms (37% and 32% respectively) than those whose partners were 5–9 years older (22%), 10 or more years older (17%) or older but the exact age difference was not known (11%). For those who were in union, young women whose last partners were 1–4 years older were more likely to use condoms at last intercourse than those whose partners were 5–9 years older (11% versus 6%).

For young men aged 12–19, we present results for only two groups, due to the small number of cases: those with partners who were 1–4 years older and those who were the same age or younger than their partners. The young men whose partners were 1–4 years older than them were somewhat more likely to use the condom (49%) than those whose partners were the same age or younger (43%). This pattern largely reflects the situation among adolescents aged 15–19.

Another factor that is often associated with condom use is the duration of relationship: Condom use tends to be negatively associated with the duration of relationship in that as relationships last longer, partners become more trusting of each other and less likely to use condoms. However, evidence from the current study is not conclusive on this issue. Although those women whose relationships lasted three months or less were the most likely to use the condom (48%), there is no clear pattern in the level of condom use among those whose relationships were longer than three months. While 23% of those young women whose relationships were 4–11 months long used condoms at last sex, 25–27% of those whose relationships lasted 1–2 years used the method and 21% of those whose relationships

were longer than two years used it at last intercourse. For males, a linear pattern emerged that showed that the longer the relationship, the higher the level of condom use. For example, while only 42% of males whose relationships were three months or less used a condom at their last sexual encounter, 54% of those whose relationships lasted two years used the method.

Receiving gifts or money for sex is another factor that can expose adolescents to the risk of STIs, including HIV, because receiving some sort of compensation for sex may make it difficult to insist on condom use. However, the data show the reverse to be true. The majority of both adolescent females and males aged 15–19 whose most recent partners were not their first partner or their spouse or cohabiting partner and who received gift or money for sex at last intercourse used condoms at last sex (51% of females and 60% of males). These proportions were higher than among adolescents who did not receive gifts or money in exchange for sex (35% of females and 41% of males). This is contrary to the conventional wisdom and suggests that those who received gifts or money for sex may have been aware of their higher risk for contracting HIV and were hence more determined to use condoms.

Another STI risk factor often mentioned in the literature is the use of alcohol at the time of sexual activity. However, unlike the case with receiving gifts or money described above, there was only a small difference in the reported level of condom use by whether or not respondents or their partners used alcohol at last intercourse.

In general, adolescent men tended to report more condom use than women. This phenomenon is not unique to the present study and possible reasons for this difference have been articulated in previous studies. The association between condom use and the factors included in Table 8.1 are not always in the expected direction, as was the case for condom use and partner's age difference and condom use and transactional sex. However, it should be noted that some of these results may have been affected by the small sample sizes involved. In such cases, the findings need to be interpreted with caution. In addition, no causal relationship is implied in the above discussion.

Table 8.2 shows reasons for not having used a condom at last sex among adolescents who had had sex in the last 12 months and did not use a condom. The reasons presented below were spontaneous responses by the respondent: no predetermined reasons were read out to them by the interviewers.

Both female and male respondents offered similar reasons for nonuse of the method. Among adolescent

females who did not use condoms at last sex, the most prevalent reasons for not using the method were that they felt they were safe (31%) and they did not have a condom (27%). Similarly, among adolescent males, the most commonly mentioned reasons for not using the condom at last intercourse were that they felt safe (36%) and didn't have condom (34%). Less prominent reasons given by young women were that their partner refused (15%) and that they wanted to get pregnant (11%).

The reasons for nonuse differed by age and union status. For young women aged 15–19, there were some differences in these responses by union status. Among those who were in union, a feeling of being safe (36%) was the most common reason for not using the condom at last intercourse, followed by not having a condom (21%). Other somewhat important reasons were wanting to get pregnant (15%) and partner refusal (13%). On the other hand, their counterparts who were not in union most commonly reported not having condom (30%) as the reason for not using the method, followed by a feeling of being safe (25%) and partner's opposition (20%). The reason for not using the condom differed somewhat between younger and older adolescent men. Those who were 15–19 years old mentioned a feeling of safety more frequently (40%) than “didn't have condom” (31%) as their reason for not using the condom. On the other hand, the reason that was most frequently given by adolescents aged 12–14 for not using the condom at last intercourse was not having a condom (41%), followed by feeling safe (21%). More than one in five of younger adolescents' responses fell into the “other” category.

It is important to note that, for both young women and men, feeling safe from STIs and not having condoms at the time of last intercourse are the main reasons adolescents do not use condoms. However, it is not known whether young people are as secure as they claimed. Much of this depends on the sexual behavior of their partners. For instance a woman may feel secure and free from HIV infection because she is having sex only with her husband. But whether or not this sense of security is true or false depends on whether the husband is having sex only with her and his HIV status. Only mutual monogamy between two uninfected partners offers true security against infection in the case of unprotected sex.

Consistent Condom Use and Reported Problems with Recent Condom Use

Condoms' effectiveness at preventing pregnancy and the transmission of HIV is determined by how consistently and correctly condoms are used. The measure of

condom use shown in most studies is condom use at last sex, which assumes that condom use at the last sex serves as a proxy for condom use at every act of sexual intercourse. In this survey, questions were also asked about the frequency of sexual intercourse and condom use among adolescent males in the three months prior to the survey with up to three different sex partners. These questions were not asked of female adolescents for three reasons: 1) the assumption was that females would not be as accurate in reporting condom use problems as males would be; 2) female adolescents report fewer sex partners on average; and 3) the focus was on condom use patterns among adolescents with multiple sex partners (i.e., those at high risk of transmitting HIV or other STIs if condoms are not used correctly and consistently).

Table 8.3 shows different measures of condom use consistency and the percentage of young men who recently experienced problems in using condoms correctly. These measures are based on the summary of all events in the three months prior to the survey (sex acts and condom use at each, for up to three partners). Those who reported “don't know” or refused to answer were coded as missing on the measures of sexual intercourse and condom use.

Sexual activity among young people is often characterized as sporadic. Almost two-thirds of young men aged 15–19 who were sexually active in the past three months had intercourse three times or less during this period, while 12% did so 10 or more times. The average number of sexual acts over the three months period was 4.5—most of them with a girlfriend or cohabiting partner (4.2, on average).

However, adolescent men reported having had intercourse more often than they used condoms, indicating that they were not using condoms consistently. Almost half (48%) of sexually active young men did not use condoms in the three months before the survey. About one-third used the method once or twice, 11% used it three or four times and the remaining 20% used it five or more times during this period.

Relating the number of acts of sexual intercourse with the number of times condoms were used in the past three months indicates that 48% of young men did not use condoms at all during any of their acts of sexual intercourse, while 35% of young men used the method every time they had sex. Seven percent used condoms in 36–50% of their sexual acts and another 4% did in 51–75% of the times they had intercourse.

In addition to using condoms consistently, correct use of the method is also important for effective pro-

tection. One measure of correct use is the particular time condoms are put on in the course of sex. Ideally, condoms should be put on before sex begins. But not all young men who use the method do this. In this study, 22% of adolescent men who had had sex in the last three months with someone who was not their first sexual partner or who had had sex more than once said they started to have sex without a condom and then put one on after some delay. However, only 7% of sexually active young men reported experiencing condom breakage or slippage in the last three months.

Knowledge and Attitudes About Male Condoms

Consistency and correctness of condom use are likely to be associated with people's knowledge and attitudes about the method. It is important to know then whether adolescents who say they have heard of the condom have seen a formal demonstration of condom use and whether they know how to use a condom correctly, and to know their views about condom use. Table 8.4 shows adolescents' knowledge about the correct use of condoms, and has one indicator of self-efficacy in condom use.

Although most young women and men said they had heard about condoms, considerably smaller proportions had seen a formal demonstration of its use. Only 37% of adolescent women had seen a demonstration, and this proportion was higher among older adolescent women (aged 15–19), compared with those aged 12–14. The same proportion of young men and women who were aware of condoms had seen their use demonstrated (37%), but the difference between younger male adolescents (24%) and older ones (48%) is larger than observed for young women.

About three-quarters of adolescent females and males agreed with the statement that the condom should always be put on before sexual intercourse starts (73% and 77%, respectively). Again, not surprisingly, 15–19-year-old adolescents were more likely to have agreed correctly with this statement than the 12–14-year-olds. In general, young women were more likely to say that they “don't know” when responding to this question than young men.

A high proportion of both young men and women also reported that they knew that condoms should be put on the penis only if the penis is fully erect or stiff. Sixty-five percent of young women and 83% of their male counterparts agreed with this statement. Among both females and males, older adolescents were more likely to agree with the statement than their younger counterparts. Also, perhaps not surprisingly, young

men aged 15–19 were somewhat more likely to agree with this statement than young women of the same age. The proportion indicating that they “don't know” the answer to the statement was about twice as high (27%) among young women as among young men (12%).

The vast majority of young women (60%) and men (69%) disagreed with the statement that condom can be used more than once. Thus, most adolescents agreed correctly that condoms cannot be reused. For both females and males, adolescents aged 15–19 were more likely to disagree with the statement than were 12–14-year-olds.

Adolescents' attitudes about condom use can influence whether and how they will use condoms. Negative attitudes (e.g., condoms reduce sexual pleasure) are likely to make adolescents less willing to use condoms consistently. Table 8.5 shows adolescents' attitudes about condom use and their confidence in using condoms.

One-third of female adolescents and almost 40% of their male counterparts agreed that the male condom reduces sexual pleasure. A slightly higher proportion of females (41%) and 36% of males reported that they didn't know. Adolescents aged 12–14 were more likely to say they did not know whether or not condom reduces sexual pleasure than those aged 15–19.

The majority of both adolescent females and males (52–54%) believed that using a condom is a sign of not trusting one's partner. Close to three in 10 (28–29%) believed that this is not so and the remainder (18–20%) had no opinion. More of the older adolescent males tended to hold this belief than the younger ones (59% versus 44%). On the other hand, the belief was equally strong among both groups of adolescent females: 52% among 12–14-year-olds and 55% of those aged 15–19. Almost twice as many younger adolescent women as older ones and about three times as many younger men as their older counterparts believed that using a condom is a sign of not trusting a partner.

A higher proportion of adolescent females (58%) than males (47%) agreed that it is embarrassing to buy or ask for condoms. This view tended to be more common among younger than older adolescents (64% versus 53% for females, and 53% versus 41% for males). Almost twice as many younger adolescent males than females said they did not know the answer to this statement.

About half of the young women (51%) believed that they were very or somewhat confident that they could negotiate condom use. Similarly, about half of young men (55%) said that they were very or somewhat confident that they knew how to use a condom. Among

both sexes, older adolescents were more likely to feel confident about negotiating condom use and knowing how to use the method than adolescents aged 12–14.

Recent Experiences with Cutting, Piercing and Injections

Other social and cultural practices that can potentially place adolescents at risk of HIV transmission are using unclean, sharp instruments or blades for cutting or piercing and using unclean needles for injections. Table 8.6 shows the percentage of adolescents who reported having received any cuts or piercing with blades or sharp instruments in the 12 months prior to the survey. Questions were not asked about whether the blades or sharp instruments were sterilized or were shared with others because of the assumption that adolescents would not readily know. The measure is simply a rough proxy for exposure to potentially unsafe blades or other sharp instruments. These practices may be cultural or social and they may be more concentrated among certain ethnic groups.

Fairly high proportions of both young women (37%) and men (46%) received any cut or piercing with blades or other sharp instruments in the past year. While these practices tended to be more common among males than females, younger adolescents (women and men) were as likely as their older counterparts to be involved in these practices. Although scarification practices were traditionally important in Uganda, such practices are no longer common and are not likely to explain these high percentages. Cuts and punctures may more likely be the result of piercing the ears, using razor blades to shave or cut nails, or performing domestic work, such as digging, cutting firewood, or peeling matooke, potatoes and cassava.

Table 8.6 also shows the percentage of adolescents who received an injection in the 12 months prior to the survey, the number of injections received and the type of person who administered the last injection. The questions are based on World Health Organization injection practice indicators. Again, questions were not asked about whether the injection needle was sterilized or had been shared with others. The measures do not show exposure to HIV transmission: they simply indicate the prevalence of injections (number per person per year) and the administration of injections by unqualified people (percentage receiving injections from an unqualified provider). Recent research has shown that unsafe injections are not a major mode of HIV transmission in Sub-Saharan Africa, and that sexual transmission remains the primary means by which HIV

has spread in the continent.³⁴ Nevertheless, the high prevalence of injection as a form of treatment in Uganda suggests that this issue should be given some attention, particularly as it points to the possibility that a high proportion of the population is seeking treatment for some health issues.

About 60% of adolescent females and males received any injections in the past year, and the percentage was higher among 12–14-year-old males than older males (70% versus 53%, respectively), but relatively similar among female adolescents in the two age-groups. The massive measles campaign, which targeted those aged 14 and younger in 2003, may partially explain these high percentages.

Almost half of adolescents (47% of females and 48% of males) who received an injection in the past 12 months received one or two injections. Another 36–37% of both sexes received 3–5 injections during the same period and 16% received six or more. There is little difference in the frequency with which young women and men received injections in Uganda. There is also no noticeable difference in the number of injections received by age among adolescent males. On the other hand, younger adolescent women received fewer injections than their older counterparts.

The overwhelming majority of young women and men who received injections in the past year did so from nurses or doctors (79–83%). Interestingly, more young men than young women reported receiving injections from doctors (32% versus 19%, respectively). Other sources of injection reported by both young women and men are friends/family and local injection doctors (7% and 11% among females, and 8% and 6% among males, respectively). Only small proportions of both sexes went to pharmacists or drug vendors or self-administered the injections.

Key Points for Programs and Policies

- Many adolescent women and men perceive themselves to be at great risk of HIV infection. This perception is higher among young women than men and among older adolescents compared with their younger counterparts. Such individual awareness leads to adolescents adopting protective behaviors, such as using condoms, avoiding unprotected sexual intercourse and going for voluntary counseling and testing. Young people who perceive themselves to be at high risk to HIV, are more likely to delay or stop sexual activity or to overcome shyness and purchase condoms more readily.

- By age 15, 32% of young women and men have become sexually active. By the time they turned 18, the majority of both young women (69%) and young men (60%) have had intercourse. However, sexual activity is usually sporadic among young people: many of those who have had intercourse are often not currently sexually active. Therefore, whether or not they use it consciously as a protective behavior, a moderately high proportion of adolescents in Uganda are protected by abstinence against the risks of STIs and/or unwanted pregnancy.
- Condom use is moderately high among adolescents, and it is the most commonly used contraceptive method among people in this age-group. Young men are more likely to report use of the method than women. At the same time, although most sexually active adolescent women and men have intercourse with only one and most often a regular partner, young men tend to engage in sex with multiple and noncohabiting partners than women. Thus, the higher reporting of condom use among young men may be associated with the higher risk of exposure to HIV. Condom use among adolescents should continue to be promoted in Uganda, particularly among high-risk groups.
- While a substantial proportion of sexually active male adolescents use the condom, the vast majority of them do not use the condom consistently. Only about one-third of young men aged 15–19 who had had intercourse in the three months preceding the survey used condoms every time they had sex. But knowledge of correct use of the condom is high among young men. Consequently there is a need to help young people translate this knowledge to actual behavior. The reasons for nonuse of the condom by adolescent males need to be further explored and better understood. Also, availability of condoms should be improved to promote consistency of its use.
- Awareness of the condom among adolescent women and men aged 15–19 is very high. However, when it comes to exactly what they know about the method, knowledge tends to lag behind awareness. For example, many of those who reported knowing about condoms have not seen their use demonstrated. Although knowledge of how to use a condom is relatively high, there is always room for improvement when it comes to educating young people about correct use; thus, promotion of condom demonstrations should continue.

There remains a great deal of negative perceptions about the condom among young women and men in Uganda. Particularly of note are the proportions that believe that using a condom is a sign of not trusting one's partner and that it is embarrassing to buy or ask for condoms. In general, young men tend to be less favorably disposed toward the condom than their female counterparts. Condom campaigns should promote condoms as a way to show care for one's partner, rather than demonstrating mistrust.

- The fact that a high proportion of adolescents received injections and most obtained them from qualified health care professionals (nurses and doctors) suggests that young people are seeking treatment from appropriate sources, even if this is more for general health than for sexual and reproductive health. Thus, while there is need for more research on this issue, the same channel that young people use to reach health care providers to obtain injections can be potentially useful to effect improvement in adolescents' access to sexual and reproductive health services by trained providers.

TABLE 8.1 Percentage of adolescents who had sexual intercourse in the last 12 months and used a male condom at last sex, by relationship type, age of partner, duration of sexual relationship, gifts or money received, and alcohol use, according to sex, age and union status, 2004 National Survey of Adolescents

Characteristic	Females				Males		
	12-14 (N=46)	15-19 Not in union (N=251)	15-19 In union (N=234)	Total (N=532)	12-14 (N=90)	15-19 (N=407)	Total (N=497)
% using condom by relationship to last sex partner							
Spouse	--	--	8.4	8.5	--	--	--
Live-in partner	--	--	11.3	15.3	--	--	--
Boyfriend/girlfriend	[27.8]	48.7	--	44.4	12.5	56.0	49.0
Casual acquaintance	--	--	--	[40.7]	--	[31.8]	25.8
Commercial sex worker	--	--	--	--	--	--	--
Other	--	--	--	--	--	--	--
% using condom by age difference with last sex partner							
Partner is 10+ years older	--	--	[12.9]	16.7	--	--	--
Partner is 5-9 years older	--	[48.0]	6.3	22.0	--	--	--
Partner is 1-4 years older	[32.0]	52.9	11.4	36.5	--	52.6	49.3
Partner is older, don't know specific age	--	--	--	11.1	--	--	--
Partner is same age or younger	--	--	--	32.4	7.0	50.9	43.2
Don't know	--	--	--	12.5	--	--	--
% using condom by duration of last sexual relationship							
Had sex one time only	--	[33.3]	--	24.5	[6.9]	39.2	30.1
3 months or less	--	[66.7]	--	48.4	[16.0]	47.3	41.5
4-11 months	--	[40.5]	[8.3]	22.5	--	49.4	43.0
1 year	--	[43.8]	[8.0]	26.7	--	55.7	52.1
2 years	--	36.4	11.5	25.4	--	[64.4]	54.4
More than 2 years	--	[45.7]	9.0	20.5	--	[62.9]	[59.5]
% using condom by gifts or money received for sex*							
Received gifts or money	--	53.2	na	51.2	--	68.3	60.3
No gifts or money	--	[40.9]	na	34.5	[11.4]	47.5	41.4
% using condom by alcohol use at last sex†							
Partner or respondent drank alcohol at last sex	--	--	[13.3]	21.4	--	[41.9]	[44.1]
No alcohol at last sex	[32.1]	47.4	8.4	27.7	12.7	52.2	45.8

*Question not asked if most recent partner was the first sex partner ever and had sex only one time or if partner was a spouse or cohabiting partner. Sample sizes: females 12-14 (N=29); females 15-19, not in union (N=185); females 15-19, in union (N=1); males 12-14 (N=66); males 15-19 (N=323). †Question not asked if most recent partner was the first sex partner ever and had sex only one time. Sample sizes: females 12-14 (N=31); females 15-19, not in union (N=218); females 15-19, in union (N=233); males 12-14 (N=66); males 15-19 (N=349). Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25-49.

TABLE 8.2 Percentage distribution of adolescents who had sex in last 12 months and did not use a condom, by reasons for nonuse of condoms at last sex, according to sex, age and union status, 2004 National Survey of Adolescents*

Characteristic	Female			Total (N=351)	Male		
	12-14 (N=21)	15-19			12-14 (N=56)	15-19 (N=169)	Total (N=225)
		Not in union (N=118)	In union (N=212)				
Wanted to get pregnant/make someone pregnant	--	5.9	15.1	11.4	0.0	2.4	1.8
Partner refused	--	19.5	12.7	14.5	1.8	5.3	4.4
Didn't have condom	--	29.7	20.8	26.8	41.1	31.4	33.8
Felt safe	--	25.4	36.3	31.3	21.4	40.2	35.6
Didn't know how to use	--	0.0	0.0	0.0	3.6	7.1	6.2
Other	--	5.9	7.5	6.6	23.2	11.2	14.2
Pregnant/partner pregnant	--	3.4	1.9	2.3	0.0	0.6	0.4
Don't know	--	10.2	5.7	7.1	8.9	1.8	3.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

*Question not asked if respondent had sex only one time with first sex partner. *Note:* Ns are weighted. "--" = N is 24 or fewer.

TABLE 8.3 Percentage distribution of males aged 12–19 who had sex in the last three months, by frequency of sexual intercourse, condom use and experiences with condom problems, 2004 National Survey of Adolescents

Characteristic	Males (N=295)
Number of acts of sexual intercourse in last 3 months	
1	34.4
2	15.9
3	12.3
4	9.9
5	5.0
6	4.6
7	2.6
8	1.7
9	2.0
10	3.1
11+	8.7
Total	100.0
Mean number of acts of sexual intercourse in last 3 months per sexually active young man	
Total	4.5
With a girlfriend or cohabiting partner	4.2
With other type of partner (casual acquaintance, commercial sex worker, other)	0.3
Number of times a male condom was used in last 3 months	
0	48.2
1	20.4
2	10.5
3	6.3
4	4.7
5	1.6
6	1.6
7	0.9
8	0.7
9	1.3
10	1.4
11+	2.3
Total	100.0
Mean number of times a male condom was used in last 3 months per sexually active young man	
Total	1.7
With a girlfriend or cohabiting partner	1.6
With other type of partner (casual acquaintance, commercial sex worker, other)	0.1
Proportion of acts of sexual intercourse where a male condom was used per sexually active young man	
0%	48.2
1–25%	3.3
36–50%	7.4
51–75%	4.3
76–99%	1.6
100%	35.1
Total	100.0
Ever started having sex without a male condom and then put one on later in last 3 months*	
No	78.4
Yes	21.6
Total	100.0
Ever had a male condom break or slip off during sex in the last 3 months*	
No	92.8
Yes	7.2
Total	100.0

*Question not asked if partner was the first sex partner ever and had sex only one time.
Sample size: males (N=151). Note: Ns are weighted.

TABLE 8.4 Percentage distribution of adolescents who have ever heard of a male condom, by knowledge about male condoms, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1034)	15–19 (N=1241)	Total (N=2275)	12–14 (N=1087)	15–19 (N=1267)	Total (N=2354)
Ever seen a formal condom demonstration						
Yes	30.3	41.9	36.6	24.4	47.8	37.0
No	69.1	57.9	63.0	75.1	52.0	62.7
Don't know	0.6	0.2	0.4	0.6	0.2	0.3
Condoms should always be put on before sexual intercourse starts						
Agree	68.4	76.6	72.9	70.0	83.8	77.4
Disagree	14.0	13.1	13.5	15.2	12.9	14.0
Don't know	17.6	10.3	13.6	14.8	3.3	8.6
Condoms should only be put on a fully erect or stiff penis						
Agree	56.4	71.6	64.7	74.7	90.9	83.4
Disagree	8.8	8.0	8.4	5.4	3.9	4.6
Don't know	34.8	20.4	26.9	19.9	5.2	12.0
Condoms can be used more than once						
Agree	23.5	22.9	23.2	15.2	14.9	15.1
Disagree	55.7	64.0	60.2	59.4	76.4	68.6
Don't know	20.7	13.1	16.6	25.3	8.7	16.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 8.5 Percentage distribution of adolescents, by attitudes about male condoms, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=1034)	15-19 (N=1235)	Total (N=2269)	12-14 (N=1091)	15-19 (N=1269)	Total (N=2360)
Condoms reduce sexual pleasure						
Agree	27.8	38.1	33.4	29.3	47.4	39.0
Disagree	22.7	27.4	25.3	23.1	27.6	25.5
Don't know	49.5	34.5	41.3	47.6	25.1	35.5
Using a condom is a sign of not trusting your partner						
Agree	52.4	54.9	53.8	43.7	59.2	52.1
Disagree	24.9	32.0	28.8	25.9	29.4	27.8
Don't know	22.7	13.1	17.5	30.4	11.4	20.2
It is embarrassing to buy or ask for condoms						
Agree	63.6	52.7	57.7	53.2	41.2	46.8
Disagree	27.9	41.2	35.2	31.3	53.4	43.2
Don't know	8.4	6.1	7.1	15.5	5.4	10.1
Level of confidence in getting male partner to wear a condom (females)/knowing how to use a condom (males)						
Very confident	20.7	41.2	31.9	13.1	38.7	26.9
Somewhat confident	21.8	17.5	19.4	26.0	29.5	27.9
Not at all confident	57.5	41.3	48.7	60.9	31.8	45.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 8.6 Percentage distribution of adolescents, by recent experiences with other potential social and cultural risk factors, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1282)	15–19 (N=1312)	Total (N=2594)	12–14 (N=1207)	15–19 (N=1299)	Total (N=2506)
Received any cuts or piercings with blades or other sharp instruments in last 12 months						
Yes	35.5	38.5	37.0	47.1	44.3	45.6
No	64.5	61.5	63.0	52.9	55.7	54.4
Received any injections in last 12 months						
Yes	60.0	57.2	58.6	69.9	53.1	61.2
No	40.0	42.8	41.4	30.1	46.9	38.8
Number of injections received in last 12 months*						
1	28.9	21.1	25.0	30.8	27.5	29.3
2	21.6	22.0	21.8	19.1	19.2	19.2
3	14.7	17.6	16.1	16.8	17.2	17.0
4	10.8	10.4	10.6	8.9	8.7	8.8
5	10.8	9.5	10.1	9.9	9.2	9.6
6+	13.2	19.5	16.3	14.5	18.2	16.2
Person who administered last injection received in last 12 months*						
Doctor	18.5	19.6	19.0	31.0	32.6	31.7
Nurse	58.6	61.7	60.1	52.4	50.1	51.3
Pharmacist	0.9	1.5	1.2	1.5	2.3	1.9
Drug vendor	2.5	1.7	2.1	0.2	0.7	0.5
Self	0.1	0.0	0.1	0.1	0.3	0.2
Friends or family	8.2	5.7	7.0	7.5	7.8	7.6
Local injection doctor	11.1	9.9	10.5	6.1	5.8	5.9
Other	0.1	0.0	0.1	1.2	0.4	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to adolescents who received an injection in the last 12 months. Sample sizes: females 12–14 (N=768); females 15–19 (N=750); males 12–14 (N=841); males 15–19 (N=692). *Note:* Ns are weighted.

Chart 8.1 Self-perceived risk of HIV among adolescents by sex and age, 2004
National Survey of Adolescents

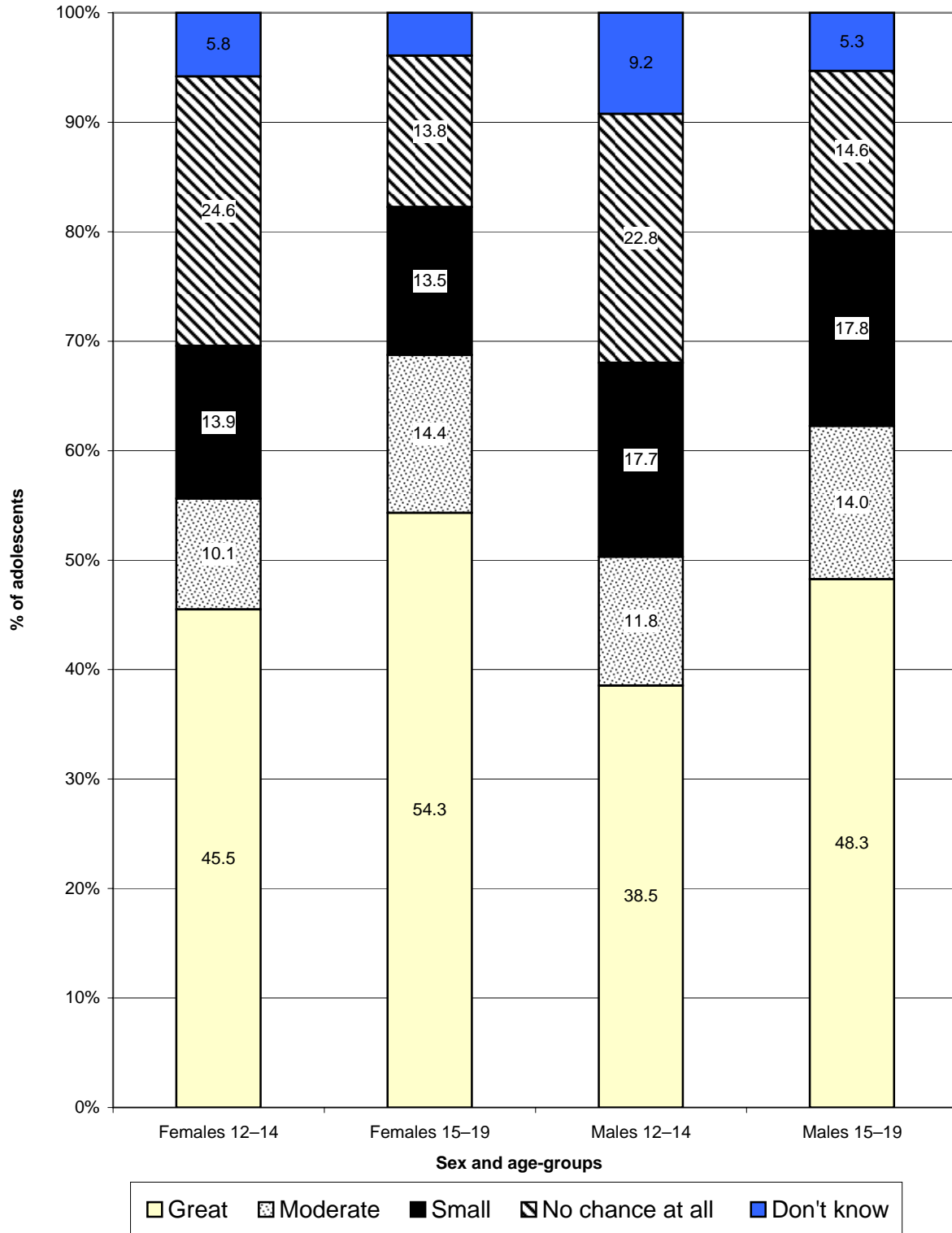


Chart 8.2 Self-perceived risk of HIV among 15–19-year-old females by union status, 2004 National Survey of Adolescents

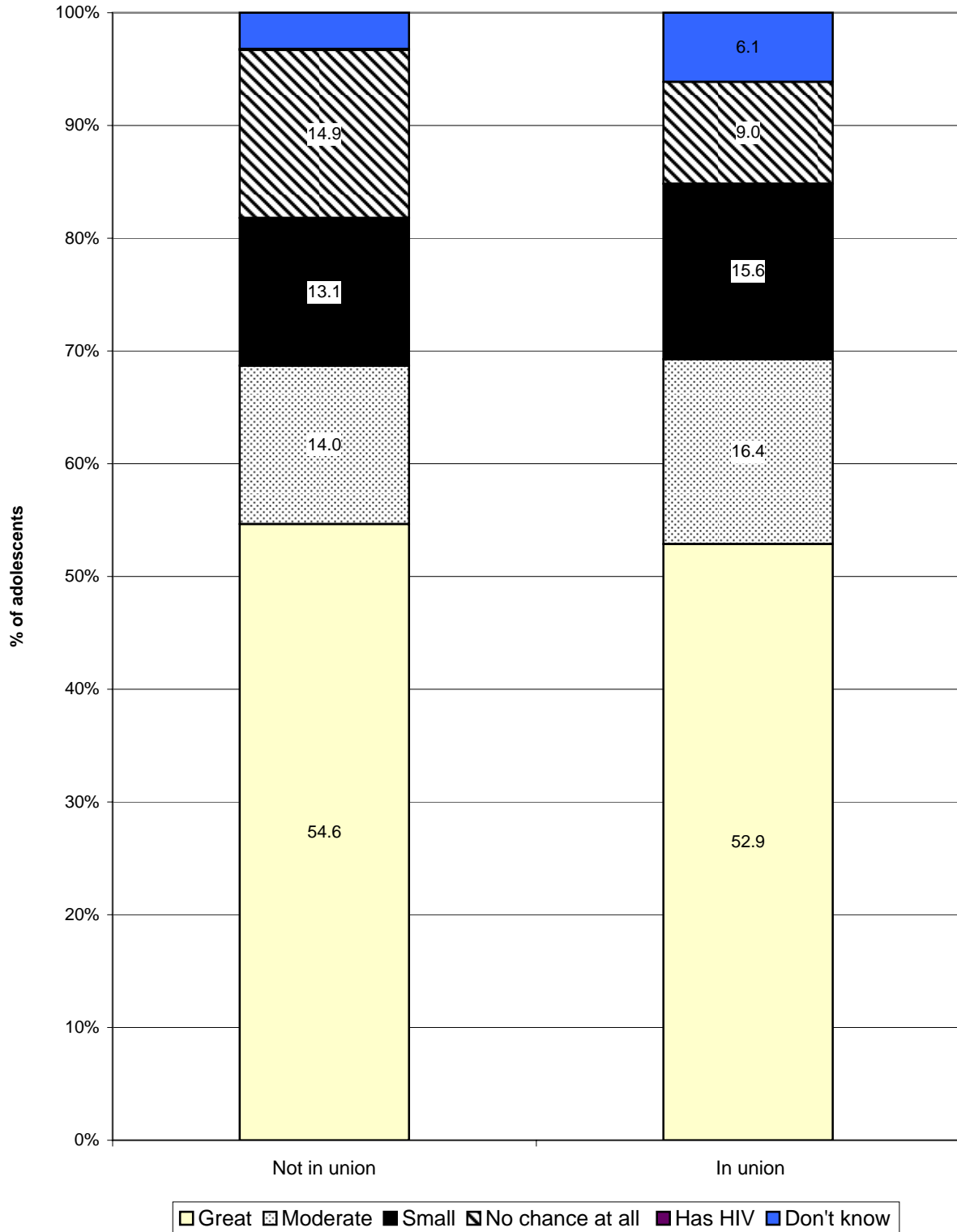


Chart 8.3 Sexual behavior and condom use at last sex among female 12–19-year-olds, 2004 National Survey of Adolescents

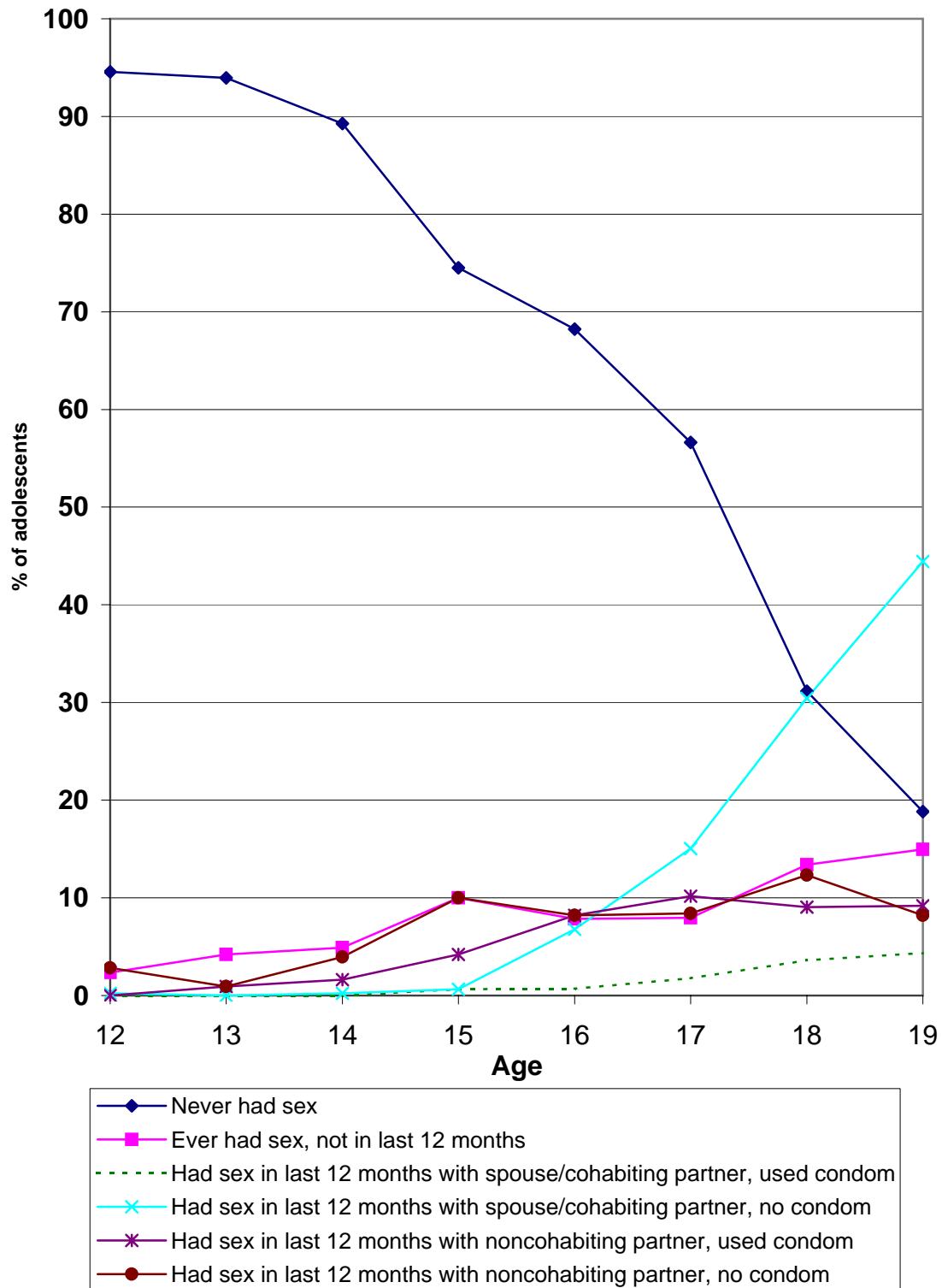


Chart 8.4 Sexual behavior and condom use at last sex among male 12–19-year-olds, 2004 National Survey of Adolescents

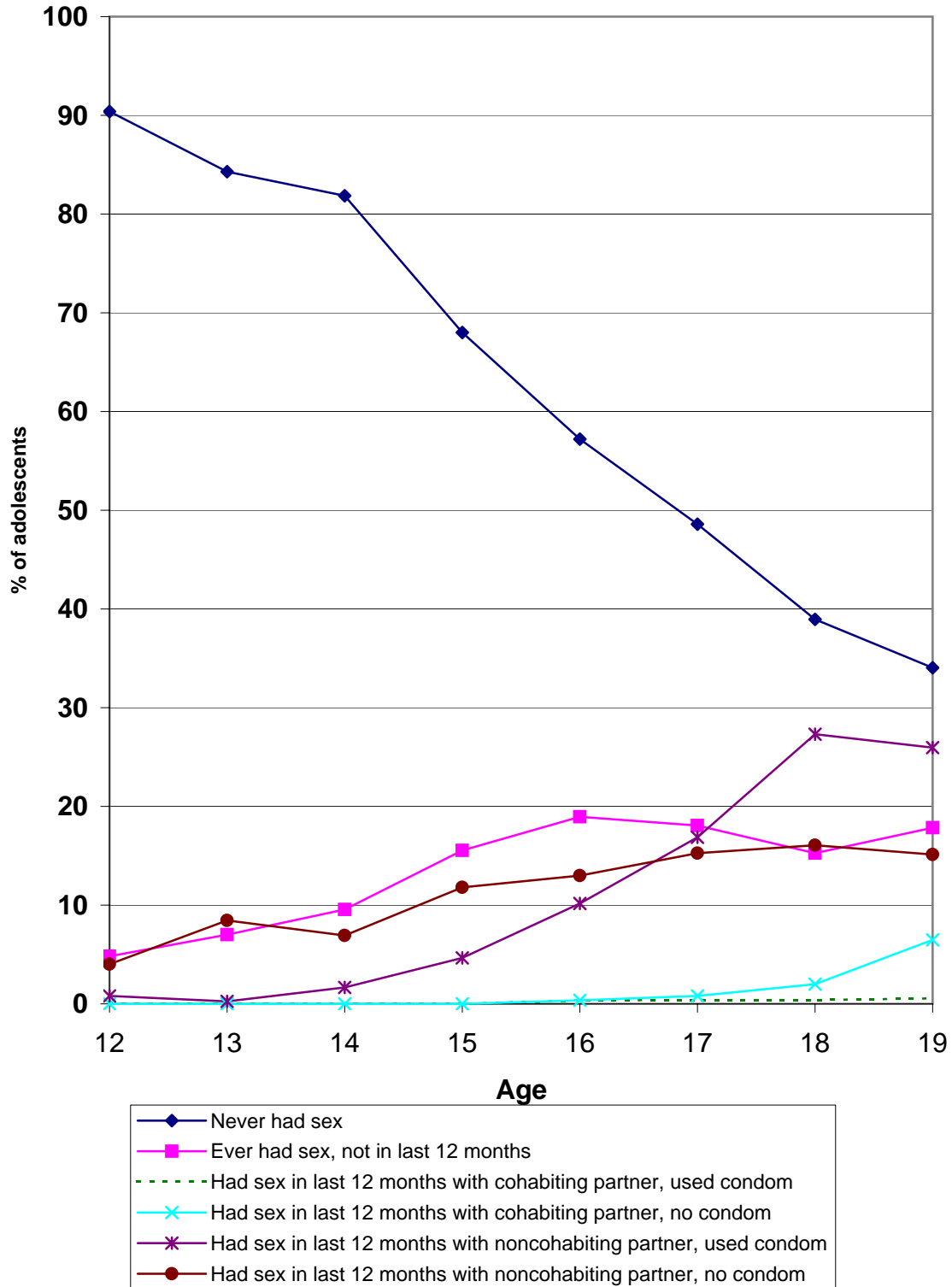
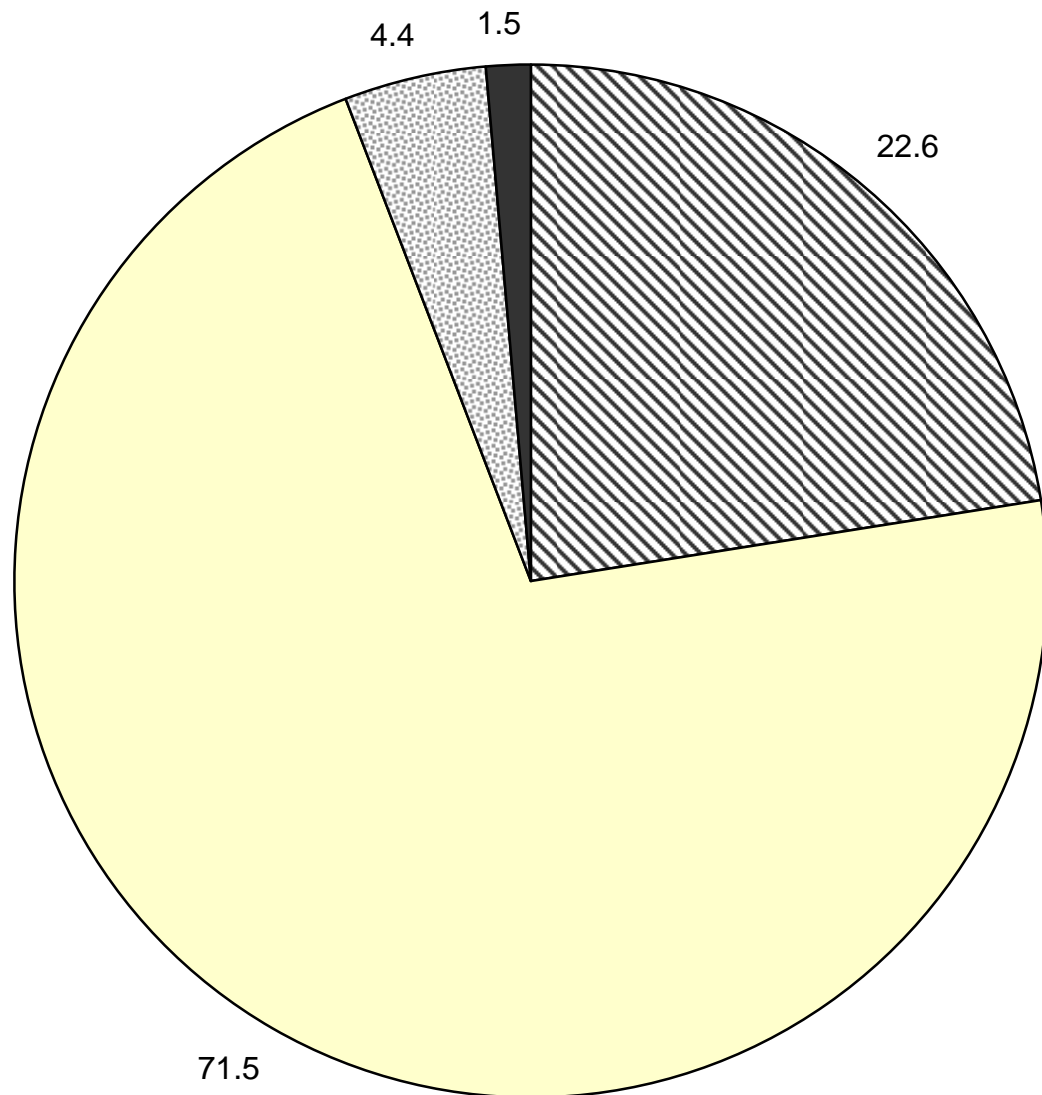
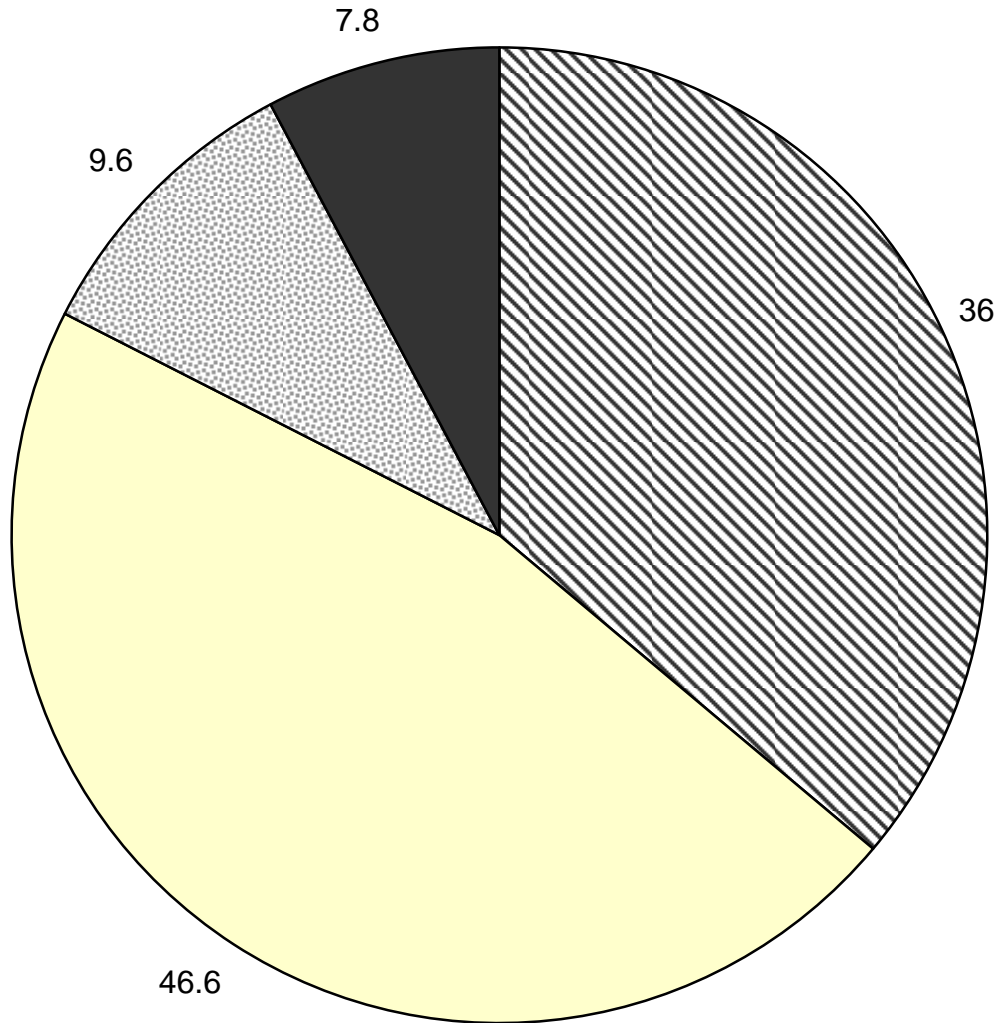


Chart 8.5 Sexual behavior and condom use at last sex among female 12–19-year-olds who had sex in last 12 months, 2004 National Survey of Adolescents



■ 1 partner in last 12 months, used condom	□ 1 partner in last 12 months, no condom
■ 2+ partners in last 12 months, used condom	■ 2+ partners in last 12 months, no condom

Chart 8.6 Sexual behavior and condom use at last sex among male 12–19-year-olds who had sex in last 12 months, 2004 National Survey of Adolescents



■ 1 partner in last 12 months, used condom	□ 1 partner in last 12 months, no condom
▨ 2+ partners in last 12 months, used condom	■ 2+ partners in last 12 months, no condom

Chapter 9

Sexual and Reproductive Health Information and Services

This chapter addresses adolescents' awareness, preferences, evaluations and utilization of different types of information sources and health providers for contraceptive methods, treatment of STIs, HIV prevention, and voluntary counseling and testing for HIV. We present results according to modern versus traditional providers, and for the public versus private sectors, as these distinctions are relevant for determining policy and program implications. Adolescents' reports of barriers to obtaining information and treatment for different sexual and reproductive health problems are also described.

Mass Media

The mass media is one means of conveying information to adolescents and to the public at large. An advantage for this mechanism is that it has the potential to reach the general population, and is less constrained than some other mechanisms (e.g., formal sex education is constrained by school attendance). A disadvantage is that not everyone has access to certain types of media and some people do not have access to any form of mass media at all.

The survey shows that access to the mass media was fairly high, with at least 75% of all adolescents having had access to at least one form of mass media (Table 9.1). The radio was the most accessed form of mass media (80% listened at least once a week) followed by newspapers/magazines (25% read it at least once a week), while the Internet was the least accessed (only 1–2% of female or male adolescents who ever attended school had ever used the Internet). The findings also reveal that there are gender differences in access to mass media. The percentage of adolescent girls who had no access to any form of mass media was about twice that of adolescent boys across all age-groups (21% and 11%, respectively). Access among adolescent boys was consistently higher than among adolescent girls across all forms of mass media (both print and electronic). It is important to note that these gender differences in media

access were more pronounced in radio listenership and, to some extent, television viewership.

Sex Education Experiences and Attitudes

Sex education experiences

Approximately half of the adolescents who had attended school said that their school offered sex education classes or talks (Table 9.2 and Chart 9.1). And an additional 10% had attended schools where they were offered classes on sex education, but they did not attend (Chart 9.1).

Regardless of gender, higher percentages of schools offering sex education were reported among adolescents aged 15–19 compared with 12–14-year-olds, indicating that sex education in schools is reaching adolescents at secondary or upper primary level. This notion is further confirmed by the indicated age at which respondents first attended classes or talks on sex education.

However, it is important to note that the age at which adolescents were exposed to sex education in schools appears to have decreased, as reflected by the relatively high percentage (27%) of 12–14-year-olds who reported having attended their first sex education talks or classes when they were younger than 12 years old. The corresponding percentage among 15–19-year-olds is only about 5%. Of those who had attended sex education classes, most reported attending prior to their first sex (87% of young women and 74% of young men). This difference may be attributed to the Presidential Initiative on AIDS Strategy for Communication to Youth. Implemented in all primary schools in 2004, this initiative provided sexual reproductive health information to all school-going children through school assemblies.

The study findings reveal a well-balanced coverage of various sex education topics in the classes attended by young people. However, a limitation of the data is that details of what was taught in a topic area are unknown (e.g., contraception could involve a simple mes-

sage of abstinence or a full introduction to different methods of contraception). On average, more than 80% of the adolescents who had ever attended sex education classes or talks in schools reported exposure to issues of pregnancy and STI prevention. It is important to note that the questions on topics covered and how classes were taught were prompted (that is, the responses shown in Table 9.2 were part of the question text read out to the respondent).

According to the findings, sex education in schools was predominantly delivered by teachers (85% of females and 86% of males) and mainly through lectures (reported by 74% of females and 80% of male adolescents who had ever attended sex talks or classes), followed by small group discussions (reported by 39% of females and 28% of males).

The above findings clearly indicate that schools are an important source of sex education for Uganda's adolescents, especially given the country's high rates of school enrollment, with 96% of females and 98% of males ever attending school.* However, a considerable percentage of adolescents (more than 50%) were not exposed to sex education in schools, primarily because their schools did not have sex education programs. Other adolescents who attended schools with sex education programs missed out on sex education perhaps because they dropped out of school early or were still attending lower primary classes where sex education is less likely to be provided.†

Given the widely recognized traditional role of the *senga* (paternal aunt or equivalent) in sex education among adolescent girls in a number of Ugandan cultures, adolescent girls were also asked whether they have ever received sex-related information from a *senga*. At least one in every four adolescent girls—one in every three among those age 15–19—had ever consulted a *senga* (data not shown), indicating that the *senga* is still an important source of sex-related information for adolescent girls.

Attitudes about sex education among adolescents

The study findings reveal that the majority of adolescents who had ever attended school were in favor of sex education being taught in schools (82% of females

and 78% of males), although 12–14-year-old males were slightly less supportive (Table 9.3). Adolescents were also overwhelmingly in favor (85% of females and 91% of males) of teaching 12–14-year-olds how to avoid HIV/AIDS and about 76% of both sexes supported teaching 12–14-year-olds about using condoms to avoid AIDS.

Despite the generally positive attitude towards sex education in schools, about 40% of adolescents felt that discussing sex-related issues with young people encourages them to have sex. These findings highlight the need for very careful packaging and delivery of sex education information to adolescents in order to reduce such perceived effects.

Information and Service Sources for Contraceptive Methods

Table 9.4 shows that teachers/schools and the radio were dominant sources of information on contraceptive methods, regardless of adolescents' sex or age. About one-half of both female and male adolescents reported that they got information about contraceptive methods from schools/teachers. Similar to results for mass media, proportionately fewer female adolescents received information from the radio compared with males (47% versus 59%, respectively). Same sex friends were another common source of information for adolescents about contraceptive methods.

A considerable proportion (47%) of young women, across all age-groups, obtained contraceptive information from family members, including their own mothers. For young men, this was not the case, with only 24% reporting having received such information from family members. These results suggest that families continue to perceive issues of unwanted teenage pregnancies as problematic for teenage girls but less so for boys.

Young people prefer to get information on contraceptive methods from teachers/schools, health workers/clinics and the radio, in that order. However, 15–19-year-old girls expressed a stronger preference for health workers as a source of information on contraceptive methods—perhaps because a larger proportion of older than younger adolescents had dropped out of school.

Unlike the males, a considerable proportion (29%) of adolescent females also expressed a preference to obtain this information from family members, particularly their mothers. Chart 9.4 summarizes the above findings and indicates that there was no single source of information adolescents used or preferred to use when it came to contraception. Nevertheless, the

*The actual net enrollment rate for primary education is 90% but completion rate is 63% (source: Republic of Uganda, National Budget Framework Paper for Financial Years 2005/06 and 2007/08, Kampala, Uganda: Republic of Uganda, 2005).

†Because of the free universal primary education, which was introduced in the country in 1997, many over-aged children who were not attending school enrolled. However, many of them drop out before or on completion of primary education.

school remained a convenient and fairly popular source for contraceptive information for those in school. While health workers/clinics were an equally preferred source for information, particularly among 15–19-year-old females, current use is quite limited, perhaps because such services are not readily available or accessible to adolescents, especially in rural areas. The radio, though commonly used, is slightly less preferred, perhaps because the lack of interaction inherent in receiving information from the radio.

The data also reveal some interesting rural-urban variations in information sources used for contraceptive methods (Charts 9.2 and 9.3). While young people in urban areas expectedly had better access to this type of information through more formal channels (e.g., schools, health workers and the media) compared with rural residents, the converse is true with regard to access to this type of information through informal channels (e.g., family and friends). This implies that, while urban areas may have better infrastructure for formal information services, the informal, social information networks in such areas may not be as strong or as relied upon by young people, as compared with rural areas.

Perceived barriers to obtaining contraceptive methods

Adolescents were asked about the kind of things that would stop young people like them from getting methods for pregnancy prevention. The responses were spontaneous—the categories were not read out loud. The study findings reveal that the majority of adolescents were fearful or felt embarrassed to seek such services (Table 9.5). This suggests a lack of availability of adolescent-friendly services, as well as lack of community support for adolescents to use contraceptive methods.

Another major barrier reported was the inability of adolescents to meet the cost of services, given that most of them did not have a regular source of income. This was particularly true for young women. Not knowing where to go for services was also reported as a major barrier, especially among adolescent males.

Known and preferred sources for contraceptive methods

Table 9.6 reveals substantial differences in the known sources for contraceptives between the different age-groups of adolescents. The majority of 12–14-year-old adolescents (66% of females and 58% of males) who knew of at least one contraceptive method did not know of a place to get methods, compared with

36–40% of 15–19-year-olds. The most known sources for obtaining contraceptive methods were government health units (clinics/hospitals), mentioned by nearly half of all adolescents who knew of at least one contraceptive method. Other fairly known sources were private health units, pharmacies/drug shops and NGO clinics, in that order of importance. Unpublished tabulations further reveal that, regardless of age and sex, awareness of sources for contraceptives was considerably higher (by over 20%) among adolescents who had ever had sex, compared with those who had never had sex. Adolescents in urban areas were also generally more knowledgeable about where to go to get contraceptive methods than were rural residents (data not shown). With regard to where young people prefer to go for contraceptives, an overwhelming majority of adolescents (78% of females and 73% of males) who knew at least one source for contraceptives stated that they preferred to obtain their contraceptives from government health clinics or hospitals. Fewer than 10% preferred to obtain contraceptive methods from private health facilities, NGO clinics or pharmacies.

Possible barriers accessing to contraceptive methods in government health units

Table 9.7 shows that adolescents who mentioned government health units as a possible source for contraceptive methods favorably rated key service delivery aspects of government health services. More than 80% of all female and male adolescents, were of the opinion that government health units treat client information with confidentiality.

About three in four adolescents expressed confidence that staff at government health units would treat adolescents with respect when they seek contraceptive methods. Respect for clients and confidentiality of information shared are quite important, given that fear and embarrassment were major barriers identified by many adolescents as preventing them from seeking contraceptive methods. About four in five adolescents also reported that they would not have difficulty getting to a government health facility if they were to seek services there.

From Table 9.8 it can also be observed that the facilities most preferred by adolescents as sources of contraceptives were also rated highly on all the four aspects of service delivery (i.e., confidentiality of information shared, distance/ease of access to the facility, client handling and affordability of services). When it comes to obtaining contraceptives, adolescents who preferred government health facilities and those who

preferred private ones tended to rank them in similar ways on the different dimensions of service.

Use of sources for contraceptives

Although most adolescents, especially younger adolescents, in Uganda had never gone to a place for contraceptive methods, the majority of those who had (60% of female adolescents and 59% of male adolescents) obtained their methods from government health units (Table 9.9). About one in four reported that they obtained contraceptive methods from private clinics/hospitals and one in five reported having gone to drug shops/pharmacies for their methods. These findings suggest that government clinics/hospitals remained the most popular and most used sources of contraceptive methods, but adolescents' reliance on drug shops/pharmacies for contraceptives is not trivial.

However, there may be some underreporting of service use for methods due to design limitations of the survey questionnaire. In contrast to Demographic and Health Surveys, the National Survey of Adolescents asked about sources used for methods in a different part of the interview from questions about actual method use. Consequently, not all users of modern methods reported going to a place for those methods. For instance, of the 722 ever-users of modern methods (unweighted cases), only 268 cases (37%) said they had ever visited places to get methods; another 337 cases (47%) said they had not ever visited any of the places they knew; and 117 (16%) said they did not know of any source for contraceptive methods. Some of this mismatch is because male condoms were the most common method used (accounting for 90% or more of modern method use), and females are not usually the ones who seek condoms. It may also be the case that an adolescents sometimes obtained condoms from a friend or a sibling, rather than a clinic or pharmacy. For example, out of a total of 357 males who ever used a condom, 161 (45%) had ever gone to a place where contraceptive methods are provided; 145 (41%) had never gone and 51 (14%) had never heard of such a place. Among females, a total of 119 females had ever used a modern method apart from the male condom (81 of whom had also ever used a male condom); 73 (61%) had ever gone to a place; 35 (29%) never went and 11 (9%) had never heard of a place for methods. Judging by this example, there seems to be underreporting of service utilization for contraceptive methods by about one-third. Service utilization data for contraceptive methods are shown as a distribution of type of source used among all adolescents who reported using a source. So while

there is likely some underreporting of service utilization for contraceptive methods (primarily because of the design of the questionnaire), the data are not misleading.

Exposure to mass media messages about family planning

Consistent with earlier findings on sex education, Table 9.10 shows that the radio was the form of mass media most often accessed by adolescents for information on sexual and reproductive health issues. According to the findings, about two-thirds of all adolescents obtained family planning information recently from the radio, yet only about one in five obtained this type of information from each of the other major sources, such as newspapers/magazines, posters and health workers.

Approximately 13% of females and 20% males 12–14 years old who reported that they did not know of any contraceptive method (e.g. 7–12% of all 12–14 year olds in Uganda) also indicated that the radio was a source of information that they might know for contraceptive methods. The study findings reveal a rather low level of exposure to different types of information sources for family planning information, with 50% of 15–19-year-olds and 70% of 12–14-year-olds of either sex having only had one type of exposure or no exposure to family planning messages in recent months.

Despite the fairly low exposure levels to different types of sources, a high proportion of the adolescents reported they had heard some of the common family planning slogans. For example, more than 80% of the adolescents had heard of the slogan “produce only children you can look after.” This is indicative of the power of short catchy slogans, as people tend to remember them for some time.

Information and Service Sources for STIs

Comparing Tables 9.4 and 9.11, it can be observed that adolescents accessed information on STIs and contraceptives from the same sources, with school and radio being the dominant information sources. As was the case with contraceptives, there were considerable gender differences regarding access to information on STIs from family members and the radio: Nearly half (44%) of the female adolescents who knew of STIs indicated obtaining information on them from family members, as compared with only 22% of male adolescents. On the other hand, 69% of male adolescents obtained STI information via the radio, compared with only 49% of female adolescents.

Preference patterns for STI information sources

were also quite similar to the preferred sources of information for contraceptives, with health unit/health providers, schools and the radio being the most preferred, in that order. Again, unlike male adolescents, about one in four female adolescents who knew of STIs expressed a preference to obtain information on STIs through family members, particularly their mothers.

Table 9.12 shows that the overwhelming majority of all adolescents (79% of females and 81% of males), who did not know of any STIs, also did not know any source of information for STIs. About one in five thought that teachers or health care workers are possible sources of this type of information.

Perceived barriers to obtaining STI information and services

Adolescents who knew about STIs were asked about the things that would stop young people like them from seeking advice or treatment for STIs. The majority of the adolescents, regardless of their age or sex, indicated that they either feel embarrassed (35% or more) or afraid/fearful (31% or more) when it comes to seeking such services (Table 9.13).

Other major barriers included the inability of adolescents to meet the cost of the services and, for male adolescents, not knowing where to go for such services. These same barriers were indicated earlier on as hindering young people from seeking contraceptive services, which again confirms the challenges in providing and increasing utilization of adolescent sexual and reproductive health services in Uganda.

Known and preferred sources for treatment of STIs

Among adolescents who knew of an STI, the majority (about two-thirds of both females and males) knew that government hospitals/clinics were a source where one could get treatment for STIs (Table 9.14). The second most known source for treatment of STIs was the private clinic/hospital/doctor, reported by about one-third of adolescents. With regard to where young people preferred to go for treatment of STIs, an overwhelming majority of adolescents (84% of females and 90% of males) who knew at least one source for treatment of STIs stated that they preferred to obtain treatment from government health clinics or hospitals. Fewer than 10% preferred to seek treatment from private health facilities, NGO clinics or pharmacies.

The data, however, reveal considerable gender differences in knowledge of sources among younger adolescents: 53% of 12–14-year-old females who knew about STIs reported that they did not know of any

source for treatment, compared with only 33% of 12–14-year-old boys. Further data analysis shows that the majority of 12–14-year-old females (55%) who had never had sex were unaware of any source of treatment for STIs, compared to only 29% of the 12–14-year-old girls who had ever had sex (data not shown). On the other hand, the differences in levels of awareness between those who had had sex and those who had not were negligible among the boys of this same age-group.

Perceptions of government health units as a source to get treatment for STIs

Adolescents were asked to give their opinions about government clinics or hospitals as a possible source for treatment of STIs in terms of whether the adolescents felt the information they would share with the health workers would be treated confidentially; whether they would be able to easily get to such health units; whether they would be treated with respect and whether they would be able to pay for the services (Table 9.15). As previously shown, most adolescents (76% or more) across all age-groups and both sexes held the opinion that health workers at government health units would treat adolescents like them with respect and that the information shared with the health workers would be treated confidentially. Similarly high percentages of adolescents also indicated that they would be able to get to such health units easily. However, the proportion of adolescents who would be able to meet the cost of services was smaller, especially among male adolescents. Thirty-eight percent of male adolescents reported that they would not be able to meet the cost of the treatment services, as opposed to 23% of the females. Further data analysis revealed that the possible sources of treatment for STIs which were preferred as sources of treatment for STIs by adolescents were rated similarly in terms of confidentiality of shared information, respect, ease of access and affordability (Table 9.16).

Self-reported STI treatment behaviour among adolescents

An attempt was made to analyze the health care-seeking patterns of adolescents who reported that they had ever had an STI. The study findings show that only about a half of the adolescents who had ever had an STI sought treatment for it. The majority (61% of females and 57% of males) who sought treatment went to government facilities and 23% went to private clinics/hospitals (Table 9.17). There were no large differences across sex in the proportion of adolescents who sought

treatment or where they sought treatment.

Adolescents who did not seek treatment for their STI indicated embarrassment (43–44%) as the major reason why they did not seek treatment. A similar proportion of female adolescents also reported the inability to pay for treatment services as a major reason why they never sought treatment. Other common reasons were that adolescents did not want other people to know or feared that other people would find out. Nevertheless, the majority of the adolescents who did not seek treatment indicated that government health facilities were their most preferred source to get treatment for their STI.

Information Sources and Exposure to Mass Media Messages About HIV/AIDS

Used and preferred sources for HIV/AIDS information

Similar to findings on contraceptives and STIs, Table 9.18 shows that the mass media, specifically the radio, and schools were the major sources of information on HIV/AIDS for adolescents. Among male adolescents, mass media, teachers/health providers and friends, in that order of importance, were the major sources of information for HIV/AIDS. On the other hand, teachers/health providers, family members and the mass media, in that order, were the major sources of information on HIV/AIDS for female adolescents. These findings again highlight the apparent gender differences in access to various sources of sexual and reproductive health information. While family members were a major source of HIV/AIDS information for adolescent females (65%), only 39% of the males reported accessing such information through family members. Apparently, mothers played a central role in providing HIV/AIDS information to their daughters, but much less so to their sons. Fathers, on the other hand, lagged behind, providing only one in six adolescents of either sex with HIV/AIDS information. It is also important to note that a substantial proportion of adolescents, particularly males, reported that they obtained HIV/AIDS information from their male friends.

The above results clearly indicate that there are still very strong communication barriers between adolescents and their parents on adolescent sexual and reproductive health issues. The situation is particularly grim for out-of-school males, who, in the absence of access to the radio or a relevant radio program, relied primarily on peers to obtain sexual and reproductive health information.

Table 9.18 also shows that teachers, health providers

and the radio were the most preferred source of information on HIV/AIDS. However, this preference varied somewhat by age-group, whereby 12–14-year-olds tended to prefer teachers, while the 15–19-year-olds tended to prefer the radio and health providers. This difference is most likely due to the fact that nearly all the 12–14-year-olds were still in school, while a substantial proportion of the older adolescents, especially girls, were out of school and were not in a position to receive information from teachers.

It is also worth noting that at least one-third of young women preferred to receive HIV/AIDS information from family members, particularly their mothers. However, this proportion represents only half of those who were actually receiving information from their family members, which is perhaps a reflection of the unease that exists between parents and their children when discussing sexual and reproductive health issues.

Exposure to mass media messages about HIV/AIDS

Table 9.19 shows that there is a fairly high level of exposure to HIV/AIDS messages among adolescents especially from the radio. About three in four adolescents of either sex and across age-groups reported having heard or seen messages about HIV/AIDS at least once in the past few months, mainly from the radio. Adolescents had less access to HIV/AIDS messages through other mass media and this varied considerably across age and sex, especially with regard to newspapers/magazines. For example, 42% of the 15–19-year-old boys reported seeing HIV/AIDS messages in newspapers/magazines in the past few months, compared with only 23% of the 12–14-year-old boys. Among adolescent girls, the percentages were 31% and 20% for 15–19- and 12–14-year-old girls, respectively.

It should also be noted that most adolescents were only exposed to one or two different types of sources for HIV/AIDS messages in the past few months. This is especially true among younger adolescents, as fewer than 40% reported having heard or seen HIV/AIDS messages from more than one type of source in the past few months. The majority of adolescents across age and sex reported that they had heard or seen most of the common HIV/AIDS slogans played in the mass media. However, the most memorable slogan seems to have been “Be aware, AIDS kills,” which was reported by over 90% of female and male adolescents. This is perhaps due to its blunt and chilling message regarding the consequences of contracting HIV/AIDS or it may be more prevalent among the slogans.

HIV Voluntary Counseling and Testing

Knowledge of and demand for voluntary counseling and testing

Adolescents who were aware of HIV/AIDS were asked whether they had heard of HIV testing; whether they knew of a place one could go for HIV testing; whether they wanted to be tested; and the reasons why they had not been tested or did not want to be tested. Table 9.20 shows that 83% or more of adolescents across age-groups and sex knew that one could be tested for HIV. However, knowledge of the places where one could go for testing was not universal and varied substantially across age categories.

Older adolescents were much more knowledgeable about places where one could go for an HIV test than were their younger counterparts. Similarly, male adolescents tended to be somewhat more knowledgeable than females. Of those who knew of a place for an HIV test, four in five reported a government clinic/hospital. It is important to note that responses were spontaneous—categories were not read out.

On the issue of whether one has to pay to get the HIV test, the responses were rather mixed with about one-third of adolescents who knew of a place for an HIV test stating that they didn't know if one had to pay for it, while another one-fourth said payment was necessary.

Chart 9.5 shows that while there is near universal awareness about HIV/AIDS, and the majority of adolescents also knew that one can get tested for HIV and where to do so, many adolescents had not taken a step to do so. Nevertheless, a considerable proportion, particularly among 12–14-year-old girls, did not know where they could go to receive HIV testing services.

The study findings also show that at least two-thirds of adolescents who had never been tested for HIV want to be tested (Table 9.21). These adolescents, however, offered a number of reasons as to why they had not done so, such as not being sexually active, worry that the cost for an HIV test is too much, and not being at risk HIV for other reasons. Not being sexually active was the most common reason given by younger adolescents, with 41% of 12–14-year-old females and 29% of their male counterparts reporting this as a reason for not getting tested. Among older males, not being at risk for other reasons was the most common reason provided (27% reported this). Cost was also considered a major barrier among both males and females, with about one in five reporting the cost of accessing such services as the main reason they have not been tested.

About one in 10 15–19-year-olds indicated that, although they want to be tested, they did not want to

know their status. Interestingly, adolescents who do not want to be tested gave reasons that are very similar to those offered for not being tested among those who want to be tested but have not done so.

Key Points for Programs and Policies

- Adolescents in Uganda are fairly well exposed to sexual and reproductive health messages, mainly through the radio and schools. However, there are considerable differences among adolescents in their mode and level of access to sexual and reproductive health information by residence (rural vs. urban), age and sex. While urban dwellers rely more on the more formal channels of information access (schools, health workers and the mass media), rural adolescents tend to rely more on the informal channels (family and friends). Reliance on informal communication channels to receive sexual and reproductive health information raises the issue of the quality of information received.
- Young adolescents generally have less access to sexual and reproductive health information than older adolescents, perhaps because they are deemed too young. Females also have less access to the mass media (electronic and print media) than their male counterparts. On the other hand, many of the adolescent females received sexual and reproductive health information from their female family members, unlike the males who relied on their peers (perhaps especially if they were out of school).
- There is a need to further strengthen dissemination of adolescent sexual and reproductive health information through the mass media, particularly in rural areas. This requires developing and supporting adolescent sexual and reproductive health programs on local radio stations that serve adolescents. This would be especially beneficial to adolescents who are out of school. In addition, there is need to support and intensify the ongoing efforts to widely disseminate adolescent sexual and reproductive health information in the print media—in the form of posters, newspaper pull-outs etc, especially in schools. There is also need to support the development and dissemination of appropriate and culturally sensitive sexual and reproductive health information for young adolescents who, presently, do not appear to be adequately catered for.
- There should be support for a countrywide campaign that promotes parental participation, particularly fathers (or father figures), in adolescent sexual and re-

productive health issues and equips them with information to effectively deal with their children's concerns. Traditionally, the role of providing sexuality education to adolescents within the family setting was played by aunts, uncles or grandparents, depending on the culture of a particular area. However, this practice has increasingly been eroded by modernization, leaving an information vacuum. Adolescents, particularly those who are out of school, now have no one to turn to—except perhaps their peers and siblings—to address their information needs and concerns on sexual and reproductive health. Some mothers are making an attempt to fill in this gap, but in light of the new adolescent sexual and reproductive health challenges, particularly those posed by HIV/AIDS, they need to be equipped with accurate information and appropriate skills to establish an effective dialogue with their children. Efforts should also be made to sensitize and persuade fathers to appreciate their roles and responsibilities so that they can become more proactive in the lives of their children.

- Most adolescents who know about contraceptives, STIs and HIV testing indicate that government health units provide contraceptive methods, treatment of STIs and HIV testing. They also prefer to seek such services from government facilities. A minority prefer private clinics. Regardless of the source, the most important factor that would promote adolescent use of these services is improving access to such services and increasing their user-friendliness, considering that most adolescents fear or feel embarrassed to seek such services and because the majority do not earn an income, they are not in position to pay the cost of services or meet transportation costs if services are far. Hence there is need to put in place special arrangements within the health facilities for providing young people with sexual and reproductive health services that are free and adolescent-friendly. In addition, young people—both in and out of school—need to be aware of the importance of overcoming their fear and embarrassment and seeking these services when they need them.

TABLE 9.1 Percentage distribution of adolescents, by exposure to mass media, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1284)	15–19 (N=1314)	Total (N=2598)	12–14 (N=1209)	15–19 (N=1303)	Total (N=2512)
Frequency of listening to the radio						
Almost every day	37.4	45.5	41.5	50.7	66.1	58.7
At least once a week	24.4	24.0	24.2	24.2	18.3	21.1
Less than once a week	10.1	9.3	9.7	8.2	4.6	6.3
Not at all	28.1	21.2	24.6	17.0	11.0	13.9
Frequency of watching television						
Almost every day	4.8	7.8	6.3	5.8	7.5	6.7
At least once a week	4.1	4.7	4.4	8.4	11.7	10.1
Less than once a week	3.3	4.6	3.9	9.0	11.7	10.4
Not at all	87.8	82.9	85.3	76.7	69.2	72.8
Frequency of reading a newspaper or magazine*						
Almost every day	2.6	4.6	3.6	4.1	7.4	5.8
At least once a week	11.4	20.0	15.6	14.5	22.7	18.7
Less than once a week	12.5	17.9	15.2	12.1	16.3	14.2
Not at all	73.5	57.5	65.6	69.3	53.6	61.2
Number of mass media sources*						
None	24.0	17.2	20.6	13.3	8.0	10.5
1	49.2	41.2	45.2	48.7	39.7	44.0
2	19.5	30.7	25.2	26.3	31.9	29.2
3 or more	7.2	11.0	9.1	11.7	20.4	16.2
Ever used the internet†						
Yes	0.6	1.5	1.0	1.0	3.1	2.1
No	21.2	30.6	25.9	28.2	40.2	34.4
Don't know internet	78.3	67.9	73.1	70.8	56.7	63.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Question asked of those who ever attended school. Sample size: females 12–14 (N=1256); females 15–19 (N=1227); males 12–14 (N=1193); males 15–19 (N=1266). †Media sources include radio, television and newspaper. Note: Ns are weighted.

TABLE 9.2 Percentage distribution of adolescents, by exposure to sex education and content and form of sex education, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=1284)	15-19 (N=1315)	Total (N=2599)	12-14 (N=1208)	15-19 (N=1300)	Total (N=2508)
Ever attended school						
No	2.1	6.4	4.3	1.5	2.9	2.2
Yes	97.9	93.6	95.7	98.5	97.1	97.8
Any of respondent's schools offered any classes or talks on sex education*						
Yes	46.9	60.4	53.6	36.8	58.6	48.0
No	51.4	38.6	45.0	58.8	39.2	48.7
Don't know	1.8	1.0	1.4	4.5	2.2	3.3
Ever attended sex education classes or talks†						
Yes	73.6	88.6	82.0	60.9	77.7	71.4
No	26.4	11.4	18.0	39.1	22.3	28.6
Age when first attended sex education classes or talks‡						
<12	27.7	5.9	14.6	27.4	3.7	11.2
12	40.9	11.1	22.9	26.7	7.5	13.6
13	23.8	21.4	22.4	31.2	10.5	17.0
14	6.9	28.4	19.9	12.0	23.6	19.9
15	na	17.8	10.7	na	25.1	17.2
16	na	10.3	6.2	na	16.9	11.6
17-19	na	4.0	2.4	na	10.5	7.2
Don't know	0.7	1.1	0.9	2.6	2.3	2.4
Attended sex education classes or talks before first sex‡						
No	6.5	16.6	12.6	17.1	30.7	26.4
Yes	93.5	83.4	87.4	82.9	69.3	73.6
Subjects covered in classes/talks‡						
How pregnancy happens	73.0	87.5	81.8	83.5	91.1	88.7
Contraception/how to prevent pregnancy	82.4	89.7	86.8	80.8	93.0	89.2
Abstinence/say 'no' to sex	91.7	92.9	92.4	79.8	91.3	87.6
STIs or diseases	79.0	90.1	85.7	79.3	92.9	88.6
How classes/talks were conducted‡						
Lecture	74.1	73.5	73.8	83.1	77.9	79.5
Small group discussion	35.8	40.5	38.7	19.9	31.1	27.6
Role play	5.1	7.0	6.2	4.5	6.3	5.7
Video/film	4.6	5.8	5.3	5.3	7.3	6.7
Other	0.0	0.9	0.6	0.8	1.2	1.1
Don't know	0.0	0.0	0.0	1.9	0.3	0.8
Who mainly led the classes/talks‡						
Teachers	91.0	80.4	84.6	91.7	83.9	86.4
Students	2.8	3.2	3.0	0.8	2.4	1.9
Nurses	4.6	11.8	9.0	4.1	11.7	9.3
Other	1.6	4.6	3.4	1.5	1.6	1.5
Don't know	0.0	0.0	0.0	1.9	0.3	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who have attended school. Sample sizes: females 12-14 (N=1256); females 15-19 (N=1228); males 12-14 (N=1191); males 15-19 (N=1262). †Limited to those who reported any schools offered sex education classes or talks. Sample sizes: females 12-14 (N=588); females 15-19 (N=743); males 12-14 (N=437); males 15-19 (N=739). ‡Limited to those who ever attended a sex education class or talk. Sample sizes: females 12-14 (N=433); females 15-19 (N=658); males 12-14 (N=266); males 15-19 (N=573). Totals may exceed 100 because multiple responses are possible for subjects covered and how classes/talks were conducted. Note: Ns are weighted.

TABLE 9.3 Adolescents, by attitudes about sex education, condoms and AIDS instruction, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1257)	15–19 (N=1229)	Total (N=2486)	12–14 (N=1191)	15–19 (N=1264)	Total (N=2455)
It is important for sex education to be taught in schools*						
Agree	78.8	84.6	81.7	70.3	85.7	78.2
Disagree	17.7	13.8	15.8	25.7	13.1	19.2
Don't know	3.5	1.5	2.5	4.0	1.3	2.6
Discussing sex education with young people encourages young people to have sex*						
Agree	42.0	42.9	42.4	35.9	41.5	38.8
Disagree	47.6	50.9	49.3	49.1	54.4	51.8
Don't know	10.4	6.2	8.3	15.0	4.2	9.4
12–14-year-olds should be taught about how to avoid AIDS†						
Yes	81.4	87.6	84.5	88.2	94.0	91.3
No	17.1	12.0	14.5	10.5	5.6	7.9
Don't know	1.5	0.5	1.0	1.3	0.4	0.8
12–14-year-olds should be taught about using condoms to avoid AIDS‡						
Yes	71.1	79.3	75.7	71.2	79.5	75.7
No	25.2	19.6	22.1	24.5	19.5	21.8
Don't know	3.7	1.1	2.2	4.3	1.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Question asked of those who ever attended school. †Limited to those who have heard of AIDS. Sample sizes: females 12–14 (N=1256); females 15–19 (N=1302); males 12–14 (N=1191); males 15–19 (N=1294). ‡Limited to those who have heard of AIDS and male condom. Sample sizes: females 12–14 (N=864); females 15–19 (N=1096); males 12–14 (N=997); males 15–19 (N=1204). Note: Ns are weighted.

TABLE 9.4 Adolescents who know of at least one contraceptive method, by used and preferred sources of information for methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1125)	15–19 (N=1270)	Total (N=2395)	12–14 (N=1115)	15–19 (N=1281)	Total (N=2396)
Where respondent got information about contraceptive methods*						
Any family	48.7	46.3	47.4	24.9	23.3	24.1
Any friends	35.5	44.6	40.3	48.3	49.6	49.0
Any teacher or health provider	60.3	66.0	63.3	49.2	65.0	57.7
Any mass media	48.2	54.1	51.3	57.6	65.7	61.9
Mother	26.2	23.2	24.6	5.3	5.4	5.3
Father	5.0	3.7	4.3	4.9	6.3	5.7
Spouse/partner	0.3	2.4	1.4	0.2	0.2	0.2
Brother	1.8	1.7	1.8	6.2	6.4	6.3
Sister	10.2	7.1	8.6	1.2	1.0	1.1
Other female family	24.4	26.3	25.4	7.5	4.6	6.0
Other male family	3.7	4.0	3.9	12.2	11.7	11.9
Female friends	34.3	43.9	39.4	3.8	7.7	5.8
Male friends	4.9	5.7	5.3	46.8	48.0	47.4
Teacher/school	53.2	51.1	52.1	44.3	58.9	52.1
Doctor/nurse/clinic	15.6	26.0	21.1	11.8	19.6	16.0
Traditional or spiritual healer/herbalist	0.3	0.2	0.3	0.2	0.5	0.3
Church	2.4	3.3	2.9	1.3	1.5	1.4
Community/neighborhood	6.4	4.3	5.3	5.1	2.4	3.7
Newspaper	7.4	10.3	8.9	6.0	15.5	11.1
Books/magazines	1.9	2.7	2.3	2.0	5.1	3.7
Radio	43.4	50.2	47.0	54.3	62.9	58.9
Television	3.3	5.0	4.2	3.8	5.1	4.5
Internet	0.1	0.0	0.0	0.0	0.1	0.0
Poster/billboard	0.6	1.1	0.9	1.9	1.5	1.7
Other	2.9	5.7	4.4	4.5	5.6	5.1
Don't know/unsure	0.6	0.2	0.4	7.1	2.3	4.5
Preferred sources for information about contraceptive methods*						
Any family	30.2	28.4	29.2	12.9	9.8	11.2
Any friends	11.1	13.7	12.5	14.1	14.5	14.3
Any teacher or health provider	60.6	62.5	61.6	54.1	61.7	58.2
Any mass media	33.8	34.7	34.3	34.6	39.1	37.0
Mother	20.2	16.2	18.1	4.4	3.5	3.9
Father	2.5	2.1	2.3	5.3	4.1	4.7
Spouse/partner	0.1	1.3	0.7	0.1	0.0	0.0
Brother	0.3	0.3	0.3	2.4	1.7	2.1
Sister	5.2	3.9	4.5	0.1	0.2	0.2
Other female family	10.3	12.1	11.3	1.4	1.4	1.4
Other male family	0.5	0.7	0.6	2.9	2.1	2.5
Female friends	10.8	13.0	12.0	1.2	1.3	1.3
Male friends	0.8	1.0	0.9	13.2	13.8	13.5
Teacher/school	42.1	27.1	34.1	34.3	36.2	35.3
Doctor/nurse/clinic	30.7	44.6	38.1	30.8	38.2	34.8
Traditional or spiritual healer/herbalist	0.3	0.2	0.2	0.1	0.2	0.1
Church	2.1	2.6	2.3	0.5	1.0	0.8
Community/neighborhood	6.4	4.3	5.3	5.1	2.4	3.7
Newspaper	5.0	5.3	5.1	3.6	7.7	5.8
Books/magazines	1.2	1.3	1.2	0.6	1.3	1.0
Radio	28.8	29.4	29.1	31.7	33.1	32.5
Television	3.2	2.8	3.0	1.8	2.0	1.9
Internet	0.0	0.1	0.0	0.1	0.2	0.1
Poster/billboard	0.0	0.2	0.1	0.2	0.2	0.2
Other	2.0	4.1	3.1	3.1	4.9	4.1
Don't know	5.8	3.1	4.4	11.5	5.2	8.1

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.5 Percentage of adolescents who know of at least one contraceptive method, by perceived barriers to obtaining methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1124)	15–19 (N=1269)	Total (N=2393)	12–14 (N=1112)	15–19 (N=1280)	Total (N=2392)
Barriers*						
No barriers	8.5	5.6	6.9	15.6	11.9	13.6
Not knowing where to go	13.2	14.4	13.8	20.9	25.9	23.6
Not knowing how to get there	4.9	6.1	5.5	5.6	8.8	7.3
Inconvenient hours/days	5.8	6.2	6.0	0.9	2.6	1.8
Privacy not respected	5.3	7.2	6.3	1.1	2.9	2.0
Not treated nicely by staff	2.0	2.6	2.3	0.8	1.1	1.0
Costly/not able to pay for services	21.5	28.5	25.2	13.4	18.8	16.3
No same sex provider	2.1	4.1	3.2	0.6	1.1	0.9
Not being allowed to go alone	4.4	4.6	4.6	1.7	1.7	1.7
Afraid or fearful	26.3	33.6	30.2	21.5	29.5	25.8
Embarrassed or shy	23.9	26.8	25.4	27.0	34.7	31.1
Too young	0.5	0.2	0.3	1.9	1.6	1.7
Other	1.2	3.6	2.5	3.7	6.9	5.4
Don't know	34.5	25.8	29.9	34.1	20.1	26.6

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.6 Percentage distribution of adolescents who know of at least one contraceptive method, by known and preferred sources for methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=1125)	15-19 (N=1270)	Total (N=2395)	12-14 (N=1115)	15-19 (N=1282)	Total (N=2397)
Known sources for contraceptive methods*						
Government clinic/hospital	32.8	56.9	45.6	38.3	60.5	50.1
Private clinic/hospital/doctor	13.0	28.4	21.2	13.9	31.0	23.1
NGO clinic	6.0	13.8	10.1	2.9	8.7	6.0
Drug shop/pharmacy	8.4	17.6	13.3	13.6	16.6	15.2
Street vendor	0.4	0.4	0.4	0.5	0.7	0.6
Traditional or spiritual healer/herbalist	2.2	2.2	2.2	3.2	5.0	4.2
Friends	3.2	6.5	5.0	3.5	7.4	5.6
School/school counselor	4.3	4.3	4.3	7.7	13.6	10.9
Church	0.4	0.9	0.6	0.6	0.6	0.6
Parents	na	na	na	na	na	na
Other	1.1	2.1	1.6	1.5	2.0	1.8
Retail shops	6.2	6.0	6.1	2.2	1.6	1.9
No source known	65.9	40.3	52.3	57.6	36.3	46.2
Preferred source for contraceptive methods†						
Government clinic/hospital	79.2	77.7	78.2	70.7	73.9	72.7
Private clinic/hospital/doctor	7.3	10.1	9.2	5.5	7.5	6.8
NGO clinic	2.9	2.6	2.7	1.5	2.6	2.2
Drug shop/pharmacy	3.6	4.3	4.1	8.7	3.9	5.7
Street vendor	0.5	0.0	0.2	0.2	0.1	0.2
Traditional or spiritual healer/herbalist	0.8	0.3	0.4	0.8	0.6	0.7
Friends	1.8	1.6	1.7	1.7	3.0	2.5
School/school counselor	1.3	1.1	1.1	5.9	5.8	5.8
Church	0.0	0.1	0.1	0.4	0.2	0.3
Other	2.6	1.6	1.9	2.8	1.5	1.9
Don't know	0.0	0.5	0.3	1.7	0.9	1.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. †Limited to those who know of any source. Sample sizes: females 12-14 (N=384); females 15-19 (N=759); males 12-14 (N=471); males 15-19 (N=813). Note: Ns are weighted.

TABLE 9.7 Percentage distribution of adolescents who know of a government clinic or hospital and who know of at least one method, by perceptions of government clinics or hospitals as sources for contraceptive methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=368)	15-19 (N=721)	Total (N=1089)	12-14 (N=419)	15-19 (N=763)	Total (N=1182)
Information shared would be confidential						
Yes	83.2	85.0	84.4	78.0	86.2	83.3
No	10.6	9.8	10.1	16.0	7.7	10.7
Don't know	6.3	5.1	5.5	6.0	6.0	6.0
Respondent would be able to get there easily						
Yes	74.2	80.0	78.1	78.7	81.7	80.6
No	23.9	19.3	20.8	19.4	18.1	18.6
Don't know	1.9	0.7	1.1	1.9	0.3	0.8
Respondent would be treated with respect						
Yes	75.7	77.0	76.6	77.9	83.1	81.2
No	16.1	18.0	17.4	13.3	9.6	10.9
Don't know	8.2	5.0	6.1	8.8	7.3	7.9
Respondent would be able to pay for the services						
Yes	68.8	71.7	70.7	59.4	63.0	61.7
No	26.9	26.1	26.4	35.6	33.7	34.4
Don't know	4.3	2.2	2.9	5.0	3.3	3.9
Reported "no" to at least one dimension of service						
	45.9	45.0	45.3	57.3	52.2	54.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 9.8 Percentage distribution of adolescents who know of at least one method, by perceptions of most preferred source for contraceptive methods, according to type of preferred source and sex, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	Most preferred source			Most preferred source		
	Govt (N=893)	Private (N=104)	Drug shop (N=46)	Govt (N=934)	Private (N=85)	Drug shop (N=73)
At (source), information shared would be confidential						
Yes	85.9	80.8	[73.9]	84.2	91.8	74.0
No	9.1	9.6	[21.7]	9.7	5.9	21.9
Don't know	5.0	9.6	[4.3]	6.1	2.4	4.1
Respondent would be able to get there easily						
Yes	79.3	78.8	[82.6]	82.7	92.9	86.3
No	19.9	17.3	[13.0]	16.5	5.9	12.3
Don't know	0.8	3.8	[4.3]	0.8	1.2	1.4
Respondent would be treated with respect						
Yes	78.3	73.1	[76.1]	83.3	87.1	72.6
No	16.1	19.2	[17.4]	9.6	10.6	17.8
Don't know	5.6	7.7	[6.5]	7.1	2.4	9.6
Respondent would be able to pay for the services						
Yes	71.8	73.3	[74.5]	61.9	68.6	87.7
No	25.3	20.0	[21.3]	34.4	24.4	6.8
Don't know	2.9	6.7	[4.3]	3.6	7.0	5.5
Reported "no" to at least one dimension of service						
	43.9	39.4	[40.4]	51.7	36.8	41.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted. [] = N is 25–49.

TABLE 9.9 Percentage of adolescents who have ever obtained a contraceptive method, by source of method, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=5)	15-19 (N=114)	Total (N=119)	12-14 (N=17)	15-19 (N=186)	Total (N=203)
Sources ever used to get contraceptive methods*						
Government clinic/hospital	--	60.0	60.0	--	59.7	59.1
Private clinic/hospital/doctor	--	28.1	26.9	--	21.0	19.7
NGO clinic	--	12.3	11.8	--	10.8	10.3
Drug shop/pharmacy	--	16.7	16.8	--	21.9	22.1
Street vendor	--	0.0	0.0	--	0.0	0.0
Traditional or spiritual healer/herbalist	--	1.8	3.4	--	1.1	1.0
Friends	--	4.4	4.2	--	3.7	3.4
School/school counselor	--	3.5	3.4	--	9.1	10.8
Church	--	0.0	0.0	--	0.0	0.0
Retail shops	na	na	na	na	na	na
Parents	na	na	na	na	na	na
Other	--	2.6	2.5	--	7.0	7.4
Don't know	--	0.0	0.0	--	0.0	0.0

*Totals may exceed 100 because multiple responses are possible. Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 9.10 Percentage distribution of adolescents, by exposure to mass media messages about family planning, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=1284)	15-19 (N=1315)	Total (N=2599)	12-14 (N=1209)	15-19 (N=1301)	Total (N=2510)
In the last few months has heard or seen messages about family planning:*						
Radio	60.0	69.7	64.9	63.4	75.8	69.8
Television	6.9	10.8	8.9	8.0	14.6	11.4
Newspaper or magazine	15.1	26.3	20.8	18.4	35.8	27.4
Poster	10.7	21.6	16.2	15.6	27.5	21.8
Leaflet or brochure	4.4	10.7	7.6	9.8	15.6	12.8
Health worker	12.1	28.0	20.2	14.4	26.8	20.8
Community or social club meeting	10.1	18.2	14.2	8.3	18.0	13.3
Number of exposures to family planning messages in recent months						
0	32.4	21.4	26.8	30.1	17.4	23.5
1	38.1	32.0	35.0	39.3	30.3	34.6
2	16.9	17.9	17.4	13.1	18.3	15.8
3-7	12.6	28.7	20.7	17.5	34.0	26.1
Has heard the message "For family planning, go to a health facility with a yellow flower"						
Yes	53.5	67.1	60.4	52.4	70.9	62.0
No	46.5	32.9	39.6	47.6	29.1	38.0
Has heard the message "Produce only children you can look after"						
Yes	78.4	90.1	84.3	77.9	89.2	83.8
No	21.6	9.9	15.7	22.1	10.8	16.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because "yes" responses to multiple items are shown. *Note:* Ns are weighted.

TABLE 9.11 Percentage of adolescents who know of any STIs, by used and preferred sources of information on STIs (apart from HIV/AIDS), according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=481)	15–19 (N=934)	Total (N=1415)	12–14 (N=455)	15–19 (N=949)	Total (N=1404)
Where respondent got information about STIs (apart from HIV/AIDS)*						
Any family	46.8	41.9	43.5	28.1	19.6	22.4
Any friend	20.6	30.1	26.9	38.5	44.3	42.4
Any teacher or health provider	73.0	70.8	71.5	71.8	76.1	74.7
Any mass media	51.4	56.0	54.4	67.4	73.2	71.3
Mother	29.8	23.8	25.8	9.5	7.4	8.1
Father	7.5	5.7	6.3	9.5	8.6	8.9
Spouse/partner	0.0	1.0	0.6	0.2	0.2	0.2
Brother	2.9	1.8	2.2	4.8	5.1	5.0
Sister	6.7	7.0	6.9	0.7	1.2	1.0
Other female family	18.1	23.6	21.7	5.3	2.1	3.1
Other male family	4.6	5.1	4.9	11.7	6.4	8.1
Female friends	20.2	29.7	26.5	2.4	6.5	5.2
Male friends	3.1	3.4	3.3	38.0	43.7	41.9
Teacher/school	64.4	56.9	59.5	65.6	67.8	67.1
Doctor/nurse/clinic	22.9	29.6	27.3	17.8	28.0	24.7
Traditional or spiritual healer/herbalist	0.0	0.6	0.4	1.3	1.4	1.4
Church	1.3	1.5	1.4	2.9	2.9	2.9
Community/neighborhood	2.5	3.0	2.8	1.8	1.5	1.6
Newspaper	10.4	12.4	11.7	13.2	21.8	19.0
Books/magazines	3.8	2.9	3.2	4.0	5.6	5.1
Radio	46.7	50.8	49.4	65.9	70.0	68.7
Television	3.5	4.6	4.3	4.2	6.8	5.9
Internet	0.0	0.1	0.1	0.0	0.3	0.2
Poster/billboard	1.3	1.1	1.1	0.7	1.1	0.9
Other	2.5	4.3	3.7	4.4	5.6	5.2
Don't know/unsure	0.0	0.0	0.0	0.9	0.6	0.7
Preferred sources for information about STIs*						
Any family	28.8	26.8	27.5	14.9	9.6	11.3
Any friend	7.5	9.0	8.5	7.9	9.1	8.7
Any teacher or health provider	68.4	66.0	66.8	68.6	72.3	71.1
Any mass media	37.8	41.1	39.9	40.9	45.3	43.8
Mother	21.7	18.0	19.3	6.2	4.7	5.2
Father	5.1	2.6	3.4	6.8	5.4	5.9
Spouse/partner	0.0	0.8	0.5	0.0	0.0	0.0
Brother	1.1	0.9	0.9	2.4	1.0	1.4
Sister	1.7	3.4	2.8	0.4	0.1	0.2
Other female family	7.4	10.4	9.4	2.0	0.5	1.0
Other male family	0.2	0.8	0.6	2.9	1.6	2.0
Female friends	7.1	9.0	8.4	0.2	0.6	0.5
Male friends	0.4	0.4	0.4	7.9	9.0	8.7
Teacher/school	45.8	27.1	33.5	48.3	40.6	43.1
Doctor/nurse/clinic	37.5	50.7	46.2	39.5	48.1	45.3
Traditional or spiritual healer/herbalist	0.4	0.4	0.4	0.2	0.2	0.2
Church	1.7	1.6	1.6	0.4	0.9	0.7
Community/neighborhood	0.4	0.7	0.6	0.4	0.4	0.4
Newspaper	5.9	7.4	6.9	7.5	9.7	9.0
Books/magazines	2.1	1.5	1.7	0.4	1.2	0.9
Radio	32.6	35.9	34.8	36.5	39.4	38.5
Television	1.9	2.3	2.1	4.0	3.0	3.3
Internet	0.0	0.0	0.0	0.2	0.0	0.1
Poster/billboard	0.4	0.3	0.4	0.0	0.0	0.0
Other	1.7	3.7	3.0	3.1	3.7	3.5
Don't know	2.5	1.8	2.1	2.6	2.4	2.5

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

TABLE 9.12 Percentage of adolescents who do not know any STIs, by perceived sources of information on STIs other than HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=803)	15–19 (N=382)	Total (N=1185)	12–14 (N=755)	15–19 (N=354)	Total (N=1109)
Sources of information on STIs other than HIV/AIDS*						
Any family	8.1	7.9	8.0	3.0	3.7	3.2
Any teacher or health provider	17.8	20.2	18.6	14.3	22.9	17.0
Any mass media	4.2	4.7	4.4	4.5	9.9	6.2
No source known	79.3	76.9	78.5	83.9	73.2	80.5
Mother	6.0	4.5	5.5	2.4	1.4	2.1
Father	1.0	1.3	1.1	2.0	2.6	2.2
Spouse/partner	0.0	0.0	0.0	0.0	0.0	0.0
Brother	0.2	0.3	0.3	0.1	0.3	0.2
Sister	1.6	1.8	1.7	0.1	0.0	0.1
Other female family	2.4	2.4	2.4	0.1	0.9	0.4
Other male family	0.1	0.5	0.3	0.3	1.1	0.5
Female friends	1.0	2.6	1.5	0.1	0.3	0.2
Male friends	0.0	0.0	0.0	1.2	4.8	2.4
Teacher/school	6.9	8.4	7.4	6.9	12.3	8.6
Doctor/nurse/clinic	13.7	14.4	14.0	10.8	17.7	13.0
Traditional or spiritual healer/herbalist	0.2	0.3	0.3	0.1	0.6	0.3
Church	1.1	0.8	1.0	0.3	0.3	0.3
Newspaper	0.5	1.3	0.8	1.3	3.7	2.1
Books/magazines	0.1	0.3	0.2	0.1	1.1	0.5
Radio	3.7	3.9	3.8	4.0	8.8	5.5
Television	0.2	0.3	0.3	0.4	0.9	0.5
Internet	0.0	0.0	0.0	0.0	0.0	0.0
Poster/billboard	0.1	0.0	0.1	0.1	0.0	0.1
Other	1.1	0.5	0.9	0.7	1.1	0.8
Don't know/unsure	0.0	0.0	0.0	0.0	0.3	0.1

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.13 Percentage of adolescents who know of any STIs, by perceived barriers to obtaining advice or treatment for STIs, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=480)	15–19 (N=929)	Total (N=1409)	12–14 (N=455)	15–19 (N=948)	Total (N=1403)
Barriers*						
No barriers	4.2	1.5	2.4	8.8	6.9	7.5
Not knowing where to go	16.3	14.4	15.0	28.4	34.1	32.2
Not knowing how to get there	8.3	5.5	6.5	9.0	12.3	11.3
Inconvenient hours/days	14.4	7.4	9.8	0.9	1.8	1.5
Privacy not respected	12.1	11.6	11.8	1.3	3.7	2.9
Not treated nicely by staff	2.3	2.3	2.3	0.4	0.6	0.6
Costly/not able to pay for services	21.9	32.4	28.8	17.2	23.4	21.4
No same sex provider	2.1	4.4	3.6	0.4	1.3	1.0
Not being allowed to go alone	4.8	3.1	3.7	2.6	1.5	1.9
Afraid or fearful	38.7	41.8	40.7	31.3	34.6	33.5
Embarrassed or shy	45.6	48.2	47.3	35.4	44.9	41.8
Treatment not effective	4.0	6.4	5.5	2.6	3.5	3.2
Too young	na	na	na	na	na	na
Feel bad/spoiled	na	na	na	na	na	na
Other	0.4	2.4	1.7	7.9	9.0	8.6
Don't know	19.3	18.1	18.5	26.2	14.5	18.3

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.14 Percentage distribution of adolescents who know of any STIs, by known and most preferred sources for STI treatment, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=480)	15–19 (N=930)	Total (N=1410)	12–14 (N=455)	15–19 (N=947)	Total (N=1402)
Known sources to get treatment for STIs*						
Government clinic/hospital	46.8	70.1	62.2	66.4	77.2	73.7
Private clinic/hospital/doctor	14.8	31.8	26.0	29.0	39.7	36.2
NGO clinic	10.4	18.9	16.0	7.9	14.3	12.2
Drug shop/pharmacy	5.4	6.8	6.3	3.7	5.8	5.1
Street vendor	0.2	0.2	0.2	0.2	0.2	0.2
Traditional or spiritual healer/herbalist	3.5	4.8	4.4	11.4	10.1	10.6
Friends	0.6	1.9	1.5	1.5	2.6	2.3
School/school counselor	2.7	2.6	2.6	5.7	6.4	6.2
Church	0.0	0.4	0.3	0.9	0.3	0.5
Parents	na	na	na	na	na	na
Other	1.9	4.6	3.7	0.9	1.1	1.0
Retail shops	na	na	na	na	na	na
No source known	53.0	28.3	36.7	33.0	21.9	25.5
Most preferred source to get treatment for STIs†						
Government clinic/hospital	88.1	82.0	83.5	88.9	90.3	89.8
Private clinic/hospital/doctor	4.9	9.0	8.0	4.9	4.9	4.9
NGO clinic	2.7	4.7	4.1	1.6	2.0	1.9
Drug shop/pharmacy	1.3	0.5	0.7	0.7	0.4	0.5
Street vendor	0.0	0.0	0.0	0.0	0.0	0.0
Traditional or spiritual healer/herbalist	0.4	0.8	0.7	1.3	0.5	0.8
Friends	0.0	0.6	0.4	0.0	0.1	0.1
School/school counselor	0.4	0.2	0.2	1.6	1.2	1.3
Church	0.0	0.2	0.1	0.0	0.0	0.0
Other	1.3	2.3	2.0	1.0	0.4	0.6
Don't know	0.9	0.0	0.2	0.0	0.1	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. †Limited to those who know of any source. Sample sizes: females 12–14 (N=226); females 15–19 (N=666); males 12–14 (N=305); males 15–19 (N=739). Note: Ns are weighted.

TABLE 9.15 Percentage distribution of adolescents who know of a government clinic or hospital and who know of any STIs, by perceptions of government clinics or hospitals as a source for STI treatment, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=222)	15-19 (N=647)	Total (N=869)	12-14 (N=301)	15-19 (N=724)	Total (N=1025)
At government clinic or hospital, information shared would be confidential						
Yes	88.3	87.0	87.3	76.4	87.3	84.1
No	10.4	9.6	9.8	15.3	7.2	9.6
Don't know	1.4	3.4	2.9	8.3	5.5	6.3
Respondent would be able to get there easily						
Yes	84.2	83.2	83.4	79.4	84.8	83.2
No	14.4	15.8	15.4	17.6	13.8	14.9
Don't know	1.4	1.1	1.2	3.0	1.4	1.9
Respondent would be treated with respect						
Yes	84.2	79.1	80.4	78.4	82.9	81.6
No	10.4	16.4	14.8	14.3	10.8	11.8
Don't know	5.4	4.5	4.7	7.3	6.4	6.6
Respondent would be able to pay for the services						
Yes	77.1	73.4	74.4	53.8	60.8	58.7
No	20.6	23.3	22.6	40.9	36.3	37.7
Don't know	2.2	3.2	3.0	5.3	2.9	3.6
Responded "no" to at least one dimension of service						
	38.1	40.5	39.9	61.8	50.7	54.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 9.16 Percentage distribution of adolescents who know of any STIs, by most preferred source for STI treatment, according to type of preferred source and sex, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	Most preferred source			Most preferred source		
	Govt (N=743)	Private (N=71)	NGO (N=37)	Govt (N=938)	Private (N=52)	NGO (N=5)
At (source), information shared would be confidential						
Yes	89.9	87.3	[91.9]	84.3	92.3	--
No	8.2	7.0	[8.1]	9.6	3.8	--
Don't know	1.9	5.6	[0.0]	6.1	3.8	--
Respondent would be able to get there easily						
Yes	84.1	81.4	[83.8]	83.9	88.2	--
No	15.2	14.3	[13.5]	14.3	11.8	--
Don't know	0.7	4.3	[2.7]	1.8	0.0	--
Respondent would be treated with respect						
Yes	84.4	83.1	[97.3]	82.3	96.2	--
No	12.5	11.3	[2.7]	11.4	1.9	--
Don't know	3.1	5.6	[0.0]	6.3	1.9	--
Respondent would be able to pay for the services						
Yes	75.3	71.8	[81.1]	58.6	65.4	--
No	22.3	22.5	[13.5]	38.0	28.8	--
Don't know	2.4	5.6	[5.4]	3.4	5.8	--
Responded "no" to at least one dimension of service						
	37.6	35.7	[24.3]	53.1	41.2	--
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 9.17 Percentage distribution of adolescents who have ever experienced STI symptoms, by self-reported treatment behavior, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=31)	15–19 (N=155)	Total (N=186)	12–14 (N=13)	15–19 (N=53)	Total (N=66)
Ever gone for treatment for STI*						
Yes	[45.2]	54.8	53.2	--	52.8	54.5
No	[54.8]	45.2	46.8	--	47.2	45.5
Service sources at last visit†						
Government clinic/hospital	--	60.0	60.6	--	[59.3]	[57.1]
Private clinic/hospital/doctor	--	22.4	23.2	--	[22.2]	[22.9]
NGO clinic	--	3.5	3.0	--	[0.0]	[2.9]
Drug shop/pharmacy	--	2.4	2.0	--	[7.4]	[5.7]
Street vendor	--	0.0	0.0	--	[0.0]	[0.0]
Traditional or spiritual healer/herbalist	--	2.4	2.0	--	[3.7]	[2.9]
Friends	--	2.4	2.0	--	[0.0]	[0.0]
School/school counselor	--	1.2	2.0	--	[3.7]	[5.7]
Church	--	2.4	2.0	--	[0.0]	[0.0]
Other	--	3.5	3.0	--	[3.7]	[2.9]
Don't know	--	0.0	0.0	--	[0.0]	[0.0]
Reasons did not go for treatment‡						
Embarrassed	--	45.7	43.7	--	[48.0]	[43.3]
Don't want partner to know	--	0.0	0.0	--	[0.0]	[3.3]
Don't want other people to know	--	12.9	17.2	--	[24.0]	[23.3]
Don't know where to go	--	15.7	13.8	--	[8.0]	[6.7]
Cost	--	41.4	42.5	--	[8.0]	[10.0]
Not a serious problem	--	2.9	2.3	--	[8.0]	[6.7]
Not painful	--	2.9	3.4	--	[4.0]	[6.7]
Normal/natural condition	--	na	na	na	na	na
Other	--	12.9	12.6	--	[24.0]	[23.3]
Don't know	--	1.4	1.1	--	[8.0]	[6.7]
Preferred service sources‡						
Government clinic/hospital	--	80.0	81.6	--	[68.0]	[63.3]
Private clinic/hospital/doctor	--	12.9	12.6	--	[16.0]	[16.7]
NGO clinic	--	1.4	1.1	--	[4.0]	[3.3]
Drug shop/pharmacy	--	0.0	0.0	--	[8.0]	[10.0]
Street vendor	--	0.0	0.0	--	[0.0]	[0.0]
Traditional or spiritual healer/herbalist	--	2.9	2.3	--	[0.0]	[0.0]
Friends	--	0.0	0.0	--	[0.0]	[0.0]
School/school counselor	--	0.0	0.0	--	[0.0]	[0.0]
Church	--	1.4	1.1	--	[0.0]	[0.0]
Other	--	0.0	0.0	--	[0.0]	[3.3]
Nowhere	--	0.0	0.0	--	[0.0]	[0.0]
Don't know	--	1.4	1.1	--	[4.0]	[3.3]
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who have ever had a STI. †Limited to those who have ever gone for treatment. Sample sizes: females 12–14 (N=14); females 15–19 (N=85); males 12–14 (N=8); males 15–19 (N=27). Multiple responses possible. ‡Limited to those who have not gone for treatment. Sample sizes: females 12–14 (N=17); females 15–19 (N=70); males 12–14 (N=5); males 15–19 (N=25). Multiple responses possible. *Notes:* Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 9.18 Percentage of adolescents who know of HIV/AIDS, by HIV/AIDS information sources used and preferred, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=1257)	15-19 (N=1303)	Total (N=2560)	12-14 (N=1192)	15-19 (N=1294)	Total (N=2486)
Where respondent got information about HIV/AIDS*						
Any family	65.5	64.4	64.9	42.4	35.5	38.8
Any friend	31.3	40.2	35.8	41.4	46.8	44.2
Any teacher or health provider	64.9	67.3	66.1	61.4	69.7	65.7
Any mass media	55.4	67.5	61.6	64.4	77.6	71.3
Mother	42.2	40.5	41.4	19.6	15.8	17.6
Father	16.9	16.6	16.7	17.3	14.9	16.1
Spouse/partner	0.1	3.8	2.0	0.1	0.4	0.2
Brother	4.5	5.6	5.0	8.9	8.5	8.7
Sister	10.6	9.7	10.2	2.8	2.9	2.8
Other female family	35.4	37.5	36.4	11.6	8.5	10.0
Other male family	12.5	15.3	13.9	17.6	15.1	16.3
Female friends	30.7	39.7	35.3	4.5	7.6	6.1
Male friends	3.7	7.5	5.7	41.0	45.8	43.5
Teacher/school	59.2	54.5	56.8	56.1	61.9	59.1
Doctor/nurse/clinic	15.7	28.4	22.2	13.3	25.3	19.6
Traditional or spiritual healer/herbalist	0.2	0.2	0.2	0.1	0.3	0.2
Church	4.9	5.3	5.1	4.2	7.0	5.7
Community/neighborhood	6.6	7.8	7.2	4.7	4.3	4.5
Newspaper	8.1	15.2	11.7	8.6	22.3	15.7
Books/magazines	2.1	3.8	3.0	2.5	6.9	4.8
Radio	52.7	63.5	58.2	62.9	74.3	68.8
Television	4.9	9.7	7.4	4.2	8.7	6.5
Internet	0.2	0.3	0.2	0.0	0.2	0.1
Poster/billboard	1.7	3.1	2.4	1.1	1.5	1.3
AIDS campaign/club	0.2	0.5	0.3	0.6	0.8	0.7
Other	2.6	4.9	3.8	5.4	5.5	5.4
Don't know/unsure	0.2	0.1	0.1	2.4	0.8	1.5
Preferred sources for information about HIV/AIDS*						
Any family	34.1	32.8	33.5	18.7	14.7	16.6
Any friend	8.4	10.7	9.6	10.5	10.6	10.5
Any teacher or health provider	59.0	63.5	61.3	57.5	62.4	60.1
Any mass media	35.9	42.8	39.4	39.5	47.3	43.5
Mother	24.4	21.6	22.9	8.4	6.0	7.1
Father	6.0	5.3	5.7	9.2	7.4	8.2
Spouse/partner	0.1	1.3	0.7	0.1	0.1	0.1
Brother	1.1	1.4	1.3	1.9	2.3	2.1
Sister	3.5	3.5	3.5	0.8	0.4	0.6
Other female family	11.2	11.5	11.3	1.2	1.0	1.1
Other male family	1.3	0.9	1.1	2.6	2.6	2.6
Female friends	8.3	10.4	9.4	0.7	0.5	0.6
Male friends	0.6	0.7	0.7	10.3	10.4	10.3
Teacher/school	42.1	30.0	35.9	40.4	36.0	38.1
Doctor/nurse/clinic	31.0	44.8	38.0	30.1	41.6	36.1
Traditional or spiritual healer/herbalist	0.2	0.1	0.2	0.1	0.1	0.1
Church	3.8	4.0	3.9	1.4	1.2	1.3
Community/neighborhood	0.2	0.5	0.4	0.8	0.5	0.6
Newspaper	5.2	6.9	6.1	3.8	9.5	6.8
Books/magazines	0.8	1.8	1.3	0.9	1.3	1.1
Radio	31.4	36.5	34.0	36.9	40.8	38.9
Television	3.0	4.2	3.6	2.1	3.8	3.0
Internet	0.1	0.1	0.1	0.1	0.2	0.1
Poster/billboard	0.2	0.7	0.5	0.2	0.3	0.2
AIDS campaign/club	0.1	0.3	0.2	0.2	0.9	0.6
Other	1.9	4.5	3.2	2.7	4.6	3.7
Don't know	4.4	2.0	3.2	6.8	3.6	5.1

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

TABLE 9.19 Percentage of adolescents who know of HIV/AIDS, by exposure to mass media messages about HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1255)	15–19 (N=1302)	Total (N=2557)	12–14 (N=1190)	15–19 (N=1292)	Total (N=2482)
In the last few months has heard or seen messages about HIV/AIDS:*						
Radio	73.9	81.3	77.7	75.0	86.9	81.2
Television	8.9	14.4	11.7	10.8	18.1	14.6
Newspaper or magazine	19.6	30.7	25.3	23.2	41.8	32.9
Poster	16.3	25.1	20.8	17.6	30.4	24.2
Leaflet or brochure	6.4	13.6	10.0	11.9	18.8	15.5
Health worker	18.4	31.8	25.3	19.8	34.0	27.2
Community or social club meeting	13.0	21.9	17.6	12.6	25.6	19.4
Level of exposure to HIV/AIDS messages in recent months						
0	20.4	13.1	16.7	20.6	9.9	15.0
1	40.6	32.9	36.7	40.4	30.1	35.0
2	19.1	18.7	18.9	14.6	18.5	16.6
3–7	19.9	35.3	27.7	24.4	41.5	33.3
Has heard the slogan*:						
"No sex before marriage"	75.2	80.0	77.6	69.0	79.5	74.5
"Life, guard it well with a Lifeguard condom"	71.0	87.1	79.2	79.0	92.3	85.9
"Abstain from sex, if you can't use a condom"	67.1	81.6	74.5	62.9	82.5	73.1
"Say no to sex"	71.6	83.6	77.7	61.6	76.6	69.4
"Be aware, AIDS kills"	92.8	96.2	94.5	88.7	95.1	92.1
"Stay safe, stay in school, the country needs you alive"	79.6	82.9	81.3	67.2	81.3	74.6
"No condom, no sex"	65.2	80.8	73.2	59.8	81.2	71.0
"Be faithful to your partner"	70.1	88.1	79.3	65.7	83.5	75.0
"Girls are six times more likely to get infected with HIV than boys"	42.6	56.8	49.8	37.8	60.9	49.8

*Totals may exceed 100 because "yes" responses to multiple items are shown. *Note:* Ns are weighted.

TABLE 9.20 Percentage distribution of adolescents who know of HIV/AIDS, by knowledge about voluntary counseling and testing, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1256)	15–19 (N=1303)	Total (N=2559)	12–14 (N=1191)	15–19 (N=1294)	Total (N=2485)
Has heard that people can get tested to see if they are infected with HIV/AIDS						
Yes	83.1	93.4	88.4	82.9	93.6	88.5
No	16.9	6.6	11.6	17.1	6.4	11.5
Knows of a place to get an HIV/AIDS test*						
Yes	58.6	74.7	67.3	65.8	79.8	73.5
No	41.4	25.3	32.7	34.2	20.2	26.5
Places known for HIV/AIDS test†						
Government clinic/hospital	88.2	87.8	88.0	93.2	94.1	93.7
Private clinic/hospital/doctor	21.4	29.0	26.0	29.3	36.7	33.7
NGO clinic	10.3	16.5	14.0	10.3	15.2	13.3
Drug shop/pharmacy	2.1	2.0	2.0	1.7	1.8	1.7
Mobile clinic	2.0	2.4	2.2	1.2	2.0	1.7
Stand alone testing center	10.6	12.8	11.9	1.9	2.8	2.4
TASO (The AIDS Support Organization)	1.8	2.2	2.0	0.9	0.0	0.4
Other	1.8	2.9	2.4	0.6	1.7	1.2
Does a person have to pay to get tested†						
Yes	24.8	28.5	27.0	25.0	28.9	27.4
No	35.1	34.3	34.6	33.8	41.0	38.1
Don't know	40.0	37.2	38.3	41.2	30.1	34.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

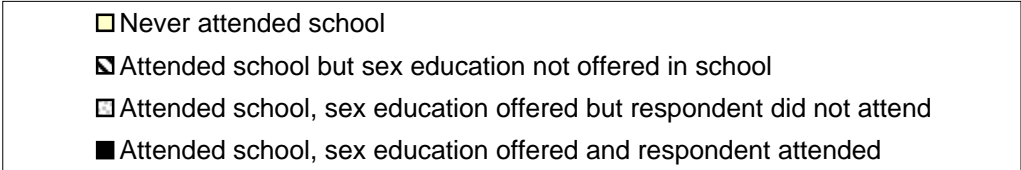
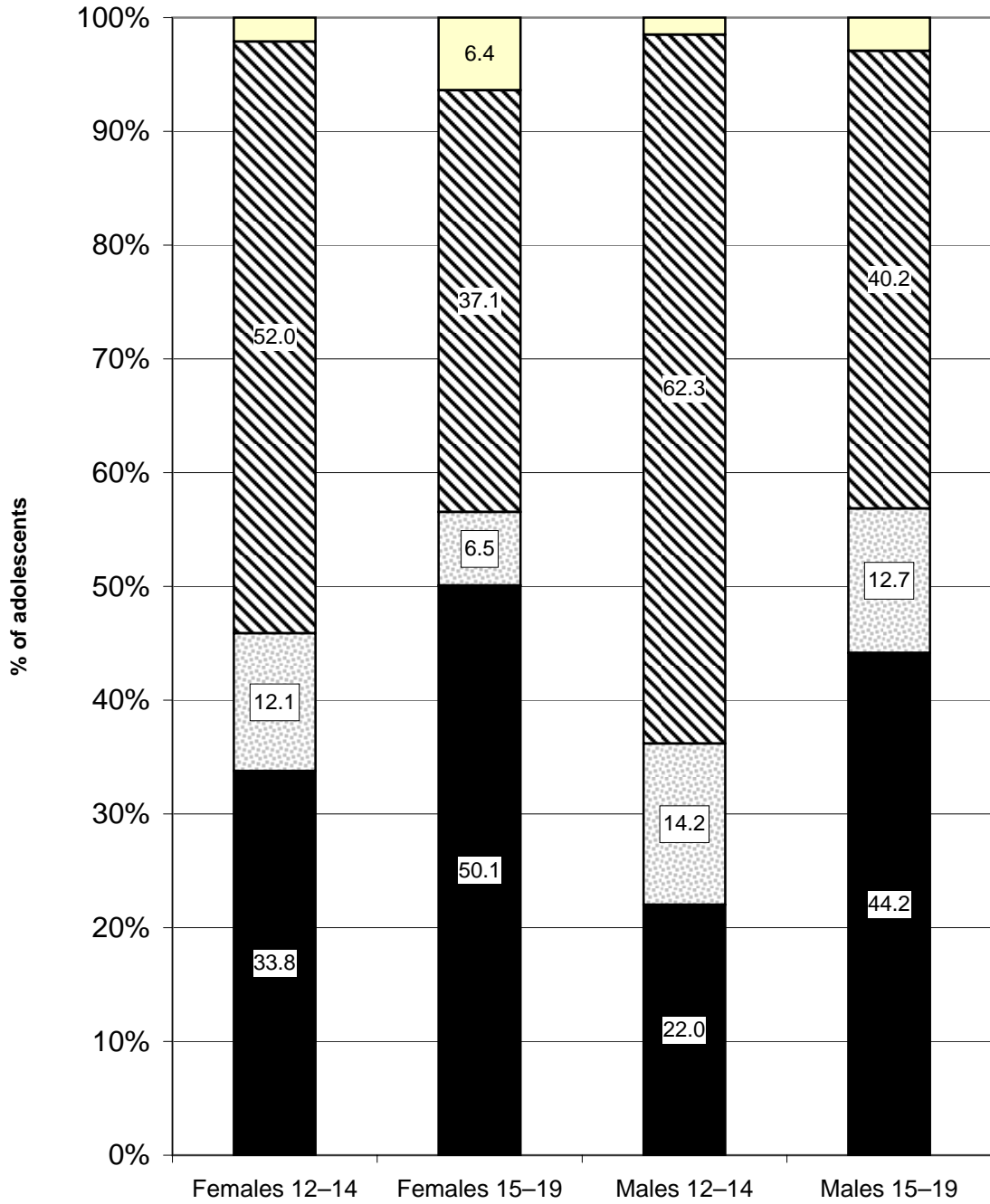
*Limited to those who are aware of a test for HIV/AIDS. Sample sizes: females 12–14 (N=1044); females 15–19 (N=1216); males 12–14 (N=987); males 15–19 (N=1210). †Question asked of those who know of a place to get tested. Sample sizes: females 12–14 (N=612); females 15–19 (N=908); males 12–14 (N=648); males 15–19 (N=965). Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

TABLE 9.21 Percentage distribution of adolescents who have never been tested for HIV and who know that a person can be tested, by desire to be tested reasons for not being tested, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=1034)	15–19 (N=1099)	Total (N=2133)	12–14 (N=983)	15–19 (N=1136)	Total (N=2119)
Want to be tested for AIDS virus						
Yes	60.4	70.3	65.5	68.3	73.2	70.9
No	39.2	29.6	34.2	31.1	26.5	28.6
Don't know	0.4	0.1	0.2	0.6	0.3	0.4
Main reason have not been tested*						
Not sexually active	41.2	20.5	29.8	28.7	20.4	24.1
Not at risk for other reasons	13.0	14.4	13.8	22.1	27.0	24.8
Do not know where to go	15.4	11.7	13.3	14.6	9.5	11.8
Costs too much	20.8	29.9	25.8	17.7	19.1	18.5
Can get infection from test	1.3	1.4	1.4	0.7	1.2	1.0
Don't want to know status	1.6	9.9	6.2	1.9	8.4	5.5
Someone might see me	1.4	2.3	1.9	0.9	1.4	1.2
Too young	0.8	0.3	0.5	2.7	0.4	1.4
No money for test	na	na	na	na	na	na
No time	0.2	1.4	0.9	0.9	3.6	2.4
Not infected	na	na	na	na	na	na
No reason	na	na	na	na	na	na
Other	4.3	8.2	6.5	9.8	9.0	9.4
Main reason do not want to be tested†						
Not sexually active	56.6	40.4	49.5	47.2	29.7	38.5
Not at risk for other reasons	19.5	22.2	20.7	27.5	33.0	30.2
Do not know where to go	2.2	2.8	2.5	3.6	1.0	2.3
Costs too much	4.4	6.8	5.4	2.0	4.3	3.1
Can get infection from test	3.9	5.2	4.5	3.3	3.0	3.1
Don't want to know status	5.6	15.7	10.1	9.2	22.3	15.7
Someone might see me	2.4	2.8	2.6	0.7	1.3	1.0
Too young	1.2	0.3	0.8	2.0	1.0	1.5
Not infected	0.0	0.0	0.0	0.0	0.0	0.0
No reason	0.0	0.0	0.0	0.0	0.0	0.0
Other	4.1	3.7	4.0	4.6	4.3	4.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who want to be tested. Sample sizes: females 12–14 (N=624); females 15–19 (N=770); males 12–14 (N=673); males 15–19 (N=833). †Limited to those who do not want to be tested. Sample sizes: females 12–14 (N=410); females 15–19 (N=324); males 12–14 (N=305); males 15–19 (N=300). Notes: Ns are weighted.

Chart 9.1 Adolescents, by school attendance and exposure to sex education, according to sex and age, 2004 National Survey of Adolescents



**Chart 9.2 Female adolescents who know of at least one method, by urban-rural difference in sources for contraceptive methods information
2004 National Survey of Adolescents**

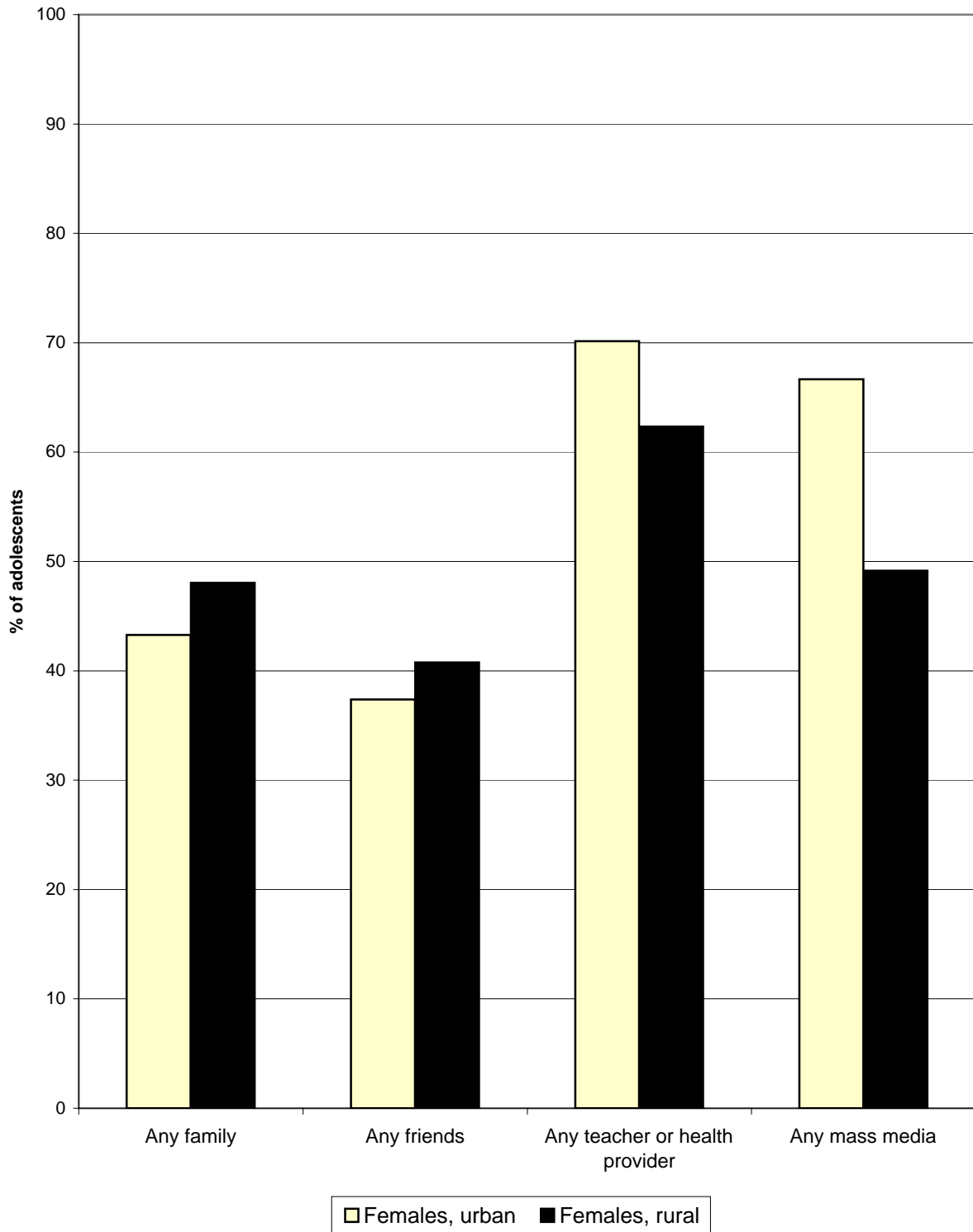
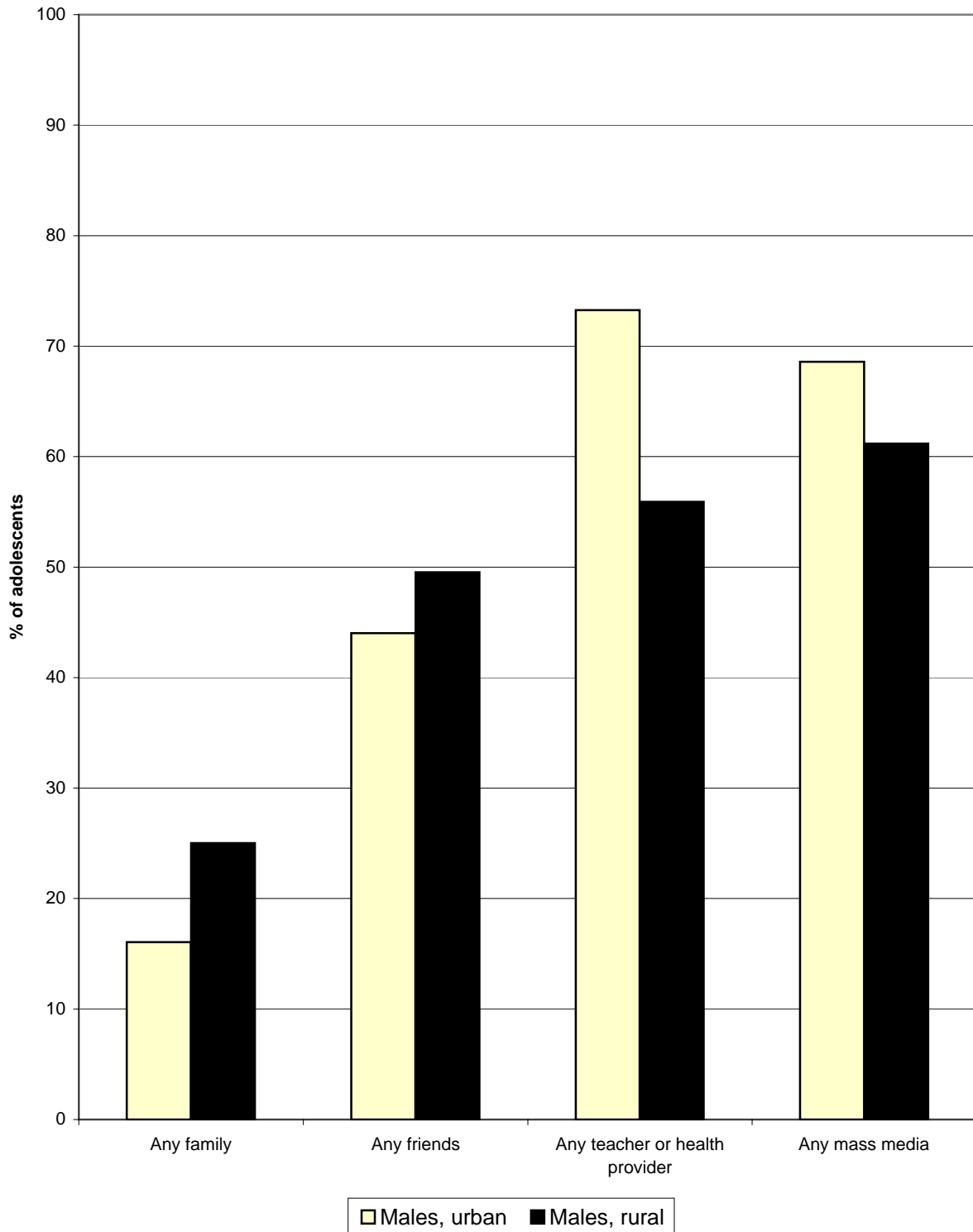


Chart 9.3 Male adolescents who know of at least one contraceptive method, by urban-rural difference in sources for contraception information, 2004 National Survey of Adolescents



**Chart 9.4 Adolescents who know of at least one contraceptive method, by used and preferred sources of information on contraceptive methods
2004 National Survey of Adolescents**

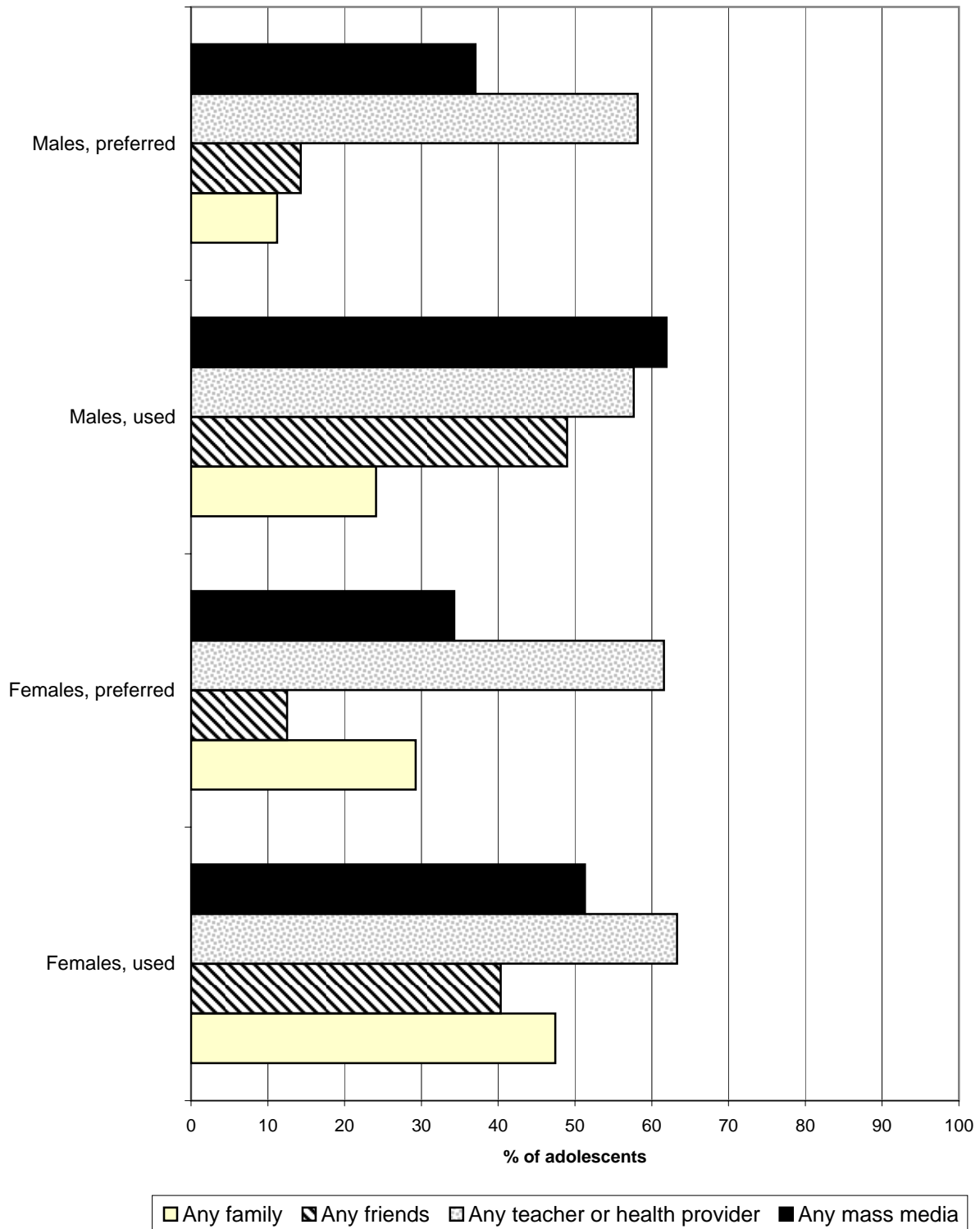
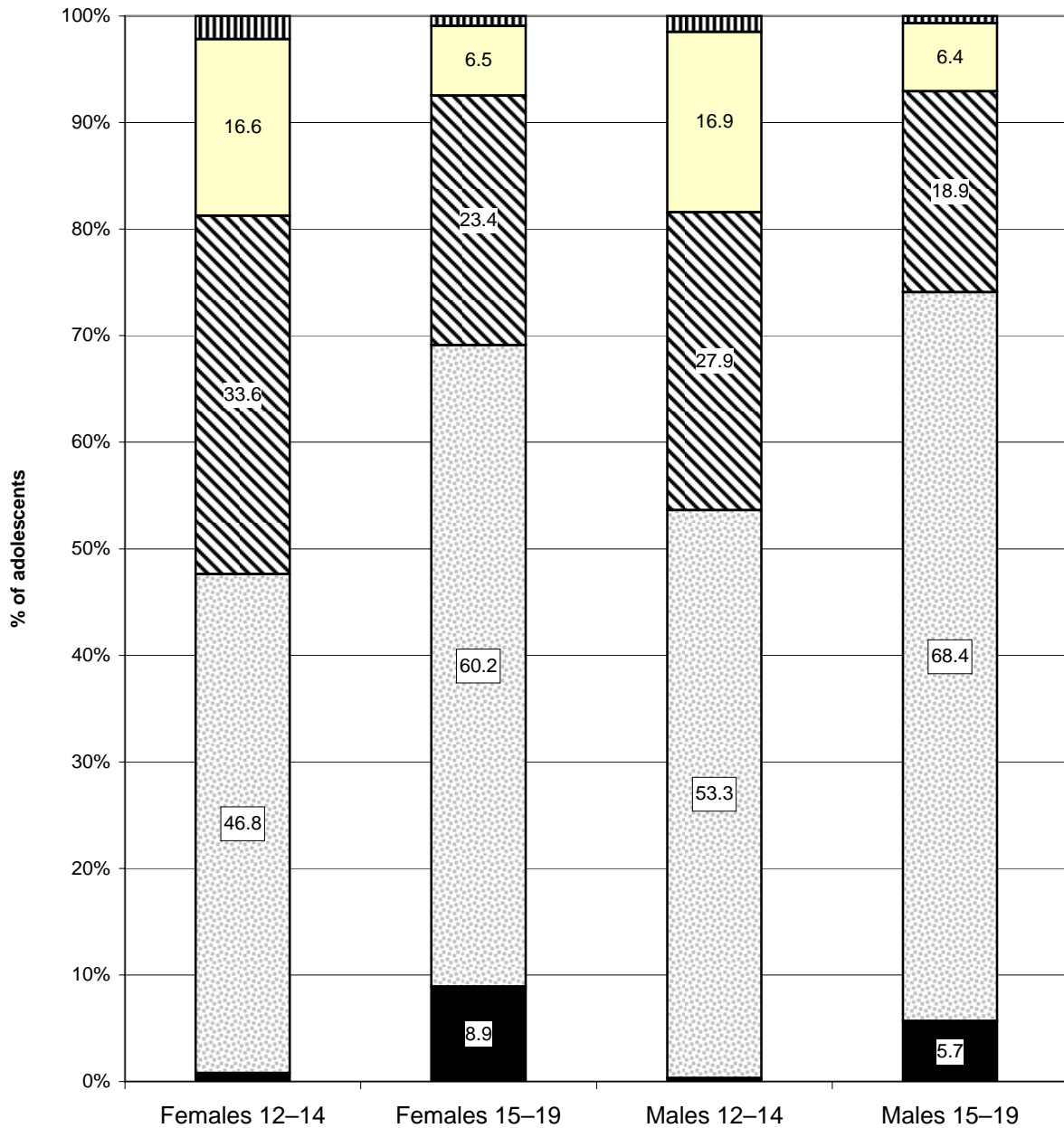


Chart 9.5 Adolescents, by knowledge and experience of voluntary counselling and testing, according to sex and age, 2004 National Survey of Adolescents



Chapter 10

Conclusions

This chapter highlights the major findings of the 2004 Uganda National Survey of Adolescents on various important aspects of young people's lives. It also draws attention to some of the salient implications arising from these findings, which, we hope, can help inform national policies and programs aimed at improving the sexual and reproductive health of adolescents in Uganda.

Although the majority of adolescents in Uganda (more than 95% of both sexes) have ever attended school, drop-out rates particularly among older female adolescents (15–19 years old) remain high. This increases their vulnerability to early and sometimes forced marriages, teenage pregnancy and STIs, including HIV. Similarly, as Uganda has one of the highest teenage pregnancy rates in the world, many female adolescents might continue dropping out of school due to pregnancy (10% identified this as the cause) unless something is done to change this situation. In general, it is important for parents and society to encourage young women to pursue higher education.

The majority of adolescents in Uganda live with their parents. A large proportion of them also report that their parents always or sometimes know where they go when they go out at night, how they spend their free time and who their friends are. At the same time, orphanhood is a common experience for many. Four in 10 children aged 18 or younger with a deceased biological parent do not live with the surviving biological parent or a parent-figure. With no parental support or adult monitoring, this group of young people is more likely to engage in high risk behavior, including sexual activity. It is also important to note that many young people in Uganda have tried alcohol, with one in four females and one in three males having tried alcohol by age 14. This is also important given that alcohol use can impair young people's judgment and ability to engage in protective sexual behavior.

While a large proportion of adolescents work, particularly males, few actually get paid. Working female adolescents are less likely to be paid in cash compared

with their male counterparts. Undoubtedly, costs of contraception and preventative measures against STIs present a major barrier to those adolescents who need them.

Although the majority (at least 90%) of adolescents have never been in a marital union, a considerable proportion of those who have never been in union, particularly those in the 15–19 age bracket, are having sex and median age for sex debut is about 15 years. Although, most 12–14-year-olds are not sexually active, they too engage in sex-related behaviors such as kissing and fondling.

Whereas avoidance of HIV and other STIs is the predominant reason cited among young people for not having sex, many adolescents are also not having sex to avoid pregnancy.

Most adolescents know of at least one method of contraception, with the male condom, injectables and the pill as the most commonly known modern methods. Some modern methods, such as implants and the IUD are not as well known, particularly among younger adolescents, and there are a significant number of 12–14-year-olds who know of no method at all. While knowledge of at least one method is relatively high, use is low.

Although most adolescents know that there are certain days in a woman's cycle when she is more likely to get pregnant, few adolescents, particularly males, can correctly identify this period. Many adolescents have misperceptions about how pregnancy occurs in general. For instance, many young people do not believe or do not know that a girl can get pregnant the first time she has sex or if she has sex standing up. More importantly, misperceptions about pregnancy are prevalent even among the sexually experienced. For instance, many of these adolescents believe that there is no risk of pregnancy when using withdrawal.

Pregnancy and childbirth is not an uncommon experience for many adolescent girls aged 15–19. And as expected, pregnancy and childbearing is more common

among those in union compared to those not in union. However, it is important to note that a substantial proportion of adolescents did not want their last pregnancy or birth at the time it occurred.

About half of young people knew of at least one method for terminating a pregnancy. As expected, older adolescents were more knowledgeable of methods than younger adolescents and the more common methods known included herbal drinks and taking tablets or pills. While few adolescents reported ever trying to terminate a pregnancy, many indicated that a close friend had. Abortion, including unsafe abortion, is not an uncommon occurrence among adolescents in the country.

Almost all young people in Uganda have heard of HIV/AIDS. More importantly, the majority know that HIV can be transmitted by having sex with a person who is infected with the virus, by sharing razors or sharp objects and by getting injections with a needle used by someone else. However, misperceptions still exist, particularly among youth in rural areas.

Knowledge of effective ways of preventing HIV transmission is also high among Ugandan adolescents, especially among urban youth. Most know that not having sex at all, having just one partner who is not infected and who has no other partners, and using a condom correctly at every sexual intercourse, as well as avoiding sharing needles are ways to avoid HIV.

While awareness of HIV is almost universal, awareness of other STIs is low among Uganda youth. Moreover, specific knowledge of STI symptoms is particularly low among Ugandan youth. Females are more likely to know of these symptoms than males. In contrast, the incidence of STIs is not low among young females, with one in four sexually experienced female adolescents reporting having had an STI. Although these results are based on self-reports, they indicate that STIs are present among the adolescent population.

Many adolescent women and men perceive themselves to be at great risk of HIV infection. This perception is higher among young women than men and among older adolescents compared with their younger counterparts. These results show that young women are aware of the higher level of vulnerability of Ugandan female adolescents (and women in general) to HIV infection, a situation that is associated largely with their low status and lack of bargaining power to negotiate protective sex. This points to the need to further empower women to have better control over their sexual and reproductive lives.

Awareness of the condom among both male and fe-

male adolescents is very high, but usage among the sexually active adolescents was moderate, with more males reporting usage than females. However, the vast majority of sexually active male adolescents do not use condoms consistently—only a third of the young men who had had sex in the three months preceding the survey reported that they used a condom every time they had sex.

Although awareness of the condom and knowledge of how it is used are quite high, only 37% of the adolescents of either sex have had a chance to see a condom being demonstrated. In fact, even among older adolescents, only 39% of the males reported that they are very confident they know how to use a condom.

Negative perceptions about condom use are still widely held among adolescents. For example, the majority of adolescents of both sexes hold the view that using a condom is a sign of not trusting one's partner.

The majority (75%) of adolescents have access to the mass media, particularly the radio, but considerable gender disparities in access exist, with 21% of the female adolescents having no media access at all, compared with only 11% of the males. Awareness-raising programs targeting youth, particularly those out of school, can reach the broadest audience by using radio, as opposed to any other single mode of communication. However, getting adolescents interested enough to tune in may pose a challenge.

Schools are an important source of sex education for adolescents in Uganda, given the country's high rates of school enrollment. However, a considerable percentage of adolescents (more than 50%) do not get exposure to sex education in schools, either because they dropped out of school in lower primary where sex education is not offered or because schools they attend or previously attended did not have sex education programs.

Adolescents are highly supportive of providing sex education in schools, and approve of teaching 12–14-year-olds how to avoid HIV/AIDS and how to use condoms to do so. However, a considerable proportion of adolescents (40%) feel that discussing sex-related issues with young people encourages them to have sex.

Exposure to sexual and reproductive health information among adolescents in Uganda is fairly high, with the majority of adolescents accessing information on contraceptives, HIV/AIDS and other STIs mainly through the radio, schools, same-sex friends and, among female adolescents, same-sex family members. Their preferred sources of sexual and reproductive health information were mainly limited to formal

sources, which included schools, health workers and the radio, in that order. However, a considerable proportion of female adolescents prefer to get information from their mothers. Substantial differences among adolescents also exist in their mode and level of access to sexual and reproductive health information, whereby urban dwellers use the more formal information access channels such as schools, health workers and the mass media, while rural adolescents rely more on the informal channels (family and friends) which casts some doubt regarding the quality of information received by adolescents in rural areas.

Policy and Program Implications

- Given the role of education in helping young people to acquire the information and services and enhancing their ability to say no to risky behavior, government, as well as parents and guardians, should ensure that young people (both male and females) attend school and help them to remain in school to complete their education. Recent government plans to introduce free secondary education are highly laudable, given that cost was identified as the dominant cause of dropping out of school.
- Research findings clearly underscore the need for targeting adolescents with safe sex messages at an early age. With the diminishing importance of traditional initiation rites, new ways of recognizing the transition from childhood into adulthood and providing information about sexual and reproductive health need to be found. This is particularly critical for young people who are out of school.
- As many Ugandan young people are sexually experienced, they need adequate information and services to live healthy sexual and reproductive lives. Sex education is a major means for achieving this. To this end, the recent efforts by government to introduce sex education in all schools, such as through the Presidential Initiative on AIDS Strategy for Communication to Youth, are laudable and need to be further strengthened and supported. Efforts should be intensified to ensure that young people are exposed to comprehensive sex education, preferably before they become sexually experienced. Adolescents should learn to various ways in which they can protect themselves from STIs, including HIV, and unwanted pregnancy.
- Although a high proportion of adolescents know about HIV, misperceptions about how it can be transmitted remain substantial and negative attitudes towards people with HIV/AIDS are still prevalent among Ugandan youth. Therefore, Uganda needs to develop effective ways of reducing misconceptions about the infection and stigma towards people with HIV/AIDS. Furthermore, knowledge of STIs other than HIV is very low among Ugandan adolescents. Programs should be directed at helping to increase young people's knowledge about different types of STIs, their symptoms, modes of transmission, ways they can be prevented and how to seek treatment for those that are curable.
- Survey findings indicate that many adolescent females become pregnant or have a birth when they did not intend to, thereby pointing to the need for teaching young people about how pregnancy occurs. Education on the female reproductive cycle, particularly when a woman's fertile period occurs, needs to be improved in order to reduce the risk of unintended pregnancy. Efforts to increase young people's knowledge of contraceptives, including an understanding of efficacy rates and correct use, is crucial in reducing their risk of unintended pregnancy. The information should also emphasize the health and social consequences of early pregnancy and childbearing.
- Since a substantial proportion of adolescents perceive themselves to be at risk of HIV, more concerted efforts need to be made to enhance HIV prevention among adolescents. This should include promoting condom use among those who are sexually active and making the method as well as voluntary counseling and testing available free of charge. Abstinence and having sex with a single partner should also be encouraged while still providing young people all information they need to make the choice that is right for them.
- As the most common and arguably the most appropriate method—particularly among young people who are not in union—and given its dual purpose of protecting against unwanted pregnancies and STIs, condoms should continue to be promoted among adolescents. Because of the misconceptions around the use of the method, condom campaigns should promote condoms as a way to show care (not mistrust) toward one's partner. There is need also to further promote condom demonstrations in order to encourage consistent and correct use of the method among adolescents.

- Findings from this study also show that young people in Uganda prefer to obtain sexual and reproductive health information from the formal health care system, schools and mass media. Also, contrary to the conventional wisdom which suggests that young people prefer to obtain health services from traditional healers and other informal providers, many adolescents indicated that they prefer obtaining health care from the formal health providers (public and private). In order to help adolescents access their preferred providers, policies and programs should ensure information and service provision that is devoid of stigma, embarrassment and shame for young people who need these services.
- The findings from this study also point to the advantages of parents' involvement in their children's lives. Relevant government agencies and program planners should make concerted efforts to educate parents and guardians about the benefits of being involved in their children's activities and lives. Appropriate programs to achieve this should be developed and promoted.
- Nearly all young people identify with a religion and most consider religion to be very important to them, with the majority attending religious services at least once a week. This is one way in which many adolescents can be reached with HIV prevention and unintended pregnancy prevention messages, provided accurate and comprehensive information is given. Both government and NGOs should continue to find a way to facilitate dialog and work with religious organizations for the common goal of helping young people avoid HIV and unwanted pregnancy. Other avenues for promoting sexual and reproductive health education include social groups and clubs to which many youth belong, such as drama, choir, football and net ball clubs. Efforts should be devoted to involving these key groups in achieving the goal of healthy lives for Ugandan adolescents.

To achieve the goal of helping young people in Uganda live healthy sexual and reproductive lives requires a multiplicity of approaches and coordinated efforts by the people of Uganda, including the government, NGOs, individuals and international agencies. Given that the young people are the future of any country and their health and well-being has an important implication for the social and economic life of the country, it is crucial that concerted efforts be made to protect the young generation from the negative impact of

HIV/AIDS and unintended pregnancy. Granted, there are financial and human resources constraints and these have implications on what the various groups can do. However, with proper coordination and planning, Uganda can develop and implement necessary policies and programs to address the issues raised by the findings in this study, thereby paving the way towards better health and life for its young people.

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