Adolescent Sexual and Reproductive Health in Uganda: A Synthesis of Research Evidence

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Introduction

In Sub-Saharan Africa, the majority of new HIV infections are sexually transmitted and among the population infected with AIDS, women outnumber men.[1] Limited access to education and to economic resources characterizes the lives not only of women but also of young people of both sexes. Young people's limited access to resources gravely undermines their health and healthcare–seeking behavior. Most young people are aware of the dangers of HIV/AIDS but continue to be involved in sexual behaviors that place them at high risk of contracting the disease.[2] There is also a growing body of evidence confirming that in many countries, most young people do not routinely seek appropriate sexual and reproductive health information and care. The overburdened and under-financed public health and education systems that are in place are often unable or reluctant to provide such services—let alone high-quality services—to young people.[3]

In Uganda, adolescents are confronted with life-threatening health risks related to unwanted pregnancies, HIV/AIDS and sexually transmitted infections (STIs). Adolescence is a life period of experimentation and frequent risk taking. Key factors for adolescent vulnerability to sexual and reproductive health problems include: lack of awareness and lack of correct information about the risks of unwanted pregnancies and STIs, peer and other social pressures, lack of skills needed to resist such pressures and to practice safe behavior, lack of youth-friendly sexual health and counselling services, poverty, traditional cultural norms that give young women a low social position, and little power to resist persuasion or coercion into unwanted sex.

HIV/AIDS was first identified in Uganda in 1982 in Rakai district bordering Tanzania. By 1985, most districts in the country were affected by HIV/AIDS. Prevalence reached a peak in 1992 with rates as high as 30% recorded in some urban sentinel surveillance sites, and an estimated average of 18% in the total adult population.[4] Beginning in 1986, Uganda adopted a broad-based and open position vis-à-vis the epidemic to combat the disease. In 1992, the government launched a multi-sectoral approach involving nongovernmental organizations (NGOs), the donor community, the private sector, academia, faith-based organizations, communities and civil society organizations. By September 2003, approximately 2,500 NGOs were involved in HIV/AIDS-related work in Uganda.[5]

Uganda is now heralded as a Sub-Saharan African country that mounted a successful response to HIV/AIDS. HIV prevalence in Uganda declined from 18% in 1992 to an estimated 5% of the total adult population by the end of 2001.[6] Since the early 1990s, Uganda adopted a comprehensive behavior change approach that focused on all three of the main methods of reducing risk of infection: abstinence, partner reduction and condom use. Survey evidence over time suggests that the rapid decline in HIV/AIDS in Uganda can be attributed to change in all three key behaviors: increased abstinence and delay of first sex, decreased numbers of sexual partners and increased condom use.[7] HIV/AIDS care and prevention initiatives that were pioneered in Uganda, such as The AIDS Support Organization program, are also being replicated in a number of countries.

Despite recent successes, the AIDS epidemic in Uganda still poses a serious threat to the future of the country's youth. Females remain at higher risk of contracting HIV/AIDS during adolescence because of the social and cultural factors that lead many to experience early initiation of sexual activity.[8] While youth in Uganda constitute nearly 50% of the total number of those infected, the vast majority of those cases are female—the male-to-female ratio of HIV infection is 1:4 for teenagers compared to 1:1 for adults.

This report provides a comprehensive overview of current knowledge on adolescent sexual and reproductive health issues in Uganda with a focus on HIV prevention. It draws upon the existing body of social science research and includes both quantitative and

qualitative studies. Its goal is to communicate key findings from existing research to a wide audience concerned with sexual and reproductive health in Uganda. The specific objectives are:

- to synthesize key findings from previous studies on adolescent sexual and reproductive health in Uganda;
- to identify information gaps in order to inform the development of future research in this area; and
- to highlight priority areas for programs and policies aimed at improving the sexual and reproductive health of youth.

The issues reviewed are sexual behavior, marriage and childbearing, sexual coercion, abortion, contraceptive use (with particular attention paid to condom use), knowledge related to HIV/AIDS and other STIs, sexual attitudes, protective practices, and health information and services.

The main sources of quantitative information are the nationally representative 1988–1989, 1995 and 2000–2001 Uganda Demographic and Health Surveys (UDHS) that included young people aged 15 and older; we also draw from various other subnational surveys (see box). In addition, qualitative studies that focused on adolescent sexual and reproductive health in Uganda provide in-depth information that supplements the quantitative data. A set of key indicators of young people's sexual and reproductive health knowledge and behaviors from the 2000–2001 UDHS is included in the appendix tables for all females and males aged 15–19 and by specific subgroups.

This report 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.* 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. This will be done by communicating new knowledge to policymakers, health-care providers and the media in each country as well as regionally and internationally with the expectation that this will stimulate the development of improved policies and programs that serve young people. The research involves focus group discussions with adolescents, qualitative interviews with adolescents and key adults and national surveys of adolescents. This research synthesis is the first activity of the project, laying the groundwork upon which the study results can be interpreted.

The Meaning of Adolescence

Adolescence is a period of transition from childhood to adulthood. This period is characterized by emotional, biological and psychological changes, putting adolescents at risk for early marriage, unwanted pregnancies, unsafe abortion, STIs, HIV/AIDS, sexual abuse and exploitation. Adolescents' sexual and reproductive health is of national concern for Uganda because the country has a youthful age structure with a broad-based population pyramid characteristic of a developing country. In Uganda, young people (10–24-year-olds) constitute about 33% of the total population, 24% are aged 10–19 and the size of the youth population is increasing rapidly.[9] In 2000, adolescents aged 15–24 were estimated to number 4.7 million and are expected to increase to 5.5 million by 2005 with the population growth rate estimated to be 3.24 percent.[10] In 2001, 48.9 percent of the population was under 15 years of age.[11]

The World Health Organization defines adolescence as ranging from 11 or 12 through 17 or 18 years of age. Most programs in Uganda have used the age range of 10–24 years to denote the age of adolescence. This report draws on survey data measures for 15–19-year-olds, but also refers to findings from studies of youths who are younger and older than this age range.

In Uganda, adolescence is regarded as the period during which the process of growth into adulthood occurs. Traditionally in Uganda, adolescents are still regarded as children and hence have been exploited in part due to the culture of silence imposed upon them as they lack a way to express their voice in family and community affairs.[12] They are not regarded as adults because they are still under the care of their parents, most do not have property, and decisions are still made for them. Adolescents are seen as needing guidance and protection from their parents, relatives and community members. They are also sometimes seen as unruly and stubborn. Many adolescents are still living with their parents and have little or no power to exercise their sexual and reproductive rights. Adolescent girls are particularly disadvantaged as males are accorded higher value than females.

A study by Programme for Enhancing Adolescent Reproductive Lives[13] in Tororo district, eastern Uganda, brought some insights to how adolescents and parents define an adolescent:

One who behaves like a child and not an adult. Men-

struation also begins for girls (Female adolescent, 20–24 years old, Tororo municipality)

Adolescents are people who are not married (Mothers, West Budama)

Growth characteristics from childhood to man/ womanhood were mentioned and include: development of breasts for girls and beards, experience of wet dreams, and changes in voice for boys. In the same study, parents defined adolescents more often in terms of behavior. Their behavior was described as bad, very stubborn, adventurous, and chaotic:

This is a stage of chaotic indiscipline and they never listen to parental advice (Mothers, Tororo municipality)

This is when a boy or a girl is in a stage of unruly behavior (Mothers, West Budama)

Adolescents are different from children because they their secondary sexual characteristics are developing and they are thought to be unruly and adventurous.

In Uganda, though there is a diverse ethnic composition, community norms and values and traditional practices relevant to adolescent sexual and reproductive behavior are relatively similar across the country. Some of the social norms and practices are beneficial for adolescent reproductive health such as upholding virginity, while others are harmful in as far as the risks of HIV/AIDS, other STIs and unwanted pregnancy are concerned. Traditionally, virginity was upheld and there were gifts given to the paternal aunt such as a goat and other gifts if the husband found the bride a virgin at marriage. However, anecdotal information reveals that this practice has long ceased to be of cultural importance and is no longer commonplace. Those practices that increase adolescents' vulnerability to reproductive health risks include early exposure to unprotected sex, early marriage and genital cutting (female circumcision is practiced among the Sabiny while male circumcisions is practiced among the Bagisu, both of Eastern Uganda). Female genital cutting has devastating effects on adolescent females' sexual and reproductive lives. Similarly, male circumcision is known to increase the vulnerability of youths to HIV/AIDS through the sharing of knives and casual sex during dancing ceremonies.[14] However, once completed, male circumcision may reduce the risk of HIV infection.[15]

There are different gender socialization processes for adolescent boys and girls in Uganda. Traditionally, discussion of sex and other reproductive health matters between adolescents and adults has been restricted to certain topics and certain people. For adolescent girls among the Bantu ethnic groups of Uganda, the traditional channel of communication about sex has been the *senga* (i.e., the father's sister or aunt),[16] while for adolescent boys community elders have fulfilled this role in some settings.[17] Given the HIV/AIDS pandemic, parental guidance and communication on such issues is mentioned in many countries as an important protective factor. Yet there is little adolescent-parent communication in Uganda today and is largely a function of social and cultural norms prohibiting direct communication about sexual matters between parents and adolescents.

National Conditions Shaping Adolescents' Sexual and Reproductive Behaviors

Poverty is an important socioeconomic factor affecting adolescent sexual and reproductive health as well as physiological development. Unemployment is a characteristic problem of youth in Uganda. Youth (10–24-year-olds) who are out of school often work as housemaids, barmaids and food venders and in other low status, informal jobs. UDHS 2000–2001 data show that most young people 15–24 years of age work in the agriculture sector, as Uganda is mainly an agrarian country. Of those who reported working, 78% of 15–24-year-old females and 58% of males in this age group are engaged in agricultural activities. Young women in rural areas and those in the western and northern regions are more likely than women in other regions to work for a family member. Barton and Wamai[18] found that adolescents are exploited by their employers, especially adolescents engaged in low-income jobs, and do not control even the little income they receive. Some are never paid and for those who are paid, the level of pay is very low and their pay is irregular. Kyadondo[19] highlighted that limited access to income and income sources contributes to a lack of access to health care services.

Ugandans have free access to mass media, including the press, radio and television broadcast. Information, education and communication programs have been found to influence behavior. There are a number of programs targeting the young people that are aired on radio and television related to adolescent sexual and reproductive health. Adolescents who have been exposed to such messages are reported to be more knowledgeable and more likely to have changed their behavior than those who were not exposed.[20]

The government of Uganda put in place a Universal Primary Education policy in 1997 to ensure that its citizens become literate: user fees for primary schools were eliminated for four children per family.[21] School enrollment at the lower levels improved, and among adolescents there has been a steady decline in the proportion who have never attended school. Figure 1 shows a general decline in non-attendance for 15–19-year-old females from 21% in 1988–1989 to 9% in 2000–2001, and among 20–24-year-olds from 30% to 15%. Yet a gender gap still exists—young women (15–24) are more likely to never have attended school (12%) compared to young men (2%).[22] Once they have ever attended school, the gender gap narrows somewhat: of adolescents aged 15–19, 35% of females and 39% of males have 7 or more years of education (Appendix Tables 2 and 3, line 1). Similarly, 23% of young women and 29% of young men 15–24 years old attained secondary or higher education (data not shown).[23]

Civil strife in some districts of northern Uganda that has characterized the area since 1987 has jeopardized the health of adolescents through abductions, rape and the internal displacement of young people and their families. Adolescent males are targeted as new recruits and females are targeted as wives for rebel soldiers. Many adolescent females have been raped, become pregnant and been forced to marry. Some have been infected with HIV.[24]

National Laws and Policies

The Government of Uganda has put in place policies aimed at improving the sexual and reproductive health of adolescents. These policies were geared towards the improvement of adolescents' health and life status by influencing future demographic trends and patterns in a desirable direction. Specifically, the policies are targeted at reducing fertility, maternal mortality, infant and child mortality and increasing life expectancy. Through 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, improving their sexual and reproductive health and increasing contraceptive use and levels of delivery attended by trained health personnel. These policies include the National Youth Policy[25] (in draft form); the National Policy on Young People and HIV/AIDS;[26] the Sexual and Reproductive Health Minimum Package,[27] the Affirmative Action Policy[28], a minimum age of sexual consent policy setting the minimum age for sexual consent at 18, a universal primary education statute[29], and laws prohibiting harmful customary practices such as early marriage. Table 1 in the appendix shows policies/ guidelines related to adolescent sexual and reproductive health that have been put in place.

A number of other national policies that have beneficial implications for adolescent sexual and reproductive health have been put in place in the 1990s: the National Population Policy;[30] the National Health Policy;[31] the National Gender Policy;[32] the Reproductive Health Policy (in draft form), the national reproductive health service delivery policy guideline; the Sexual and Reproductive Health Minimum Package for Uganda; national AIDS control policy proposals;[33] and the Decentralization Policy (see Appendix Table 1).

Some of the reasons inhibiting full implementation of some of these policies include:

- lack of funds and inadequate mechanisms to popularize, distribute and disseminate the policies throughout the country;
- lack of awareness of various stakeholders of their roles and responsibilities in implementing policies;
- lack of stakeholders knowledge about how and whether to use some of the policies; and
- bureaucratic delays.

Nevertheless, these initiatives foster a supportive and conducive environment for adolescent sexual and reproductive health.

When the African Youth Alliance (AYA) started its operations in Uganda in 2000, it carried out an assessment on policies and found that many stakeholders at national and district levels were not knowledgeable about these laws and policies, partly explaining the limited implementation.[34] AYA in its policy and advocacy component produced and widely disseminated booklets and brochures of relevant provisions of adolescent sexual and reproductive health related laws and policies to policy makers, civic leaders, religious and cultural leaders, school board of governors, youth advocates and parents.[35] It is hoped that this dissemination will improve knowledge and actual implementation of these policies.

Adolescent Sexual and Reproductive Experiences

Young people are more likely to engage in sexual behavior that puts them at risk for HIV/AIDS, unwanted pregnancy, unsafe abortion, early marriage, early childbearing and sexually transmitted infections. In this section we review existing evidence in Uganda on adolescents' age at first sex and marriage, number of sexual partners, types of sexual relationships and other outcomes such as abortion.

First Sexual Intercourse

Young people in Uganda start sexual activity at an early age. Trend data from the UDHS[36] show an increase in the median age at first sex among adolescents.[37] The median age at first sex for female adolescents (15–19 years) was 16.0 years in 1988–1999, 16.3 years in 1995, and 17.1 years in 2000–2001 (see Figure 2). For male adolescents in the same age range (15–19 years), the median age at first sex increased from 17.7 years in 1995 to 18.3 years in 2000–2001.[38] Among female adolescents age 15–17 in 2000–2001, 34% have had sex (Appendix Table 2, line 5). The proportion of males the same age who have ever had sex (27%) was lower than that of females. By age 18–19 the proportion sexually active was substantially higher for both sexes (77% and 59% respectively) (Appendix Tables 2 and 3, line 5). Although median age at first sex for both adolescent males and females has slightly increased over the years, females on average still start having sex before males. Yet adolescents, especially those who are not in a union, tend to have sex sporadically. The proportion of sexually experienced adolescents aged 15–19 who were currently sexually active in 2000–2001 was 76% for females and 57% for males (Appendix Tables 2 and 3, line 8).

The age of the sexual partners can be used as a proxy measure for power in the relationship. Sexual coercion of females has been shown to be more likely to occur with an older male partner. Data from the 2000–2001 UDHS showed that only 3% of females aged 15–24 said that their first sex partner was either younger or the same age, 25% of females had partners who were 1–2 years older, the majority had male partners were 3 or more years older, and about 1 in 10 male partners were 10 or more years older.[39]

First Union/Marriage

Early marriage for adolescents in Uganda remains common but is declining. The 1995 UDHS showed that 48% of females and 11% of males aged 15–19 had ever been in a union.[40] Data from the 2000–2001 UDHS show 32% of females and only 7% of males aged 15–19 were ever in a union (Appendix Tables 2 and 3, line 10). Relatively few adolescents marry at the youngest ages: 7% of women aged 15–19 were married by age 15 in 2000–2001.[41] By age 20, 74% of women had ever been in a union compared to only 26% of men.[42] Data from the 2000–2001 UDHS also show that the median age at first marriage was 17.7 years for women 20–24 years old and 21.9 years for men 25–29 years old (Appendix Tables 2 and 3, line 11).

Early marriage exposes adolescent girls to risks of early pregnancy that might result in complications such as prolonged labor, stillbirth, postpartum hemorrhage, maternal distress and mortality. Adolescent mothers who are single are at higher risk of incurring complications related to pregnancy since many adolescent single mothers do not attend antenatal care because they are either ashamed of their pregnancies or they do not realize they are pregnant.[43] Consequently, complications related to pregnancy are often not detected early enough amongst this population, thus increasing the severity of pregnancy complications. These factors may explain why the highest percentage of births delivered by caesarean section is to mothers under age 20.[44]

Number of Sexual Partners

Engaging in multiple sexual relationships is known to be one of the factors that significantly increases the risk of HIV infection. In Uganda, multiple sexual partners

are not uncommon among adolescent males. According to 2000–2001 UDHS data, 4% of sexually experienced 15–19-year-old females had 2 or more sex partners in the 12 months prior to the survey compared to 15% of sexually experienced males (Appendix Tables 2 and 3, line 9). Trend analysis shows that these numbers have been declining. Among sexually active adolescents, the proportion with two or more sexual partners declined substantially for females from 1989 to 2000–2001 and for males from 1989 to 1995 but changed little between 1995 and 2000–2001.[45] Data from the 1989–1995 Global Program for AIDS surveys showed that the proportion of unmarried, sexually active 15–19-year-old females who had 2 or more recent sex partners declined from 32% to 17% and for males from 66% to 35%.[46] A study by Busulwa and Neema in Mubende, Central Uganda, revealed that one in four adolescent females (15–24) admitted to having had a sexual partner who they knew had other concurrent sexual partners.[47]

Sexual Partnerships

Another factor driving the HIV/AIDS epidemic among adolescents is cross-generational sex that is often unprotected.[48] Evidence from Uganda shows that some adolescents have sexual relationships with older, usually wealthier, men or women called sugar daddies and sugar mummies.[49] These types of sexual relationships are increasing because of the AIDS epidemic since older men seek out adolescent girls as sexual partners in an attempt to avoid contracting HIV since it is believed that adolescents are still "safe" from infection.[50] The oppressive poverty experienced by adolescents makes it difficult for them to afford some of their basic needs, making sexual relationships in exchange for material goods or money more tempting.[51] A study by Busulwa and Neema in Mubende, Central Uganda, revealed that some adolescent girls expected favors or gifts were as a reward for having sex.[52] In a sexual networking study in Rakai District, 50% of female adolescents' sexual partners were 20–24 years of age, 18% were 25–29 and 9% were over 30 years old. Male partners were mainly traders and salaried workers, relatively high status professions in Uganda[53] Adolescent males are less likely to have significantly older sexual partners. Ninety-six percent of males reported sex partners who were in the same age range (15–19 years) as themselves and the females were mainly students and housemaids.[54] Data from the 2000–2001 UDHS showed that younger men were more likely than older men to have paid for sex (2% of men age 15–24 and 2% of men age 25–34 years who had had sex in the prior 12 months as compared to 1% of men 35–54 years of age had paid for sex at least once).[55]

Sexual Coercion

Sexual coercion of adolescents is not uncommon in Uganda. It is more likely to happen when the woman is younger than her sexual partner. A study among secondary school youth in the Kabale district of western Uganda found that 31% of girls and 15% of boys reported that they had been forced to have sex.[56] In a qualitative study using focus groups, Neema and Kiguli found that sexual abuse of female adolescents was common and the people who were abusing them were usually people known to the adolescents.[57] Circumstances leading to sexual abuse that were brought up by the participants included poverty or economic dependency; dressing "indecently" which can entice a rapist; staying with people of the opposite sex in closed places; leaving children by themselves and leaving children with other people such as house boys. House girls (maids) are particularly vulnerable to unwanted sexual advances when the wife of the head of the household is absent. A study in the Rakai District using 1998–1999 survey data from 4,279 women of reproductive age focused on coercive sex *within* current sexual partnerships and found that young women (under age 25) were significantly more likely to have been coerced to have sex by their partner than older women (35 years and older).[58] Having first sex at a very young age (before age 15) was also associated with a higher likelihood of coerced sex with the current partner compared to women who had their first sexual experiences at 18 years of age or older.[59]

Female Genital Mutilation

Female genital mutilation is still practiced in a few areas of Uganda, where it remains a rite of passage for girls and young women. Female genital mutilation causes severe pain, may result in excessive bleeding and increases the risk of infection including HIV. Other consequences are painful intercourse, difficulties during childbirth and low sexual desire.[60] Uganda's demographic and health surveys of 1988–1989, 1995, and 2000–2001 did not collect data on female genital mutilation. The Sabiny ethnic group in eastern Uganda's Kapchorwa District is the main ethnic group that practices genital cutting. Other ethnic groups that practice it are the Pokots in Karamoja District, the Kalengins in Tororo District, the Busia, the Bugiri, the Kamuli, the Iganga, the Masindi, the Kumi and residents of Mbale District and Luwero Districts, specifically

Nubians.[61]

Although there are no laws in place that prohibit female genital mutilation, the government does condemn it. The Sabiny Elders Association has made an effort to find alternate rituals to this practice. The association partnered with the United Nations Population Fund (UNFPA) in 1996 to address female genial mutilation and has since served as a model of global best practice. The Reproductive Education and Community Health Project in Kapchorwa, where genital cutting is taking place, has tried to devise other means to initiate adolescents into womanhood and discourage the practice. Similarly, various community-based educational interventions were designed and put into practice by the Family Planning Association of Uganda (FPAU) that addressed female genital mutilation among the Sabiny community of Kapchorwa.[62] A study by Kirya and Kibombo[63] showed that the decline of genital cutting started in 1992. The Sabiny are beginning to change their perceptions towards female genital mutilation, particularly young and educated community members. The study revealed that 82% of the females eligible for circumcision objected to the practice. Among the community members surveyed, only 21% wanted the practice to be maintained, 11% wanted it modified and 68% were in favor of complete eradication.[64] The results were attributed to mobilization and sensitization of community members against the practice.

Pregnancy and Childbearing

Unwanted adolescent pregnancy and childbearing and the associated consequences pose a serious public health concern and contribute to rapid population growth in Uganda. Ten percent of births (in the 5 years prior to the survey) to 15–19-year-old mothers were not wanted at all and 23% were mistimed.[65] Complications of pregnancy, abortion and childbirth are the leading causes of disability and death among women between ages 15 and 19 in Uganda.[66] Aside from health consequences, teenage pregnancy results in school abandonment and lost career opportunities.[67] Until recently, adolescents who got pregnant in Uganda were prevented by their parents and the school system from going back to school. Because of universal primary education instituted by the government and new attention being paid to the rights of female adolescents, adolescents who get pregnant are now allowed to go back to school after delivery.

Teenage pregnancy has decreased in Uganda over the past decade. In 1995, 43% of 15–19-year-old females were pregnant or had already had a child compared to 35% in 2000–2001 (Appendix Table 2, lines 12 and 13).[68] The proportion of women in Uganda who have had a first birth before age 15—and are therefore at very high risk for poor health outcomes—has also decreased over time. In the UDHS 2000–2001, approximately 10% of women 30–34 years old reported giving birth before age 15 compared to only 2% of 15–19-year-olds.[69]

Abortion

In Uganda, abortion is highly restricted by law, although it is practiced clandestinely. Hence it is difficult to obtain complete information on abortion using direct questioning, as is often done in surveys. A large 1992 study in Uganda by Agyei (n=2695) showed that 15% of female youth (aged 15–24) who had ever been pregnant had terminated a pregnancy.[70] A more recent study done by FPAU in Mbarara in 1997 revealed that 82% of female adolescents knew an adolescent who had been pregnant and 78% knew someone who had had an induced abortion. According to this study, induced abortions were mainly performed (36%) using local methods such as taking herbs, tea leaves, and drugs such as aspirin, and 23% were performed by medical health workers.

A study by Mirembe showed that in the local teaching hospital in Uganda, 68% of abortion patients were 15–19-year-olds.[71] AYA conducted a baseline study in sampled districts of Uganda found that 9% of male adolescents had been involved in an abortion (e.g., helping their girlfriends to abort), while 3% of female adolescents reported that they had ever had an abortion.[72] Given the likelihood of underreporting abortion in face to face interviews, these are probably underestimates of actual proportions. High rates of maternal mortality and morbidity as well as increased school drop out, violence and expulsion from home have been associated with high rates of induced unsafe abortion.[73]

Contraceptive Knowledge and Use

While contraceptive knowledge and approval of contraception among adolescents is high, the level of actual use among sexually active adolescents is low. Recent UDHS data from 2000–2001 show that while 96% of married 15–19-year-old women know of at least one contraceptive method (and 95% know of at least one modern method) and more than three-quarters of both male and female adolescents approve of family planning (Appendix Tables 2 and 3, line 20), only 30% of them have ever used a method.[74] This percentage of ever use of a contraceptive method is higher than the 1995 figure of 24% ever use among married

15–19-year-old women.[75] Among all sexually active 15–19-year-olds, 35% of females and 44% of males have ever used a modern method, the majority of them using the male condom (Appendix Tables 2 and 3, lines 15 and 16). Some of the reasons given for contraceptive nonuse include side effects; lack of appropriate knowledge about methods; opposition to use (personal, social and religious); misconceptions attached to safety of use; and costs related to purchase. In 2000–2001, the main reasons for nonuse of contraceptives among married women aged 15–29 who were not using and did not intend to use a contraceptive method included side effects (30%), intention to get pregnant (12%), partner's opposition (10%), health concerns (10%) and religious prohibition (5%).[76]

Unmet Need for Contraception

Unmet need for contraception usually refers to a situation where women do not want any more children or want to delay their next child for two years or longer but are not using any method of contraception. Despite early marriage and high fertility, there is still a high unmet need for contraception among young women in Uganda. Younger women predominantly wanted family planning for spacing rather than limiting, as many had not yet started their childbearing. Using sexual intercourse in the past month as a measure of exposure to the risk of unintended pregnancy among fecund women, the proportion of never married 15–19-year-old women with an unmet need for family planning is fairly low and stable: 8% in 1988–1989 and 6% in 1995. However, among all sexually experienced fecund never-married adolescents 15–19 years old, the group that is at more immediate risk, unmet need is fairly substantial: 20% in 1988–1989, 22% in 1995.[77] Among married women aged 15–19, the proportion of unmet need for family planning is higher but also stable: 25% in 1995 and 26% in 2000–2001.[78]

Condom Use

By the mid 1990s, the Uganda Ministry of Health and the AIDS Control Programme overcame initial condom stigma and the open promotion of condoms began through the assistance of donor agencies including UNICEF, UNFPA, the FPAU and CMS. Despite strong opposition against the promotion of condoms by religious groups and parents arguing that condom availability would promote immorality, the demand for and the actual usage of condoms among young people in Uganda has been increasing.[79] The percentage of sexually experienced adolescent females who had ever used a condom rose from 3% in 1988 to 31% in 2000–2001 among 15–17-year-olds and from 3% to 26% among 18–19-year-olds in the same time period.[80] The corresponding increase in condom use among sexually experienced adolescent males was from 25% in 1995 to 42% in 2000–2001 among 15–17-year-olds and from 38% to 46% among 18–19-year-olds.[81]

Among adolescents who had sex in the 12 months prior to the UDHS 2000–2001, 19% of 15–19-year-old females and 42% of males had used a condom at last sex (Appendix Tables 2 and 3, line 19). Condom use is much higher among educated adolescents and those living in urban areas, sometimes by a factor of 3 or more (Appendix Tables 2 and 3, line 19). The 2002, the AYA baseline survey in 24 Ugandan districts found even higher percentages of condom use at last sex among sexually experienced adolescents: 62% for 15–19-year-old females and 50% for 15–19-year-old males.[82] Barriers to using condoms include lack of knowledge about how to use them, cost, availability (especially in rural areas), fears and distrust about condom effectiveness, and the perception that condoms themselves are a source of the HIV virus.[83]

Data from the 2000–2001 UDHS show that young women use male condoms for preventing pregnancy or both pregnancy and STIs, while young men primarily use male condoms to prevent STIs. Nearly one-quarter (23%) of 15–19-year-old females said they used a condom at last sex to prevent STIs, 36% to prevent pregnancy and 40% to prevent both STIs and pregnancy (see Figure 3 and Appendix Table 2, lines 30–32). Young men in the same age group were more likely to use condoms for STI prevention (55%), whereas 15% used condoms to prevent pregnancy and 27% to prevent both (Appendix Table 3, lines 30–32).

Adolescent Knowledge, Attitudes and Experiences with HIV/AIDS and Other STIs

HIV/AIDS and STIs

HIV/AIDS in Uganda is recognized as a serious health and development concern. The most vulnerable group is individuals 15–40 years of age. In Uganda, HIV prevalence is very low among 5–14-year-olds and begins to rise in the 15–29 age group, particularly among females.[84] Until the end of 2000, HIV prevalence was highest among adolescents 15–19 years of age with females 3 to 6 times more likely to be infected than males.[85] The highest infection rate is now amongst married females.[86] Modest declines in HIV prevalence rates have been registered in the young age group in urban and rural areas. Surveillance data, based on testing carried out at a few selected sites, show modest declines over the one year period 2000–2001 in two sites (one in Kampla and one in eastern Uganda) and substantial declines over a long period, 1993–2001, in a site in northern Uganda. For example, data from St. Mary Lacor Hospital in Gulu, northern Uganda showed declines in HIV prevalence among 15–19-year-olds from 22% to 6% from 1993 to 2001, and from 32% to 11% among 20–24-year-olds from 1993 to 2001. In Nsambya Hospital in Kampala, the HIV prevalence rate declined from 9% to 8% among 15–19-year-olds from 2000 to 2001 and from 12% to 7% among 20–24-year-olds from 2000 to 2001.[87]

Other sources of prevalence data from a longitudinal study in Masaka District showed that HIV prevalence among adults age 13 years and above was 5% in 2002, with prevalence rates of 5% among males and 6% among females, and overall prevalence rates among children ages 12 and under were 1%.[88] Data from antenatal clinic attendees in 2002 show HIV prevalence rates of 7% for 15–24-year-old women in major towns and 4% outside major towns.[89] Data from the AIDS Information Centre (AIC) 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.[90]

Asiimwe-Okiror et al. carried out serological surveys from 1989 to 1995 and population-based behavioral surveys in 1989 and 1995 among pregnant women attending antenatal clinics in eastern Uganda. Results from the serological surveys indicated substantial declines in HIV prevalence. According to the population-based survey results, the decline in HIV prevalence can be attributed to changes in sexual behavior and increased use of condoms. These changes include delayed age at first sexual intercourse among young people aged 15–24 a decrease in exchanging money for sex, and an increase in condom use among both males and females. The proportion of young men who never had sexual intercourse increased from 31% in 1989 to 56% in 1995 and increased among young women from 26% in 1989 to 46% in 1995. Exchanging sex for money decreased by almost 50% among both men and women. Between 1989 and 1995, the ever-use of condoms among sexually active respondents more than tripled among men (15% to 55%) and increased from 6% to 39% among women.[91] This analysis did not find a significant change in the number of non-regular sexual partners that adolescents were having in the time period under study.

Nationally representative data from the three Demographic and Health Surveys conducted in Uganda substantiate these trends. Between 1988 and 2000–2001, the percentage of 15–17-year-old females with sexual experience decreased from 50% to 34% and among 18–19-year-olds from 81% to 77%. Among males 15–17 years of age, the percentage with sexual experience decreased from 29% to 27% between 1995 and 2000 and for 18–19-year-olds from 71% to 59% in the same time period.[92] Unlike the Asiimwe-Okiror et al. study, Singh et al. found a significant drop in the number of non-regular sex partners between the first two surveys. In 1989, 27% of 15–17-year-old females had had multiple partners (either married with a non-regular partner in the last 12 months or unmarried with 2 or more partners in the last 12 months) while by

1995, that percentage had dropped to 9%. For 18–19-year-olds, the percentage dropped from 13% to 5% in the same time period. For males 18–19 (the sample size for 15–17-year-old males was too small) the percentage dropped from 59% to 17% in this same time period.[93] The percent of 15–17-year-old females who used a condom between 1988 and 2000 increased as well (see previous discussion).

Knowledge and Attitudes Toward HIV/AIDS

Given that there is no known cure for HIV/AIDS, the extent and quality of knowledge about the epidemic and how to prevent it are of utmost importance. Knowledge regarding HIV/AIDS has increased dramatically in Uganda. Most people, including adolescents, know about HIV/AIDS, its modes of transmission and available preventive options. The most recent UDHS data show universal awareness of AIDS among adolescents (Appendix Tables 2 and 3, line 22).[94] The same data show that 86% of male and 78% of female 15–19-year-olds knew two or more effective ways to avoid HIV/AIDS.[95] 83% of male and 69% of female adolescents knew of condoms and over 80% of adolescent males and females knew that limiting the number of sexual partners were ways of avoiding HIV/AIDS.[96] About 80% of male and 72% of female adolescents said a healthy looking person can have the AIDS virus, while only 11% of male and 12% of female adolescents reported that they did not know if HIV/AIDS can be transmitted from mother to child (Appendix Tables 2 and 3, line 26).[97] Yet in a qualitative study of Mbale adolescents, Hulton et al. revealed that there is a gap between knowledge of safe-sex behavior and actual behavior. [98] The authors contend that the underlying barriers to behavioral change are rooted within the economic, social and cultural context of young people's lives. One important barrier identified by the authors to improving sexual health is young men's lack of accountability for the outcomes of their behavior.

Yet there is not complete knowledge about what it means to be living with AIDS. A recent study by Wabwire-Mangen et al. in the five divisions of Kampala found that 83% of young people between 15 and 24 years of age knew that it is not possible to cure AIDS and 59% believed that anti-retroviral drugs are effective at treating HIV/AIDS.[99]

Stigma-related issues were explored in the UDHS 2000–2001.[100] About 37% of male and 49% of female adolescents believed that people should be allowed to keep their HIV-positive status private. Just under 1 in 5 adolescents said they were willing to care for a relative with AIDS at home. Over half of male and female adolescents (55% and 54%, respectively) did not believe HIV-positive teachers should be allowed to keep teaching.[101] In Kampala, young adults were slightly less tolerant than older age groups. Wabwire-Mangen et al. found that when 15–24-year-olds in the Kampala District were asked whether people infected with HIV/AIDS should not be allowed to stay in the same community, 14% agreed compared to 9% of 25–34-year-olds, and 10% of those aged 35 and older.[102]

Voluntary Counseling and Testing

Uganda was at the forefront of Sub-Saharan African countries when it introduced voluntary and confidential HIV testing and counseling services in 1990. As of 2002, the AIC, the main NGO providing voluntary counseling and testing (VCT), listed 70 VCT sites serving 55,000 clients.[103] Most Ugandan adolescents say they are willing to get tested. Among those who have never been tested, 72% of male and 67% of female adolescents reported they wanted to be tested (Appendix Tables 2 and 3, line 29). Data from an AIDS Information Centre in Kampala reveal that a great number of those who come for VCT are youths.[104] However, overall the proportion of youths who report having been tested is far short of the reported demand: 3% of males and 6% of females 15–19-year-old said they have ever been tested for HIV/AIDS (Appendix Tables 2 and 3, line 28).

An important example of recent VCT activity focused on adolescents in Uganda is the Naguru Teenage Information Centre, which started providing VCT services in May 2002. In their first year and a half of service, a total of 3,576 young people accessed counseling there with the majority of clients being female. This is may be because adolescent females are more likely than adolescent males to perceive that they are at high risk for HIV. Out of the 2,032 young people who accessed VCT at Naguru Teenage Information Centre in 2003, 129 (6%) tested positive. Out of the 129 who tested positive, 85% were female.[105]

Knowledge and Experiences with Other STIs

Knowledge of other STIs is much lower than knowledge about HIV/AIDS. Thirty percent of male and 34% of female adolescents had no knowledge of STIs other than HIV. Among 15–19-year-olds who had ever had sex, 2% of males and 7% of females reported they had had an STI and/or STI symptoms in the 12 months prior to the interview.[106] Survey data from 24 districts in Uganda collected in 2002 by AYA showed that about

1 in 20 10–14-year-olds reported that they had ever contracted an STI (4% of males and 6% of females), 5% of male and 9% of female 15–19-year-olds reported having had an STI, and about 1 in 10 20–24-year-olds reported ever contracting an STI (10% of males and 14% of females).[107]

In spite of these low national prevalence statistics, data from Naguru Teenage and Information Centre show that STI management is still the main medical problem that young people present at the youth center.[108] In 2002, STIs comprised 64% of all the clinical problems presented. In 2003, STI management accounted for 37% of persons attended, followed by 30% seeking advice regarding body changes and 33% with pregnancy related problems.

Risk Assessment

Exposure to a friend or relative dying of AIDS can make one recognize the risk involved in one's own behavior. With HIV/AIDS, perceived susceptibility to risk is a precursor to taking effective action. The more susceptible one feels, the more likely one is to take preventive action. Due to the stigma attached to HIV/AIDS, not many people openly accept that they are susceptible,[109] and not many studies have assessed people's HIV/AIDS risk perceptions. Nationally representative survey data from 1995 showed that 5% of male and 8% of female 15–19-year-olds reported they were at great risk of contracting HIV.[110] A recent study by Wabwire-Mangen et al. in Kampala showed that 13% of young people aged 15–24 years reported they were at high risk of getting AIDS, 21% reported a medium risk, 56% reported a low risk and 10% did not know.[111] Compared to other age groups, proportionately more young people reported their risk as low compared to older adults.

Influence of Others on Adolescent Behavior

Peer pressure is a significant force that helps shape youth's behavior, attitudes, values, and knowledge as they grow up.[112] For example, a midterm review of Straight Talk Foundation revealed a strong positive association between adolescents who engage in unprotected sex and adolescents who associate with peers who engage in risky behavior.[113] The role of peers increases in importance when the role of parents is diminished. Another finding from this study was the weak role that parents played in communicating with their adolescent sons and daughters about sexual matters.[114] Kinsman et al. highlighted that schoolgirls have encountered a wide range of influences such as parents, paternal aunts, peers, school, and different types of media.[115]

Sources of Information and Health Services

Youth face multiple barriers to accessing sexual and reproductive health information and services. Sometimes services may not exist at all or where they exist, the services are not affordable or are opposed by adults.[116] Adolescents get their information from traditional and modern sources. The *senga* (a traditional channel for sex education to be passed from older women to younger women) still exists, albeit in weakened form, but the sex education provided is limited in nature—maintaining one's virginity before marriage and labia elongation are commonly discussed, but risk practices for HIV are frequently not.[117] Since these traditional systems of communicating information about sex are weakening, peer groups, schools, churches, the media, traditional health practitioners, and NGOs have emerged as the most prominent sources of health information for young people in Uganda.[118]

The paternal aunt (*senga*) figure is being revived, especially in the central region of Uganda.[119] Some recent initiatives, for instance, by the Buganda Kingdom have tried to use the existing structure of the *senga* to improve adolescents' access to reproductive health information and other resources for healthy sexual behavior decision-making and to empower young girls with the skills to say "no" to unwanted sex, negotiate safer sex and delay their sexual debut if they were not yet sexually active.[120]

Various international and national organizations have developed interventions aimed at behavior change and service delivery strategies for adolescents. These organizations (and their interventions) include the UNICEF (Basic Education, Child Care and Protection, and Adolescent Development), UNFPA, Programme for Enhancing Adolescent Reproductive Lives, the Family Life Education Programme, and Delivery of Improved Services for Health, which has provided services aimed at improving adolescent use of reproductive health services in public health care facilities. UNFPA-supported NGOs contributed to increasing awareness, motivation and adoption of safe reproductive health behaviors and increased accessibility and utilization of reproductive health services. Other organizations include the African Medical and Research Foundation and the AYA. The goal of the efforts spearheaded by these organizations was to contribute to the reduction of adolescent reproductive health problems including the incidence of HIV/AIDS, other STIs and unwanted pregnancy in Uganda through a multi-sectoral, nationwide scaling up of services.

"Youth-friendly" services are reproductive health services prepared for, convenient to, and utilized by youth and adolescents that include counselling, contraceptive services, post-abortion care, VCT, and STI information and management, including referrals. However, studies show that most of the sexual and reproductive health services in Uganda are not youth-friendly and have not attracted many adolescent clients.[121] It is now recognised that youth-friendly services are important and needed if young people are to receive adequate sexual and reproductive care. These services have to meet young people's needs in a comfortable and responsive way. No matter where the services are provided (clinical setting, teenage center, informal avenues, etc.), certain youth-friendly characteristics are essential to any effective program. A minimum package of youth-friendly sexual and reproductive health services typically includes:[122]

- information and counseling on safe sex and reproductive health;
- contraception and protective method provision (with emphasis on dual protection);
- STI diagnosis and management;
- HIV counseling (and referral for testing and care);
- pregnancy testing, antenatal, delivery and post natal care;
- counseling on sexual violence and abuse (referral for needed services);
- postabortion care, counseling and contraception (providing referral where necessary); and

- service providers oriented to render youth-friendly services.

Ugandan youth experience limited access to youth-friendly services and information which could help them have protected sex or to postpone sex. While most services in the country are generally offered to all people, there are few units that have services focused on youth. Even when services are offered, adolescent are not accessing the services due to lack of confidentiality, rudeness among service providers, ignorance about the existence of these services and fear of embarrassment.

Within these youth-focused programs, the range of care options vary.[123] A study by Mbonye[124] assessed the impact of youth-friendly health services in the Jinja District by conducting a Knowledge Attitudes and Practices study among adolescents and providers at eight health services locations, four of which had implemented youth-friendly services. Results showed that more adolescents were accessing services from the youth-friendly sites than those at non-youth-friendly sites. Adolescents accessing services from the youth-friendly sites were more knowledgeable about adolescent health problems and the factors that contribute to these problems, contraceptive methods and HIV and other STIs. However, the inconsistent supply of contraceptives and STI drugs were a major impediment to the quality of services offered at these locations. The author concludes that the package of adolescent-friendly services improved access to reproductive health care and the use of services.

One reputable youth-friendly service provider is Naguru Teenage and Information Centre in Kampala. The services offered include medical services covering STIs, pregnancy and general problems, as well as VCT, condom distribution and referrals. The demand for services has increased over the years. One service rarely accessed by adolescents but offered at the center is pregnancy testing, and young people have steadily been increasing their demands for this service. In the past, the out-of-school young have accessed this service more than the in-school. Almost half of those tested positive—of the 906 who took the test, 485 (54%) were pregnant.[125]

In Uganda, both cultural and religious NGOs have played a major role in providing health information and service needs for youth. Religious institutions such as the Kampala Diocese, Uganda Catholic Secretariat, Diocese of Namirembe, and Uganda Muslim Supreme Council all have programs targeting youth sexual and reproductive health. Similarly, cultural institutions and kingdoms, such as the Buganda Kingdom, have programs targeting youth through awareness-building. Unfortunately, most of the sexual and reproductive health services are still situated in urban areas. Remote and rural areas remain largely underserved.

HIV/AIDS Services

HIV/AIDS initiatives aimed at young people in Uganda exist in both the public and the private sector. In the public sector, ministries whose mandate includes youth education and reproductive health have been influential. They include the Ministry of Education, the Ministry of Local Government, National Council for Children, the Ministry of Gender and the Ministry of Health. The private sector includes over 640 NGOs and community-based organizations which are providing health care including a range of interpersonal communication services for youth, as well as outreach through print and mass media.[126] The civil sector also plays a key role in providing VCT services in Uganda. As of 2003, civil society organizations provided 80% of VCT and 90% of post-test counselling and care.[127]

Currently, adolescents are vulnerable to HIV infection mainly through sexual abuse and, for females, early marriage. School-going children, especially girls, are vulnerable to male teachers while most who are out of school are either child laborers or are married off by their parents/guardians (Makerere Institute of Social Research, 2003). Early interventions targeting this age group were implemented through school-based programs such as the School Health Education Project, Health Education Network and Save Youth from AIDS. These programs focused on integrating HIV/AIDS in school curricula and building the capacity of teachers to handle topics related to HIV/AIDS. Currently programs such as free hot lines, phone-in radio programs, Internet and print media have been initiated, targeted at school-going children. These programs help adolescents get answers about various issues surrounding sex and sexuality in a confidential manner. In addition, several community-based programs have integrated child rights protection awareness into their programs to empower children and parents to fight child abuse. Strict laws including death penalties for those convicted and proven guilty of sexual abuse have also been instituted.

Between 1992 and 1998, several innovative, peer-support interventions were implemented, mainly in secondary schools and tertiary institutions. These programs emphasized the formation of AIDS Challenge clubs (which hold interschool debates on HIV/AIDS topics), the provision of youth-friendly information, education and communication materials and the training of peer leaders and counselors. Since 1999, other innovative programs have been initiated such as the Programme for Enhancing Adolescent Reproductive Life; the Sara Communication Initiative; the Naguru Teenage and Information Centre; Basic Education, Child Care and Protection, and Adolescent Development; and Straight Talk Foundation. These programs generally seek to enhance youth skills in communication, sexual negotiation, responding to peer pressure and developing positive relationships with the opposite sex. In addition, the programs help youth to acquire life skills for use in actual situations such as responding to sexual advances, avoiding an attempted rape and making life long development plans. Other initiatives include teaching improved decision making and problem solving with regard to AIDS, sexuality and health.[128]

Youth-friendly messages have also been developed by the Uganda Ministry of Health that emphasize abstinence until marriage (A), faithfulness for those in relationships (B) and use of condoms if the first two fail (C)—the ABC approach.[129] Most researchers who have investigated the role of ABC in the decline of HIV/AIDS in Uganda agree that the decline can be attributed largely to that approach. Yet there is disagreement determining the roles of each of the three prongs (A, B and C) in the decline. Some analysts attribute the decline to A and B, with C contributing minimally or insignificantly to the decline.[130] Contrary to this claim, however, some other researchers have shown that all three prongs changed substantially during the period of the HIV/AIDS decline in Uganda and that it is important to emphasis the importance of all of these components in efforts to explain the decline.[131]

Health services targeting adolescents are often limited to schools. These services include curative servic-

es and information, education and communication on growth and development through film shows, plays, seminars and talks. Yet there are other locations of service provision beyond the school. Information, education and communication programs found in schools, health units and religious institutions mainly focus on HIV/AIDS and other STIs, sex education, growth and development, life skills education and behavior change. There are also services being offered by NGOs, churches and health-care providers. Posters, media talks and seminars are used to convey health information to young people.[132] The programs for the most part stressed abstinence over contraceptive use. Adolescents have to be socially connected to one of these service provision agencies to get access to the services. However, a number of young people are not benefiting from these services at health units because of the unfriendliness of the health staff.

Straight Talk Foundation communication strategy targets in- and out-of-school adolescents. Mass media interventions reinforce the program messages through a weekly 30-minute English-language radio show broadcast on FM stations addressing different adolescent sexual and reproductive health messages including HIV/AIDS. *Straight Talk* (targeting 15–19-year-olds) and *Young Talk* newspapers (targeting 10–14-year-olds) are produced in English every month for the in-school adolescents. A *Teacher Talk* newspaper is also produced for primary school teachers to complement teacher training in adolescent sexual and reproductive health and the *Young Talk* newspaper. The School Environment Programme aims to make the school environment in both primary and secondary schools safer and more supportive of adolescents' reproductive health. The program involves school visits, workshops on sensitization for primary and secondary teachers and school clubs in secondary schools. Challenges all of these program face include: an increasing demand for *Straight Talk* programs, which has not yet been met due to the number of staff available at the foundation; that behavior change is more likely to occur in places where services are available (yet Straight Talk Foundation is not in the business of service delivery); and social objection. Some sections of society still accuse Straight Talk Foundation of "promoting immorality" among young people because they feel, for cultural and moral reasons, it is wrong to have open discussions about sexuality with young people.

Information, education and communication materials such as posters, newspapers, and other newsprint are access channels. *Straight Talk* and *Young Talk* newspapers supplied by Straight Talk Foundation have targeted in-school adolescents with messages concerning adolescent sexual and reproductive health. Created in 1993, *Straight Talk* circulates on a monthly basis and addresses issues of sexuality, relationships, HIV and other STIs. The newspaper publishes articles by and for young people, features from health-care providers and letters from readers.[133] Videos, films and drama have been used by NGOs to sensitize adolescents and the rest of the populace to HIV/AIDS. Seminars conducted by NGOs, such as AIC and The AIDS Support Organization, and by community health workers are another important information, education and communication medium. Adolescents who come to health centers for treatment are also given sexual health information. Behavior change and communication programs in Uganda include FPAU, The Care and Support Project, AIDS Information Centre/Commercial Market Strategies, VCT Communication Campaign and Straight Talk Foundation's Straight Talk Programme.[134]

The Care and Support Project was started as a pilot project to address out-of-school youth involved in transient trades who were not being reached with HIV/AIDS prevention, medical care and psychological/social support. Activities included monthly discussions and home visits on adolescent sexual and reproductive health topics carried out by 30 peer educators, a youth phone helpline and outreach activities from churches every Sunday. Two particular challenges to the programs were that peer educators need continuous refresher training to strengthen and expand their counselling skills and information, education and communication materials were only available in English, which limited the number of people who could read them.

Because the AIC noticed a drop in VCT clinic attendance in 2000, a CMS Project was initiated by the United States Agency for International Development in the same year to develop and implement a social marketing communications campaign to increase attendance at VCT clinics. CMS built its message strategy centered on a testimonial communications campaign that presented real-life couples talking about VCT. An analysis of these testimonials allowed CMS to decide which aspects of VCT to market and to which target groups. The main strategy was to popularize the "what," "where" and "why" of VCT. In 2001, CMS assisted AIC to reverse this downward trend in a pilot project in Mbarara and Kasese districts by targeting couples aged 18–60 with a number of intervention strategies. The interventions included demand creation

(radio, print, outdoor billboards, and launch events); the creation of a support network and the promotion of a referral network. While the intervention depends heavily on service availability, services at government units are already spread thin (problems include a lack of private space for counseling, the heavy workload of health workers and the transience of trained staff) and the campaign created high demand for VCT services which at times could not be met at government sites.

The president of Uganda, Yoweri Museveni, has been well known for his crusade against HIV/AIDS. The Presidential Initiative on AIDS Strategy for Communication to the Youth, which intends to improve HIV prevention support to the youth throughout the country by increasing and sustaining HIV/AIDS education for school-going youth, is being drafted and debated. Modalities for the initiative to start are already in place and will be headed by the Ministry of Education. Following this initiative, the Ministry of Education in collaboration with the Uganda AIDS Commission, Straight Talk Foundation and Ministry of Health information, education and communication unit, are developing assembly messages related to HIV/AIDS and pregnancy prevention for all government schools. These messages are still in draft and the stakeholders are working on it to come up with a book targeting mostly in school-going adolescents.

Special Groups at Risk

As of 1994, children, adolescents and women were identified as the populations most susceptible to acquiring HIV/AIDS due to the fact that the majority of the reported AIDS cases belonged to these groups. However, owing to the growth of the AIDS epidemic and its change in dynamics, more groups have since been added to the list. These include soldiers, refugees, internally displaced persons, commercial sex workers and fishermen.[135] Risky cultural practices and norms, social expectations, war and insurgency, and early school attrition are important risk factors which make these groups particularly vulnerable.[136] In Uganda, there are a number of special groups of adolescents at risk: street children/adolescents, young sex workers, orphans, adolescents in war and refugee situations, HIV-infected youth and adolescents working in the informal sector.

Street Children/Adolescents

Due to civil strife, family disintegration, AIDS-related morbidity and mortality, lack of basic necessities at home, urbanization and the general poverty, some children are forced to live in the street.[137] A survey conducted by Fehling at al. found that many street children were orphans who left their homes in search of company in towns and slums.[138] Street children and adolescents survive through manual labor such as carrying loads for business people, stealing, pick pocketing, and prostitution (for girls). These children are vulnerable to voluntary sexual activity as well as rape, and are therefore at risk for unwanted pregnancies, abortions and abandoning their children.[139] Of the street children in Fehling's study, 27% used psychoactive substances like marijuana, alcohol and petroleum fuel. Use of these substances increases these children's risks of engaging in unprotected sexual behavior, making them vulnerable to contracting and transmitting HIV. A number of organizations have come in to help street children, including Friends of Children Association and Uganda Youth Development Link. However, there is still a need for such services.

Adolescent Commercial Sex Workers

Although there has not been a systematic study, anecdotal information and observations reveal that adolescent commercial sex workers are on the increase in Uganda. Neema and Atuyambe (2003), in a participant observation part of a study, revealed that there were quite a number of adolescent commercial sex workers observed in both high class and slum areas of Kampala. These adolescent commercial sex workers may not have much bargaining or negotiating power to force their clients to use condoms, and are hence vulnerable to HIV/AIDS and unwanted pregnancy. This calls for an in-depth investigation and the forging of ways of preventing adolescents from going on the street as commercial sex workers.

Orphans

In the last twenty years many children were orphaned in Uganda due to the numerous internal wars and HIV/AIDS that struck at the beginning of 1980. In Uganda, it is estimated that there exist 1.7 million orphans.[140] Care of orphaned children in Uganda usually falls to the extended family irrespective of whether the extended family can cope or not. In most cases, the extended family can not afford to absorb this additional burden, as they find themselves battling to survive with the current economic hardships that everyone else faces.[141] Orphans not cared for by the extended family look after themselves and their siblings or are shuttled between relatives. Many orphans have to make crucial life decisions without guidance or support from parents or elders. Poor parenting, poor socialization and fragmented schooling negatively affect these children. Furthermore, even those who become part of another family can be vulnerable to abuse—especially orphaned girls—while others are turned into housemaids at a tender age. The situation can be even worse when both parents die, leaving only young orphans in the family and resulting in child-headed households.[142]

Although child-headed households are not a new

phenomenon, they have become more common in the recent past. Child-headed households are families or households headed by children between the ages of 13 and 17. This definition of child-headed households includes children heading households with bedridden and elderly guardians. A study by Neema et al. in Rakai district revealed that female adolescents in such households have suffered sexual abuse or have engaged in early sexual activities in exchange for basic necessities at home.[143] Consequently, some have become married or pregnant at an early age.

Children/Adolescents in Conflict Areas

Large parts of northern and western Uganda have been affected by war since the late 1980s. This war is characterized by destruction of property, abduction of children and adolescents, mutilation and torture, separation of families, loss of life, orphanhood and displacement. It is estimated that over 20,000 children were abducted between 1990 and 2001. Of these abductees, 5,000 have officially returned.[144] Civil strife and armed conflict, which have led to massive displacement and family disintegration, have inhibited the ability of parents to provide necessary care and protection to young people. A recent study by Lwanga, Ntale and Opok among the internally displaced people in northern Uganda reported a lack of adequate health care services and an increase in rape and the incidence of HIV and other STIs.[145]

Low levels of knowledge of HIV/AIDS and limited access to health information and services tend to make young people in refugee camps or who live on the streets especially vulnerable to HIV infection. Displaced and refugee females are frequently exposed to sexual abuse.[146] In northern Uganda and parts of western Uganda, many female adolescents and children are raped by the warring factions. Some adolescents as a result of being raped are forced into early and unplanned marriages.[147] Black, studying the effects of war on female adolescents and children in northern Uganda, revealed that female captives frequently become wives of commanders (warlords).[148] Adolescent females may be given to lower ranking soldiers after the commanders are no longer interested in them sexually.[149] Those that escape from rebels are traumatized and in poor health. Angulo reported that though both males and females are abducted to become soldiers for the Lords Residence Army, females are subject to the added terrors of sexual slavery, rape and forced marriage, all of which have implications for their reintegration into society after they escape the army.[150] Rape, unwanted pregnancy, STIs, infertility and HIV/ AIDS result in females being stigmatized, shunned, abused and sometimes ostracized by their families and communities.

The government and civil organizations have been working to end the conflict and promote respect for human rights. A psychosocial support program for children, adolescents and their families in war-torn areas was introduced in 1998 and is now in 10 districts of Uganda. The program focuses on rehabilitating formerly abducted children and adolescents, establishing community support systems and infrastructure rehabilitation. Government soldiers have also been trained in promoting children's rights in conflict situations.[151]

Refugee Populations

Uganda has been the recipient of refugees from various countries surrounding it, especially the Democratic Republic of Congo, Somalia, Rwanda and Sudan. Most of the refugees are children and women, and many live in overcrowded settlements and camps. Studies have indicated that many of them lack sexual and reproductive health information and services, and many are raped and have been psychosocially affected.[152] In the internally displaced people's camps in northern Uganda, adolescents are vulnerable to sexual abuse; it was reported that they get pregnant at an early age and some are infected with HIV/AIDS.[153]

HIV-Infected Adolescents

HIV-infected adolescents often experience discrimination and stigmatization from family as well as the public. Some infected youth are not given the opportunity to go to school because their guardians feel it is a wasted effort, so resources are diverted to the uninfected children in the family. Furthermore, infected adolescents and children are stigmatized at school.[154] Uganda still lacks care and support services that are friendly to infected adolescents. An intervention study is currently being conducted by Academic Alliance at Mulago main referral hospital concerning HIV-positive adolescents. With the free anti-retroviral drugs in place, these adolescents have access to treatment.

Adolescent Girls Working in the Informal Sector

Girls employed in the informal sector or living on the streets are particularly vulnerable to HIV/AIDS. Studies show that in the Rakai and Masaka districts, young girls who become household heads upon the death of both parents often seek employment in the informal sector where they are underpaid and often sexually abused.[155]

Conclusions and Recommendations

- Uganda has been able to drastically reduce the one time high HIV prevalence both at the national level and among subgroups including adolescents. HIV prevalence continues to show modest declines among 15–19-year-olds and 20–24-year-olds, though more females continue to be infected than males. However, more needs to be done not only to sustain the gains have already been achieved but also to further reduce the prevalence of HIV/AIDS in the country.

- Adolescents in Uganda are quite knowledgeable about HIV/AIDS prevention measures and have taken precautions through abstinence, being faithful to their partner and using condoms. There is an increased delay in initiation of sex: age at first sexual intercourse has increased and fewer adolescents experience sexual intercourse by age 15. The number of sexual partners among adolescents has declined over time.

- Some adolescents use condoms to protect themselves, but a fairly substantial proportion of adolescents have more than one sex partner and do not use condoms. Among condom users, little is known about consistent and correct use of condoms. STI and HIV risk among young people remains high.

- Age at marriage and age at first birth is increasing in Uganda, but adolescent marriage and fertility remain high. Policies and programs to promote delayed marriage and childbearing should continue to be formulated and implemented.

- Contraceptive knowledge and use among adolescents has increased slightly since 1995. Yet not all young people in need of protection against unintended pregnancy are using a method. There still a high unmet need for family planning among young people in Uganda.

- Adolescent sexual and reproductive health services and information are still inadequate and not "youth-friendly," though there are centers in some main towns that cater solely to adolescents.

- Information, education and communication materials on reproductive health for adolescents in the form of videos, posters, leaflets, Straight Talk, and radio programs are available but have not been adequate in terms of quantity, quality and types/choices presented. Misinformation, inaccuracies and myths about adolescent sexual and reproductive health still exist and may inhibit positive behavior change.

- While some studies have shown the importance of peers in shaping adolescent risk and protective behaviors, little is known about how parents can communicate with and influence their adolescent children. There is also a need to educate both parents and adolescents on child statutes so that parents and adolescents can take legal action when the rights of adolescents have been violated.

- Special high risk groups, such as adolescents in refugee camps and internally displaced people's camps, HIV-positive adolescents and street adolescents, have not been targeted and hence continue to remain vulnerable and lacking in services that cater to their needs.

- Though there are a number of policies in Uganda related to adolescent sexual and reproductive health, many of them have not been fully disseminated and utilized. These policies need to be disseminated throughout the country, and lower-level government agencies need to be empowered to implement these policies.

- Many interventions for young people to date focus mainly on promoting reproductive and sexual health

among the sexually experienced. However, adolescents need information even before they become sexually active in order, to be adequately prepared to make choices protecting their health.

- Lessons learned from previous and ongoing interventions do not seem to be informing the programming of subsequent youth HIV initiatives. Such interventions are often poorly documented and evaluated (if at all), limiting the possibility for providing scientifically valid evidence that could be the basis for improving subsequent interventions.

- The demand for adolescent sexual and reproductive health services has continued to remain high for young people, as existing services have limited coverage and resources and typically have not been scaled-up to meet the needs of the vast majority of young people.

- VCT is an important preventive measure against HIV and can be a gateway to anti-retroviral drugs. Though there is high demand for VCT, few adolescents have utilized the services. More information is needed on the adequacy of available VCT services, access to these services and barriers that may prevent young people from using them.

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Figure 1: Trends in percent of women who never attended school, Uganda Demographic and Health Survey 1988–1989, 1995, 2000–2001

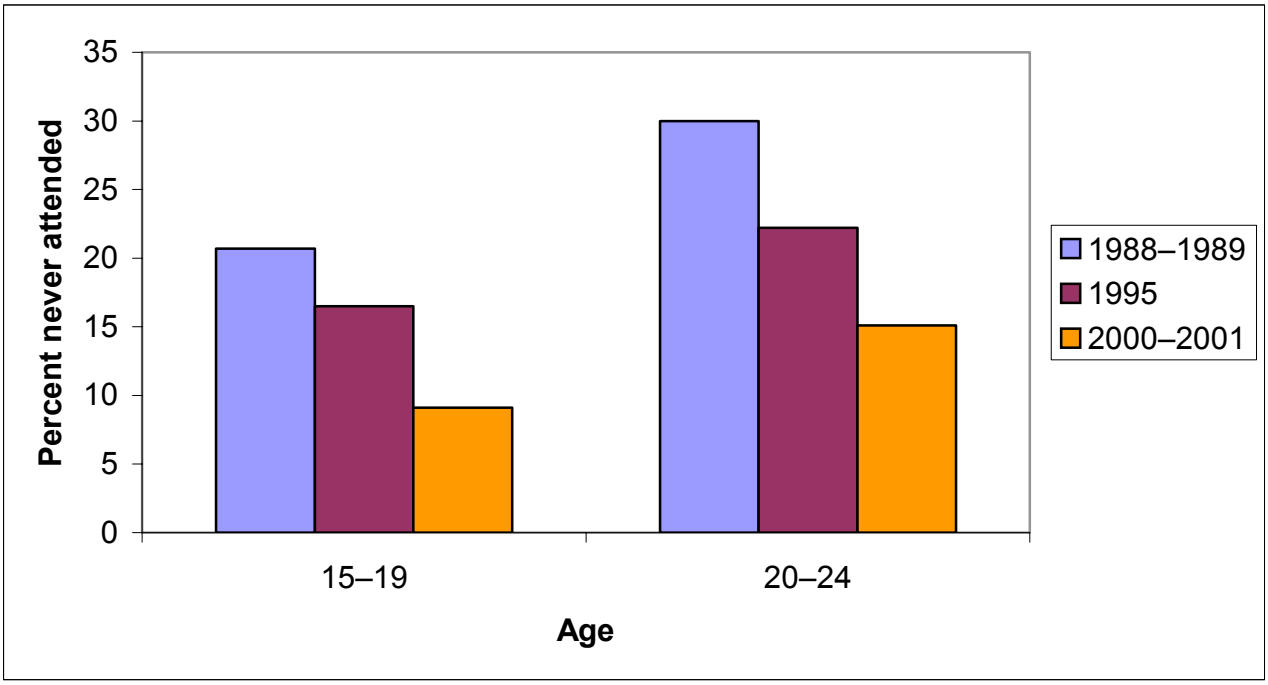

Figure 2: Median age at sexual debut among 15–19-year-olds, Uganda Demographic and Health Survey, 1988–1989, 1995, 2000–2001

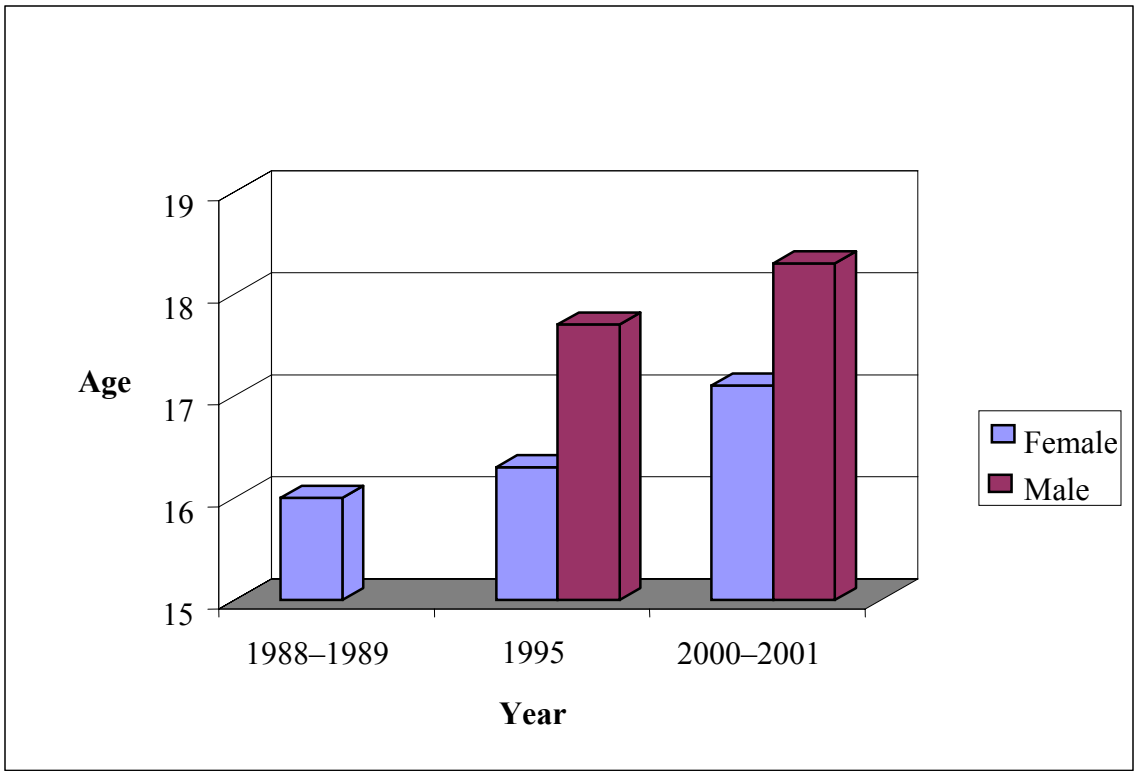

Figure 3: Reasons why 15–19-year-olds used condoms, Uganda Demographic and Health Survey, 2000–2001

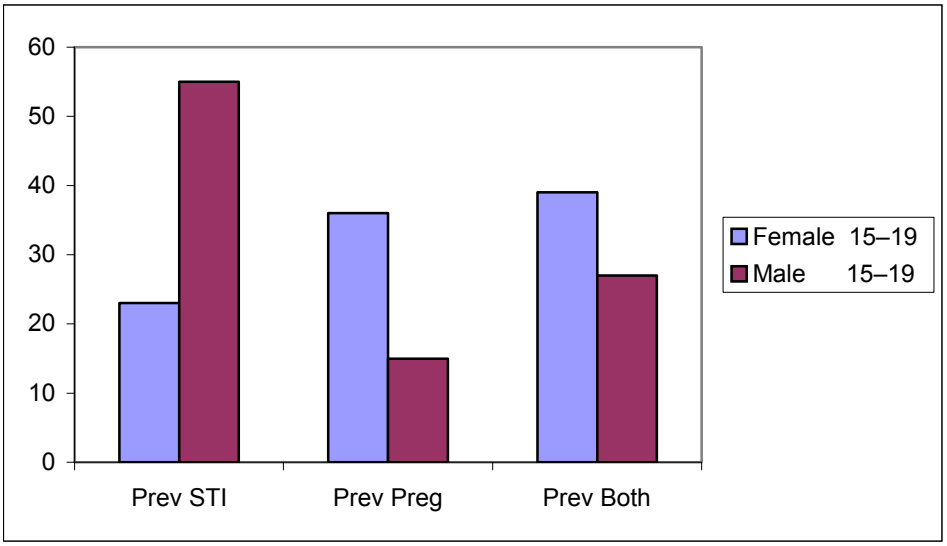

Table 1. Ugandan policies related to adolescent sexual and reproductive health

Youth-focused policies	Key pertinent issues	Remarks
National adolescent health policy	• To mainstream adolescent health concerns in the national development process in order to improve the quality of life and standard of living of young people. • To address adolescent problems and need in a multifaceted way. • To reinforce the commitment of government to integrate young people into the development processes. • Recognizes the critical role that adolescents can play in promoting and emphasizing the need for their participation in planning, implementation, monitoring and evaluation of programs. • To provide an enabling social and legal environment for the provision of good quality, accessible adolescent health interventions. • Specific themes are considered and include: reproductive health, substance abuse and mental health, accidents and disabilities, nutrition and oral health, and socioeconomic consequences/occupational health.	This policy is still in draft form.

National policy on young people and HIV/AIDS, 1998 (Uganda AIDS Commission)	• To address the transition from childhood to adulthood to avoid adolescent sexual and reproductive health problems (such as teenage pregnancies) likely to contribute to a heavy disease burden and high mother to child HIV transmission rates.	It is a draft and was submitted to the Ministry of Gender, Labor and Social Development for inclusion in the youth policy.
National youth policy, 1999 (Ministry of Gender, Labor and Social Development)	• To fulfill government obligations in development of youth as was agreed upon at the 1994 International Conference on Population and Development in Cairo and other international conventions.	Has been approved but needs to be disseminated and promulgated at national and district levels.
Affirmative action policy for females at the university, 1990 (Ministry of Education and Sports)	• To promote equity by awarding an extra 1.5 points to females entering university. • To keep girls in school at higher levels (university).	Has already been implemented. 1.5 points are added on to the grades of every female.
Minimum age for sexual consent (Ministry of Gender, Labor and Social Development)	• Consent age has been set to 18 years; sex below that age is regarded as sexual abuse. Maximum punishment is death.	Final debates are taking place.
Other policies with implications for youth SRH		
National population policy, 1995 (Ministry of Finance)	• To address annual population growth and related maternal morbidity and mortality. • Implemented by ministries of education, agriculture and culture.	Needs to be revised to incorporate emerging issues, such as the concepts of reproductive health, adolescent sexual and reproductive health, poverty eradication, decentralization, and updated UDHS and census data.
National health policy, 2000 (Ministry of Health)	• Includes targeting the youth sexual and reproductive health.	Needs to be disseminated to the districts.

National gender policy, 1997	• To integrate gender into development efforts at all levels. Gender concerns have to be mainstreamed in all development efforts including adolescent sexual and reproductive health.	Needs to be popularized, especially at district levels.
Reproductive health policy (draft)	Promotes increased availability and accessibility of services to adolescents.	It is still a draft and will need dissemination.
Sexual and reproductive health minimum package for Uganda	• Promotes increased availability and accessibility of services to adolescents.	Has been disseminated to all districts, but needs to be disseminated at lower levels.
National AIDS control policy proposals, 1996	• Multi-sectoral response to the epidemic. • Includes adolescent sexual and reproductive health. • Access to voluntary counseling and testing.	Has areas which the different sectors (e.g. education, agriculture etc) could address.
Universal primary education (UPE), 1997	• To raise school enrollment. To empower the future generation—especially for girls—socially, economically and politically so that they can demand their reproductive rights and reproductive needs.	Free primary education. Has worked countrywide—many children are now in school.
Decentralization policy, 1993	• To strengthen local governments and communities. • To bring services including adolescent sexual and reproductive health to the people. • To create an opportunity for adolescents to participate in programming on issues that affect them. • In the decentralization structure, young people are represented from village council level to the national level.	Has been implemented in all the districts.

Appendix Table 1: Selected background characteristics and measures of sexual and reproductive behavior among adolescent women aged 15–19* in Uganda, Demographic and Health Survey 2000–2001

		Age		Education		Residence		Region				Media exposure at least once a week	
Characteristics and measures	Total	15–17	18–19	<7 years	≥7 years	Rural	Urban	Central	Eastern	Northern	Western	No	Yes
Unweighted N	1687	986	701	1008	678	1059	628	622	390	236	439	598	1089
A. Background characteristics													
1. Percent with ≥7 years of education	35	32	39	–	–	28	62	53	29	13	28	14	50
2. Percent currently working	55	49	63	62	41	61	27	36	60	69	68	66	46
3. Percent with some exposure to mass media (at least once a week)	58	57	59	45	83	51	89	81	52	26	52	–	–
4. Percent living in urban areas	19	20	19	11	35	–	–	38	13	7	6	5	30
B. Sexual behavior													
5. Percent ever had sexual intercourse	52	34	77	53	51	52	54	58	57	46	41	54	51
6. Median age at first sexual intercourse among 20–24-year-olds	16.6	–	–	16.2	17.7	16.5	17.0	16.6	16.1	16.4	17.4	16.2	16.9
7. Percent had premarital sex before age 20 among 20–24-years-olds§	44	–	–	39	54	40	57	50	51	37	31	40	47
8. Among sexually experienced, percent had sex in last 3 months	76	67	82	80	68	78	69	73	78	81	76	79	73
9. Among sexually experienced, percent had≥2 partners in last 12 months	4	3	4	2	7	3	5	5	2	5	2	4	3
C. Union and fertility													
10. Percent ever in union‡	32	14	58	39	20	35	20	28	41	35	27	41	26
11. Median age at first marriage among 20–24-year-olds	17.7	–	–	16.9	20.2¥	17.4	19.7	18.2	16.9	17.1	18.0	17.1	18.2
12. Percent ever had a child	26	10	48	30	17	27	19	26	30	30	18	31	22
13. Percent currently pregnant	9	4	16	11	7	10	5	9	12	7	9	11	8
D. Contraceptive knowledge and use													
14. Among all, percent know where to obtain a condom	53	48	61	40	78	46	82	82	46	21	39	32	69
15–16. Among sexually experienced, percent ever used:													
15. Any modern method of contraception for family planning	35	35	36	24	57	27	67	57	22	23	19	21	46
16. The condom for any reason	29	34	27	17	53	22	61	51	18	6	17	14	41
17–18. Among sexually active, percent currently using:													
17. Any modern method of family planning	19	20	18	13	31	14	39	33	12	7	8	9	26
18. The condom for any reason	12	18	9	7	22	9	27	21	10	4	3	6	17
19. Among those who had sex in the last 12 months, percent used the condom at last intercourse	19	29	13	11	36	14	40	33	12	5	10	8	27
20. Among all, percent who approve of family planning	77	72	84	70	89	75	87	84	76	59	79	68	84
21. Among nonusers, percent who intend to use a method later	61	58	67	54	77	60	68	68	66	46	59	52	69
E. Knowledge and attitudes about HIV/AIDS													
22. Percent who have heard of HIV/AIDS	100	99	100	99	100	100	100	100	100	99	100	99	100
23–25. Among all, percent who correctly identified that one can prevent HIV/AIDS by:													
23. Using the condom	56	52	61	44	77	50	78	76	57	28	42	40	67
24. Abstaining from intercourse	53	56	49	46	66	50	65	62	42	27	68	47	57
25. Limiting sexual partner to one	37	31	45	35	41	37	36	37	33	44	36	36	37
26. Among all, percent who know that it is possible for a healthy looking person to have the AIDS virus	72	69	77	65	85	68	87	87	69	58	61	64	78
27. Among those who have ever heard of HIV/AIDS, percent who think that children aged 12–14 should be taught about using a condom to avoid AIDS	64	64	65	61	71	63	70	70	72	53	55	58	69
28. Among those who have ever heard of HIV/AIDS, percent who have ever been tested for HIV	6	3	10	3	12	5	11	10	5	2	4	2	9
29. Among those who have never been tested for HIV and among those who have ever heard of HIV/AIDS, percent who would want to be tested for HIV	67	63	73	66	69	67	65	63	71	68	66	66	67
F. Protective behavior													
30–32. Among those who used a condom at last intercourse, percent who use condoms at last intercouse:													
30. To prevent pregnancy only	36	37	36	39	36	37	35	35	36	33	43	41	35
31. To prevent STIs only	23	23	23	21	24	23	25	24	28	17	14	22	23
32. To prevent STIs and pregnancy	40	39	42	39	40	39	40	41	36	33	43	33	41

* Measure is among adolescent 15–19 unless otherwise stated.
§ Premarital sex is the percent of all women aged 20–24 who had intercourse before age 20 and were never married at first intercourse.
‡ Ever in union includes currently married, formerly married and cohabitating.
¥ Among 25–29-year-olds, as median not reached among 20–24-year-olds.

Appendix Table 2: Selected background characteristics and measures of sexual and reproductive behavior among adolescent men aged 15–19* in Uganda, Demographic and Health Survey 2000–2001

		Age		Education		Residence		Region				Media exposure at least once a week	
Characteristics and measures	Total	15–17	18–19	<7 years	≥7 years	Rural	Urban	Central	Eastern	Northern	Western	No	Yes
Unweighted N	440	277	163	247	193	298	142	177	88	55	120	83	357
A. Background characteristics													
1. Percent with ≥7 years of education	39	34	49	–	–	32	73	49	36	24	34	13	47
2. Percent currently working	27	19	42	33	19	28	24	31	7	17	45	24	28
3. Percent with some exposure to mass media (at least once a week)	79	79	78	69	93	75	95	90	69	60	78	–	–
4. Percent living in urban areas	18	17	22	8	34	–	–	34	13	7	4	4	22
B. Sexual behavior													
5. Percent ever had sexual intercourse	38	27	59	34	46	37	48	44	53	35	18	28	41
6. Median age at first sexual intercourse among 20–24-year-olds	18.4	–	–	18.4	18.4	18.5	18.3	18.1	17.6	18.7	19.7	18.6	18.3
7. Percent had premarital sex before age 20 among 20–24-year-olds§	67	–	–	62	71	64	76	74	77	57	50	59	68
8. Among sexually experienced, percent had sex in last 3 months	57	44	67	63	50	57	58	65	42	†	53	44	60
9. Among sexually experienced, percent had ≥2 partners in last 12 months	15	8	21	17	13	14	18	22	8	†	21	11	16
C. Union and fertility													
10. Percent ever in union‡	7	0	17	8	4	8	3	3	7	19	6	6	7
11. Median age at first marriage among 25–29-year-olds	21.9	–	–	21.0	23.2	21.4	24.2	23.6	20.8	21.1	20.9	21.2	22.3
12. Percent ever had a child	5	0	13	6	4	6	1	3	4	15	4	6	5
13. Among those currently in union, partner currently pregnant	30	†	30	†	†	27	†	†	†	†	†	†	†
D. Contraceptive knowledge and use													
14. Among all, percent know where to obtain a condom	63	63	63	58	71	61	73	69	63	30	71	46	68
15–16. Among sexually experienced, percent ever used:													
15. Any modern method of contraception for family planning	44	42	46	34	56	39	63	56	46	†	15	19	49
16. The condom for any reason	44	42	46	34	56	39	63	56	46	†	15	19	49
17–18. Among sexually active, percent currently using:													
17. Any modern method of family planning	42	56	34	30	61	33	68	50	47	†	†	†	45
18. The condom for any reason	40	53	32	30	54	33	57	46	47	†	†	†	43
19. Among those who had sex in the last 12 months, percent used the condom at last intercourse	42	55	33	29	56	38	56	48	55	†	†	†	47
20. Among all, percent who approve of family planning	79	79	79	74	87	78	85	76	78	69	91	64	84
21. Among non-users, percent who intend to use a method later	69	65	77	62	82	67	77	65	71	48	81	53	74
E. Knowledge and attitudes about HIV/AIDS													
22. Percent who have heard of HIV/AIDS	100	100	100	100	100	100	100	100	100	100	100	100	100
23–25. Among all, percent who correctly identified that one can prevent HIV/AIDS by:													
23. Using the condom	74	73	78	66	87	73	83	79	69	69	74	54	80
24. Abstaining from intercourse	67	65	69	63	73	65	73	74	46	60	78	59	69
25. Limiting sexual partner to one	29	26	36	23	39	28	37	22	33	74	16	34	28
26. Among all, percent who know that it is possible for a healthy looking person to have the AIDS virus	80	79	82	75	88	78	91	95	60	53	88	61	85
27. Among those who have ever heard of HIV/AIDS, percent who think that children aged 12–14 should be taught about using a condom to avoid AIDS	55	54	56	55	56	53	63	59	62	52	44	48	57
28. Among those who have ever heard of HIV/AIDS, percent who have ever been tested for HIV	3	3	5	2	5	4	1	4	4	4	2	3	3
29. Among those who have never been tested for HIV and among those who have ever heard of HIV/AIDS, percent who would want to be tested for HIV	72	72	71	67	78	73	66	69	65	85	76	70	72
F. Protective behavior													
30-32. Among those who used a condom at last intercourse, percent who use condoms at last intercouse:													
30. To prevent pregnancy only	15	15	16	†	16	11	20	16	†	†	†	†	14
31. To prevent STIs only	55	52	56	†	61	46	73	74	†	†	†	†	53
32. To prevent STIs and pregnancy	27	26	28	†	23	37	7	10	†	†	†	†	29

* Measure is among adolescent aged 15–19 unless otherwise stated.
† Unweighted N less than 20.
§ Premarital sex is the percent of all men aged 20–24 who had intercourse before age 20 and were never married at first intercourse.
‡ Ever in union includes currently married, formerly married and cohabitating.

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