Control over sexual reproductive health: stressors and resources for Makerere university students Kampala, Uganda. An exploratory study.

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Abstract

Background: Sexual reproductive health (SRH) and rights play a central role in overall human wellbeing. Unfortunately, unsafe sexual practices constitute the second highest risk factor for disability and death in the world's poorest communities. Despite the increase of contraceptive methods, unmet need for SRH services and information remains high in developing countries. University students suffer the highest rates of sexually transmitted infections, unwanted pregnancies, abortions and several other reproductive health problems. In Uganda, programs and strategies have been developed to improve youth's SRH. However, a knowledge gap remains regarding youth's own experiences with management of SRH risks and problems. In order to identify students' resources and coping mechanisms for SRH problems, the study employed a Salutogenic model of health that focuses on how people use available resources to stay healthy, giving an insight into how health is realized and how it can be maintained. The main aim of this study was to explore the experiences, perspectives and attitudes of university students on their control over sexual reproductive health in Kampala, Uganda. Specifically to: explore what is known about SRH and sources of information, to explore the main stressors related to SRH and to explore what generalized resistance resources and coping mechanisms help university students take control of their SRH.

Methods: The study used a qualitative method of data collection and a phenomenological research design in approach. Data collection took place between June-September 2015. Data collection was through semi-structured in-depth interviews, observations and document analysis. Interviews were conducted at Makerere university (Kampala-Uganda) with 18 participants in total, including 11 students (five male, six female); seven key informants (the Dean of students, two health workers, Local Council Chairperson, one religious leader, two hostel wardens). Interviews lasted 30-90 minutes and were audio taped. A thematic network analysis was used to code and analyze the data. Prior to data collection, ethical approval was sought from respective institutions and persons.

Findings and discussion: The university students referred to SRH in terms of services, behaviour and risks involved including, having sex, abstinence, prevention and cure, how you handle yourself sexually, to mention but a few . They cited common sources of information as peers, media, posters and billboards, places of worship, seminars, conferences, internships, curriculum and health centers. Stakeholders reported parents as influential sources of

information. Students recognized some stressors that predisposed them to risky behaviours: peer pressure, low self-esteem and the need for belongingness, ignorance about SRH risks, economic/academic constraints and sex addiction, among others. Stakeholders acknowledged freedom & lack of parental supervision and misleading sources of information as prompting factors for risky behaviour. Other stressors were identified as consequences of those behaviours: unintended pregnancies and STDs from unprotected sex, abortion, emotional and mental breakdown, low self-esteem and lack of self-worth, violence from sexual partners, academic dropouts due to pregnancy and being disowned by parents. The students stated resources that helped them manage SRH problems like religion and spiritual support, social support from peers, relatives and health workers, contraception use, faithfulness, abstinence, VCT and learning from previous experiences. They also adapted coping mechanism like abortion and dropping out of school to find work.

Students knew what SRH was, however in-depth knowledge was lacking, that is to say SRH rights. Sources of information were significant in influencing decision making. The students were sexually active therefore aware of the risks involved with risky sexual behaviour. Students encountered stressful situations in their lives even before decisions to take risks were made. The challenges students faced are common and consistent therefore the students have become accustomed to them. Single stressors do not always independently affect decision making, they are influenced by other factors affecting the lives of the students. Students adopted ways to manage negative outcomes of risky behaviour, some students relied on multiple resources at a time and it was found that most of the coping mechanisms worked alongside each other, whereby a student would use more than one resource for a certain stressor. It was established that using multiple resources helped yield better results

Conclusion: Students were empowered enough to make their own decisions, they all demonstrated knowledge of SRH. However despite high levels of knowledge, important aspects of SRH were excluded from their accounts, that is to say, knowledge of SRH rights. Despite understanding of risks involved, some students still got involved in risky sexual behaviour and were not worried about the potential outcomes of unsafe sex. The majority encountered the extreme challenges involved with unsafe sex and the problems appeared to be familiar to the students. But, it emerged that for every stressful situation, there was a resource to manage it. The students sought out and utilized resources like religion and spirituality, friends and colleagues, knowledge and information of SRH, medical/professional support and services. Students had a strong S.O.C when the theory of Salutogenesis was

applied to their experiences. It was illustrious through their understanding their problems, ability to recognize and utilize resources and willingness to recognize the challenges and handle them.

Acronyms and abbreviations

FPAU   Family planning association of Uganda

GRRs   General resistance resources

ICPD   International conference on population and development

LC1   Local council one chairperson

RHU   Reproductive health Uganda

SH   Sexual health

SHE   Sexual health education

SOC   Sense of coherence

SRH   Sexual reproductive health

SRHR   Sexual reproductive health and rights

SSA   Sub-Saharan Africa

STIs   Sexually transmitted Infections

STD   Sexually transmitted diseases

TASO   The AIDS support organization

VCT   Voluntary counseling and testing

WHO   World health organization

CHAPTER 1.

1. Introduction

Among other essentials vital to the health of an individual, sexual reproductive health (SRH) and rights play a central role in overall human wellbeing (WHO, 2013). Sexual health (SH) is an unclear term that is difficult to define as it has evolved along the years since its original definition in 1975 by the World Health Organization (WHO) (Edwards & Coleman, 2004). Many SH definitions have a similar starting point based on WHO foundations, however they differ within the context of their definition. Evidence indicates that definitions have evolved over time due to political, social and cultural forces including reproductive & abortion rights, disparities between sexes, struggles against discrimination within the lesbian and gay communities, impact of the AIDS epidemic and so forth (Edwards & Coleman, 2004). More recent studies have included issues like mental health, responsibility and sexual rights to earlier definitions of the term.

 SH in some studies is referred to as both the physical as well as the social aspects of human interaction (Wingood & DiClemente, 2013). SH includes a range of aspects; it is the psychosocial and emotional relationships between individuals and in others; it is the preventive programs from the acquisition of sexually transmitted infections including HIV; it is also understood as enhancing the ability to cope with SRH conditions (Wingood & DiClemente, 2013). For a long time, many have referred to it narrowly, only dwelling on the reproductive aspects, however some scholars have gone as far as exploring an individuals' self-concept for instance the perceptions of their own body (Wingood & DiClemente, 2013).

Reproductive health goes hand in hand with SH and it is defined as the complete physical, social and mental wellbeing, not merely the lack of infirmity in any matter relating to reproductive systems and it functions including a safe sex life with freedom to reproduce and the right to information and choices in regards to family planning (Glasier, Gülmezoglu, Schmid, Moreno, & Van Look, 2006) .

SRH and rights as essentials for human wellbeing are achievable, as methods of contraception are constantly being improved and made available, STIs treatable and people taught skills that help create a safer sexual life (Glasier et al., 2006). Unfortunately, the second highest risk factor for disability and death in the world's poorest communities is

placed on unsafe sexual practices and despite the increase in contraceptive methods in many parts of the world, unmet need for SRH services and information remains high in most developing countries (Glasier et al., 2006). Also, although it is one of the major causes of mortality and morbidity, SRH has for a long time been neglected in various third world countries (Glasier et al., 2006).

The importance of recognizing the rights of individuals in the area of SRH was put into perspective by the International Conference on Population and Development (ICPD) held in Egypt, Cairo 1994, calling for universal access to sexual and reproductive health services and rights by 2015 (UN, 1994). It defined SRH as individuals being able to have a satisfying and safe sex life with the capability to reproduce and the freedom to decide on their own if, when and how often to do so. It built on the World Health Organization's (WHO) definition of health by stating that reproductive health involves "complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes"(UN, 1994, p. 43). The conference set into motion efforts to improve the neglected area of SRH and rights in the world.

In 2000, a list of sexual concerns that would be tackled to promote overall SH was designed by the World Health Organization (WHO), World Association for Sexology (WAS) and Pan American Health Organization (PAHO) in Antigua, Guatemala (WHO, 2000). The list included concerns like: the need for freedom from contracting or transmitting sexually transmitted infections (STIs) including HIV; knowledge about the body as related to sex; promotion of sexual relationships practiced in a safe and responsible manner, non-exploitative and honest relationships (WHO, 2000).

Efforts were made by several governments around Africa with recommendations from the ICPD, to meet the educational and health service needs of young people in the area of SRH as it was suggested that Africa stood to benefit more if improvements were focused on the SRH of youth as the future of Africa (Okonofua & Olagbuji, 2014). Africa's population is Characterized by the youth bulge with 294 million between the ages of 10-24 years, a population estimated to rise to 561 million by 2050 (Okonofua & Olagbuji, 2014).

Expectations for beneficial efforts to improve SRH are highest in Africa than anywhere else in the world; however, Africa has experienced the most harmful outcomes of SRH as well as

showing slow progress in improving SRH indicators (Okonofua & Olagbuji, 2014). Reports suggest that it is suffering more among the younger population (Okonofua & Olagbuji, 2014), in comparison to the older population, rates in HIV/AIDS and other STIs are higher among the youth. This is blamed on a number of issues including higher youth sexuality, lack of accurate knowledge and information on SRH, vulnerabilities in their socio-economic lives and rigid cultural norms and beliefs. But most importantly all these issues are suggested as being a result of failure to integrate the principles of ICPD with the indigenous development plans and strategies of Africa (Okonofua & Olagbuji, 2014).

Negative outcomes of unsafe sex threaten the health and wellbeing of people in the second decade of their life more than any other age group (Bearinger, Sieving, Ferguson, & Sharma, 2007). UNAIDS has documented that 40% of all new HIV infections occur globally in persons under the age of 25 years (UNAIDS & WHO, 2006). This age group is referred to as the youth. The terms 'youth' and 'young people' can be used interchangeably to describe individuals in the period of time marking transition from childhood to adulthood (Khan & Mishra, 2008). 'Youth' is a widely contested term, but for the purposes of this study, WHO's definition will be used. WHO groups the youth between the ages of 15-24 (WHO, 1989).

Young people go through a phase of self-discovery involving physical, cognitive and social development maturing into adulthood (Choudhury, Blakemore, & Charman, 2006). In addition, increased sexual motivation and activity are defining features of this age bracket with sexual debut subject to both negative and positive influences (James, Ellis, Schlomer, & Garber, 2012). The quality and length of their adult lives depends on the challenges they face and the decisions they make during this stage. USAID reports that it is a time of both risk and opportunity as many important life events and health damaging behaviours are experienced during this time (Khan & Mishra, 2008).

Young people have a range of influences on their sexual behaviour including hormones, self-concept, attitudes, delinquency, family structure, peer context (James et al., 2012). Alarming is that, trends have shifted the causes of morbidity and mortality among the youth from mainly infection related deaths to life-style practices (DiClemente, Hansen, & Ponton, 2013). Furthermore, initiation of risky decisions is taking place at increasingly younger ages today, it is indicated that trends in youth risk behaviour will ultimately become more problematic in the future, a behaviour currently being referred to as *'risk behaviour epidemic'* (DiClemente

et al., 2013, p. 3) This behaviour is reportedly fueled by their willingness to experiment, seek, and participate in risk behaviours.

Globally, students in higher institutions of learning aged 19-25 are in the age range with the highest rates of new sexually transmitted infections, unwanted pregnancies, abortions and several other reproductive health problems (Lewis, Malow, & Ireland, 1997). New found freedom with little or no guardian supervision, experienced in the environment of higher institutions of learning has been considered an opportunity/aiding agent for risky sexual experimentation (Shiferaw et al., 2014). On top of newfound freedom, young adulthood is noted as a challenging period in relation to psychosocial development because this is when the young people struggle to find and test identities, look for belonging, to build self-esteem and doing all this is through experimentation and pushing of limits in different areas including sexual relationships (Agardh, Cantor-Graae, & Östergren, 2012).

1.1 Context

In Uganda, special attention has been placed on the SRH of the young people ages 10-24, and this is because the size of their population is a third of the overall population in Uganda (Ministry of Health, 2013). Uganda has the world's youngest population with 78% under the age of 30 (Ministry of Finance, 2013), characterized by major physical and emotional changes making them vulnerable to a combination of social and health problems (Ministry of Health, 2013). From the introduction 1.0 above, it is evident that there is inadequate literature on young people in Uganda, the majority of the studies are on western youth.

Family planning services were introduced in Uganda in 1957 by Family planning association Uganda (FPAU) (Ministry of Health, 2013) mainly providing contraception and curative services. In 1984 reproductive health was integrated into family planning services and adopted as a method of primary health care. Recently human rights have also been introduced with advocacy against violation of SRH rights as the main approach (Ministry of Health, 2013). For over a decade, Youth's SRH has been on Uganda's national agenda and a number of policies and guidelines created to guide the process including the 2001 National Policy for Guidelines and Service Standards for Reproductive Health Services, National youth policy and the 2004 National Adolescent Health Policy, together with the help of various regional and international partners who have aided in promoting the youth SRH agenda through

provision of funds, promoting of International SRH goals and networking (Crossland, Hadden, Vargas, Valadez, & Jeffery, 2015).

Partner Programs and initiatives in the region designed to address young people's problems and needs in Uganda include the African Youth Alliance (AYA), a five year initiative cutting across four countries in sub-Saharan Africa including Uganda, Tanzania, Botswana and Ghana to tackle SRH areas of policy, communication & information, capacity building & life skills and youth friendly services. Organizations like Reproductive Health Uganda (RHU), Pathfinder, Plan Uganda, Marie stopes to mention but a few (RHU, Pathfinder, & Mariestopes, 2011) have also initiated programs designed for youth SRH. For instance in 2005, Pathfinder International in collaboration with Makerere University Medical Students Association (MUMSA) reached out to students with information and services regarding safe sexual reproductive health (Pathfinder, 2005). Six thousand students were reached through peer to peer service provision whilst referring them to the University hospital and other nearby health centers (Pathfinder, 2005).

A lot of effort has been put into promoting young people's sexual health in Uganda, and studies on the subject indicate that knowledge on SRH increased from 2003-2004 to 2012 (Crossland et al., 2015). However the knowledge is reported to be inaccurate with only half of the young people being able to identify an STI (Crossland et al., 2015). Also, some vital aspects of the evolving trends in young people's sexual lives have been ignored, marginalized and concealed in taboos, culture, religion and strict laws that have deemed these areas of their lives unlawful for example homosexuals, transgender and lesbians, leaving them vulnerable to risks. Also sociocultural norms and strong religious beliefs have contributed to the neglect of certain areas of SRH of young individuals in Uganda (Tamale, 2007).

With all the efforts to help reduce negative outcomes of unsafe sexual practices and the belief that youth are knowledgeable about such issues, young people are still the most vulnerable group in Uganda (UNAIDS & WHO, 2006). Also, sexual reproductive health is noted as an evolving issue in this ever globalizing world, therefore attempts to deal with it should constantly be modified (Bearinger et al., 2007). USAID suggests that making more progress will require, building on existing successes, taking into account lessons learnt and referring to them, improved coordination of effort with the service providers and the recipients, and

effective action to deal with societal determinants of risk and vulnerability (Khan & Mishra, 2008).

1.2 Problem statement

A lot of effort has been put into the best programs and strategies to improve young people's SRH needs in Uganda, yet the SRH of young people has not improved. Previous studies have focused effort on the undesirable causes and outcomes of unsafe sexual practices with HIV/AIDs being the dominant area of inquiry (Shiferaw et al., 2014). Furthermore, although numerous studies have been conducted on SRH in Uganda, a knowledge gap exists with regards to studies on young people's own perspectives on their experiences with management of SRH risks and problems. Furthermore, it is hard to find studies in SSA that have used theoretical insights into improving the SRH of young people or designing reproductive health promoting interventions (Klepp, Flisher, & Kaaya, 2008).

The understanding of SRH is always shifting (Bearinger et al., 2007) therefore there is an emergence of new ways of thinking that are constantly shaping sexual behaviour and redefining how young people are reacting to SRH today. This implies that the effectiveness of old strategies of tackling the problems of SRH is temporary, therefore there is a need to modify strategies to fit young people's ways of thinking (Klepp et al., 2008). And this can be done through exploring their perspectives on management of the SRH risks that they are currently facing.

1.3 Rationale of the study

The challenges and risks of sexual reproductive health jeopardize the physical, emotional, economic as well as the social wellbeing of young people in Sub Saharan Africa (Klepp et al., 2008), this goes against the intended goal of health according to WHO (1984). In order to begin to protect young people from ever growing and changing risk of sexually transmitted infections, unwanted pregnancies, abortions, rape, death and other problems arising from unsafe sexual encounters and factors leading up to decision making, it is imperative that policy makers, program developers and any organization in this field attain better understanding of the decisions young people are now making (Chatterji, Murray, London, & Anglewicz, 2005). Using a Salutogenic approach, this study will explore how students make the decisions about sexual reproductive health relating it to their personal, social and economic influences putting in mind that many of these students are making these decisions without their parents. Furthermore the study will explore what resources give these young

people more control over their sexual reproductive health lives, providing policy makers and program developers with an insight into the minds of the youth, to help edify strategies accordingly. It is important to note that this study does not disregard currently running programs and does not advocate for scraping away of already existing interventions, its aim is to obtain views from young people that can help inform existing programs to increase their effectiveness.

1.4 Objectives of the study

Main objective:

To explore the experiences, perspectives and attitudes of university students, on their control over sexual reproductive health.

Specific objectives:

1. To explore what is known about SRH and sources of information.

2. To explore the main stressors related to SRH.

3. To explore what generalized resistance resources and coping mechanisms help university students take control of their SRH.

1.5 Structure of the thesis

Following the above chapter 1 of the introduction, the thesis goes on to chapter 2 to present relevant literature to the study, covering previous studies on young people's knowledge and information about SRH, SRH stressors, resources and coping mechanisms. This section also relates the study to the theory of Salutogenesis. Chapter three presents the Methodology, study design and analysis while chapter 4 goes on to present the results that emerged from data collection. Chapter 5 presents the discussion in relation to existing literature and the findings of the study and in addition, I apply the findings to the theory of Salutogenesis. Chapter 6 presents the overall conclusion of the study in relationship to the objectives and analysis of findings plus it suggests recommendations for the gaps in the study.

CHAPTER 2

2. Literature review and theoretical framework

As stated earlier, several studies reveal that Africa has for a while now experienced harmful outcomes in SRH despite decades of interventions by respective governments, national and international Organizations to help prevent extreme outcomes. This on one hand is blamed on illiteracy, rigid cultures, poverty and related factors, but on the other hand, ineffectiveness of programs is said to be caused by the inability to integrate the principles of ICPD and western programs with indigenous planning of programs in Africa (Okonofua & Olagbuji, 2014). Despite this challenge, research has shown that understanding how individuals perceive and cope with stress concerning high risk sexual behaviour can have significant implications for strategic interventions (Folkman, Chesney, Pollack, & Phillips, 1992).

With this in mind, the study set out to explore University students' control over sexual reproductive health to understand their attitudes and perceptions. This chapter therefore reviews previous research to identify studies with a relationship to the aims of this study while noting the existing gaps in the area. The chapter goes ahead to explore and relate Salutogenesis as the theoretical framework in the context of students managing their SRH risks and problems.

2.1.1 Knowledge and sources of information

A third of young adults aged 12-14 years are reportedly already sexually active and have initiated or experienced some form of intimate sexual activity including sex, kissing or even fondling (Bankole, Biddlecom, Guiella, Singh, & Zulu, 2007), this is based on a study carried out in four SSA countries including Uganda, Malawi, Ghana and Burkina Faso on adolescent sexual activity and knowledge. With this in mind, their level of awareness about some sexual issues including pregnancy and condom use is reported to be very high, however further inquiry depicts that this awareness is only on pregnancy, contraception use and HIV related information but awareness of detailed overall SRH issues was extremely low. Related studies reveal that the knowledge about simple aspects of SRH is universal for example condom use, and many young people have heard about HIV/AIDs, however little knowledge still exists about deeper aspects of SRH (Ministry of Health, 2013).

Awareness does not always indicate depth of knowledge as literature indicates that students have very high levels of awareness about SRH but very little in depth knowledge about the

matter (Bankole et al., 2007). Reasons for this could possibly be explained by a related study carried out on primary school pupils in Canada that found that even though young people are taught earlier on in life about sexual health education (SHE), it is lacking as it mainly focuses on negative outcomes of sexual behaviour including STIs and unplanned pregnancies, yet there are deeper features to SH beyond the dangers, therefore in-depth information is left wanting (Basian, 2015). Also an inquiry on perceptions, knowledge and sources of HIV/AIDs information in USA, Turkey, Nigeria and South Africa adds that, not only is there diminutive understanding but misinformation and myths about SRH including HIV still exist among young people across all cultures around the world, despite numerous efforts throughout the three decades of efforts to spread information on the matter (Abiona et al., 2014).

Knowledge that young people may have about SRH issues is also highly subjective. A study conducted on young adult's contraception knowledge, norms and attitudes in America found that young users are knowledgeable about contraceptive use and methods, however this knowledge is restricted to methods they are only directly associated with and ignorant about methods they do not use (Frost, Lindberg, & Finer, 2012). Nonetheless, it was further revealed that even the subjective knowledge is also minimal and the majority of young people still underestimate the effectiveness of the contraception methods (Frost et al., 2012), this is reportedly liable to young people's suspicion of the government, advertisement and the safety of the contraception methods.

Young men and women in Uganda aged 19-24 years also display knowledge of HIV and related risks (Ministry of Health, 2006). Reports indicate that the young people in Uganda, have a very high awareness about HIV and related SRH problems like pregnancy and other STDs, even though several studies emphasize that in-depth knowledge is still lacking (Bankole et al., 2007). These young people reportedly acquire this information from a range of sources, sometimes from multiple sources at a time (Bankole et al., 2007). The East African Community and AMREF add that about one half of youth in Uganda (46.7%) in universities receive HIV messages frequently, with the majority (71%) discussing HIV related issues with their peers (EAC/EALP, 2010), citing the most frequent sources as television and other audio-visual media like radios, the internet, religious leaders, seminars, print media including posters, pamphlets and billboards (EAC/EALP, 2010). (Bankole et al., 2007) also add that young people in SSA including Uganda receive awareness from schools and teachers, health facilities and professionals although not a major source and finally

parents, however other relatives play a bigger role than parents in teaching young family members about sexual issues.

Over the years, programs to inform youth about sexual issues have been created in Uganda. For example in 2006, the government introduced an educational initiative that was considered one of the most pragmatic among the youth; it demonstrated significant results in behavioural change, targeting youths' risky sexual behaviour, and it was called the ABCs, elaborated as "Abstain, Be faithful and use Condoms" (Murphy, Greene, Mihailovic, & Olupot-Olupot, 2006). However the effectiveness of this initiative was short lived because critics considered it controversial and panned it for promoting abstinence-only sex education while the emphasis on abstinence over condom use seen as leaving majority of women vulnerable because most young women are still not empowered enough to demand for abstinence or fidelity from their partners (Murphy et al., 2006).

All universities in Uganda have preventive activities together with counselling and psychosocial support services in regards to SRH, but most accurately a code of conduct for students within each individual university (EAC/EALP, 2010), even though they add that enforcement of codes of conduct is simply inadequate. Students have also had peer to peer programs that target sexual safety for example through the Makerere University Medical Students Association, offering reproductive health information and services (MUMSA, 2011). However, studies note that even though such preventive activities and efforts have been carried out for example encouraging safe sex and use contraception, even where these services are free and awareness of risks made high, such campaigns have often had poor results (Marston & King, 2006).

Former general secretary of the UN noted, "*Knowledge is power. Information is liberating. Education is the premise of progress…*" (Kofi Annan cited in Bankole et al., 2007, p. 6). Studies in support of this statement suggest that Youth need protective information and skills, preferably before they are sexually active in order to be prepared for the risks involved (Bankole et al., 2007). This same study however brings to light the challenges in provision of SRH information in existing policy, political and social debates in the African society that point out that teaching young people about sex has potential to encourage premature sexual debut. But because of the dire need for more in depth information there has been increased acknowledgement for the importance and need to educate and equip the youth with skills to

facilitate informed SRH decisions. However the study notes that in African society, the debate still lies in determining the specific information, the appropriate sources and exact age to start (Bankole et al., 2007).

2.1.2 Perspectives on sexual reproductive health risks and stressors

In Uganda, for young people the start of university life marks the beginning of freedom (Shiferaw et al., 2014) and independence (Aluzimbi et al., 2013) because it is the norm for university students to leave their parents' homes and join halls of residence or hostels around campus. At this point, the students are very excited about the prospect of controlling their own lives away from parental supervision but they are reportedly in a state of confusion because they are not quite adults but also not adolescents anymore (Aluzimbi et al., 2013). Therefore they are identified as having a bicultural identity with beliefs and cultures copied from else-where (Aluzimbi et al., 2013). In this state they are prone to involvement in risky behaviour because they are free to participate in social activities like going to clubs and drinking alcohol, which are reported to expose them to experimenting with sex (Aluzimbi et al., 2013). Unlike the past where infections accounted for high mortality, youth morbidity today is reported to have gone higher due to lifestyle practices which as mentioned earlier are influenced by social, economic, environmental and behavioural factors also referred to as social morbidities (DiClemente et al., 2013). These behaviours are likewise influenced by outcomes like STDs, unwanted pregnancies, abortion, to mention but a few. Research points out that socioeconomically disadvantaged youth are at a higher risk to experiment with risky behaviour (DiClemente et al., 2013).

Transactional sex is the most common lifestyle practice taking place among sexually active youth in Africa and a leading cause of SRH problems and risks among university students in Uganda. It is sex in exchange for benefits including money, favors or material gifts (Choudhry, Östergren, Ambresin, Kyagaba, & Agardh, 2014). Though similar, it should not be confused with prostitution, as transactional sex happens only under the conditions of a relationship even if the relationship is unclear or brief (Zembe, Townsend, Thorson, & Ekström, 2013). Transactional sex is a challenge to define as it is considered as prostitution by some (Zembe et al., 2013) and an economic arrangement or symbol of love by others (Zembe et al., 2013). Reports suggest that transactional sex is not a recent occurrence in African communities, it is only the definition that has changed (Zembe et al., 2013). Exchange of benefits for sex has always been part of black African sexual behaviour

supported by cultural statements like *"no self-respecting woman would remain in a friendship without material recompense"* (Ankomah A, 1992 cited in Zembe et al., 2013, p. 2). However the risks involved with it have changed people's perspectives towards it. Transactional sex is typically common between young women and older wealthier men (Zembe et al., 2013) though changes in lifestyle have subjected young men to the same trend.

Transactional sex is reported to coexist with other risky sexual behaviours like inconsistent condom use, early sexual debut, coercion, violence (Choudhry et al., 2014). A study carried out on youth in a South African university found that it is a lucrative economic strategy among student communities especially the female, it represents opportunity including meeting subsistence and consumption needs, entrance into social groups, providers for younger sexual partners, avoiding sexual exclusion and allowing for them to acquire what youth prioritize today (Zembe et al., 2013). However all these benefits are reported to present with domination from the older sexual partners which undermines negotiation, therefore unprotected sex is expected of these young women which increases their vulnerability to the risk of STDs and unintended pregnancies (Zembe et al., 2013).

Unprotected sex, in other words absence of contraception use among sexually active youth, is one of the leading causes of SRH problems in Uganda. Reports suggest that there has not been significant change in contraception use among the unmarried sexually active young people in Uganda since 2000, whereby statistics reported 38% usage then and the same percentage in 2011 (Guttmacher Institite, 2013). A fifth of young people aged 15-24 are reported to be sexually experienced and 1/10 sexually active, however only 2/5 of these are reported to use modern contraception (Singh, Prada, Mirembe, & Kiggundu, 2005). Availability of family planning services is noted as being deficient in many parts of Uganda, provision declined between 1995 and 2000-2001 from 47% to 36% (special tabulations of data 1995 and 2000-2001 UDHS cited in Singh et al., 2005). Despite improvement of contraception methods between 1988 and 2001, the overall level of use in Uganda is reported to be low and some of the reasons for this are the fear of associated side effects and inconvenience that comes with using contraception (Singh et al., 2005). Other studies attribute lack of contraception use on coercion, transactional sex, rape (Choudhry et al., 2014). Unintended pregnancy which is also a leading cause and effect of youth's SRH problems, is attributed to non-use of contraception by those not willing to have a child yet (Guttmacher Institite, 2013). Although most unmarried youth do not want to get pregnant,

many are not taking precaution. In Uganda, more than half of pregnancies are unintended & nearly a third of these result in abortion.

Abortion is one of the main stressors affecting University students and unmarried youth today. Unplanned pregnancies and the need to prevent them is the root cause of abortion and this is partly attributed to the stigma that arises from pregnancy out of wedlock (Singh et al., 2005). The Ugandan constitution permits abortion under some circumstances authorized by the law (Guttmacher Institite, 2013). However the policies are reported to be unclear and a number of people unaware of the specifics of what is legally permitted (Guttmacher Institite, 2013). The 2006 National Guidelines and Services Standards for SRH and Rights state that abortion is permitted in case of foetal anomaly, rape, incest, if the woman is HIV positive (Guttmacher Institite, 2013) or if her life is at risk (Singh et al., 2005). Legal abortions are quite rare because interpretation is reportedly ambiguous, the process of obtaining paperwork for the procedure quite tasking including obtaining of certification from three different doctors before any procedure (Singh et al., 2005), and doctors are also reportedly still afraid to perform the procedure, however if they do, it is done in furtive and sometimes unsafe environments (Guttmacher Institite, 2013). In 2003 a study found that the annual abortion rate was 54 abortions per 1,000 women (297,000 women) and 15 out of those 1,000 (85,000 women) (Singh et al., 2005) were treated for abortion related complications in Uganda and in 2008 the Uganda Ministry of Health added that abortion related causes accounted for 26% of maternal mortality (Guttmacher Institite, 2013). Young women fear or delay seeking treatment for fear of judgement and the law, also majority of nurses and health care providers that are accessible to the people lack proper training (Guttmacher Institite, 2013).

There is a strong link between mental health problems and SRH risks, noting the relationship between the onset of mental health and the age group of the youth whereby risky sexual behaviours and mental health problems are at their peak during these years playing a big role in influencing decision making and substance abuse which have been noted to cause risky sexual decisions. (Agardh et al., 2012). Little attention is placed on the role of mental health in regards to sexual risks and even though mental health is included on the Health sector strategic plan II of Uganda, it's focus on SRH as an independent health issue is minimal (Agardh et al., 2012) A survey carried out in the USA found a relationship between depression, failure to use condoms, acquisition of STIs and having three different partners in

the period of one year (Agardh et al., 2012). However it is hard to find evidence of such research on youth in Sub Saharan Africa.

Psychology has placed the influences of young adults' sexual behaviour on a number of factors including biological triggers like hormones and physical growth, psychological influences like self-image, attitudes and values, individual behaviour like substance abuse and delinquency, family determinants like structure and upbringing, peer and social context like religion and school impact (James et al., 2012). Involvement with these influences foster particular patterns of sexual decisions. According to the social control theory (James et al., 2012) in relation to these influences, these factors either trigger or control involvement in problem behaviour and engagement in risk behaviour is when these premises are weakened (James et al., 2012). On top of this, evidence indicates that risk behaviour is interrelated with common influencing factors (Wild, Flisher, Bhana, & Lombard, 2004). Kirby (2001) adds that youth's vulnerability to sexual risks is influenced by family dynamics and connection to one's parents and close social relationships. He adds that partners, peers' values and support towards contraception and safety are common determinants. To the young people, religious institution, their emotional wellbeing, and characteristics of their relationships with romantic partners, past history of sexual abuse, their personal sexual beliefs, attitudes and motivation all influence their actions and sometimes determine how they control a situation (Kirby, 2001).

In earlier years, young people who grew up during the advent of HIV/AIDS were complacent towards the disease and were not afraid to engage in risky sexual relations, (Pool, 1997 cited in Nyanzi, Pool, & Kinsman, 2001) This behaviour still exists today. A similar study carried out in Kenya noted a comparable observation that individuals perceived HIV as being serious; however there was a general misconception that their own risk to the disease was low or non-existent (WHO, 2002), this is noted by Klepp et al. (2008) as being caused by an apparent lack of knowledge in the area but this mindset is one of the reasons young people are willing to take risks on their health today.

2.1.3 Resources and coping mechanisms for sexual reproductive health

Youth SRH problems are considered preventable problems (DiClemente et al., 2013) however in cases where the problems are experienced, individuals are reported to adopt ways to manage these problems. Youth is marked by stressful events and cumulative changes,

therefore the skill to cope is considered important for young people's mental health (Persike & Seiffge, 2012). Since this study is employing the theory of Salutogenesis (discussed in 2.2 below) to help identify how students manage SRH stressors, resources which are features within or around an individual that are effective in combating stressors while focusing on a shift towards health (Lindström & Eriksson, 2010), will be used alongside coping which is related to resources as they both manage stressors, but slightly differing in the fact that coping may also combat stressors, but it may not always indicate a movement towards health (Cummings, Greene, & Karraker, 2014), for example substance abuse to deal with low self-esteem (Wild et al., 2004). For the purpose of this study, coping is defined as thoughts and behaviours used by an individual to manage or alter the problem that is causing distress (Folkman et al., 1992).

Coping has different meanings within different contexts. In some, it is a form of adaptation or a defense mechanism (Cummings et al., 2014), it is not stable and its mechanisms can be modified during an encounter as it unfolds and evolves. A study on individuals' responses to threatening and challenging events in one's lifespan, found that it has two functions, management of a problem and regulation of emotion, viewed as either a feature of personality or of a person-environment relationship (Cummings et al., 2014). It was discovered that coping is influenced by social and environmental factors, what is at stake and the existing options for coping. Also combinations of coping strategies must be considered in that it is multidimensional.

Young people today control their own inception of sexual relations (Klepp et al., 2008), which implies that they also have individual management and adaptation to the events there-in. Management on one hand may be characterized by negotiating, seeking support and having emotional outlets, however on the other hand other individuals may tend to lean more towards denial and withdrawal as coping mechanisms (Persike & Seiffge, 2012). They are also faced with an intergenerational struggle for authority in negotiating and construction of sexual relations with the expectation of having control over the outcomes of the negotiation (Klepp et al., 2008). A study conducted on suicide as an escape from self, reported that in some circumstances, young people may turn to risky behaviour as another way of coping with stress for example people with low self-esteem turn to risky behaviour like substance abuse as a way of coping with the stress of having to experience the undesirable feelings of low self-worth (Wild et al., 2004). How an individual perceives risk determines the decision

one would choose, for instance if making a decision depended on whether the outcome was described as a loss or a gain (Reyna, 2004).

Religion plays a significant role in helping individuals cope with stress. A study examining the relationship between coping and stress among young gay individuals in the United States found that some people rely on spiritual beliefs and prayer to cope with a given stressful situation. This was found to work in two ways, using spiritual beliefs to obtain guidance in decision making or prayer as an emotional and spiritual outlet for challenging outcomes (Folkman et al., 1992). However, because of different spiritual and cultural values around the world, religion may only apply to particular communities and young people may exhibit different ways of coping.

Knowledge about a given problem equips people with the ability to manage a difficulty. A study carried out on universities in Uganda reports that having an accurate knowledge about HIV transmission is a tool for individuals to equip themselves with preventive mechanisms to protect against acquiring the disease (EAC/EALP, 2010). However even though having more knowledge regarding the consequences of certain behaviour is expected to lead to an adjustment in attitudes and decision making, the ability to predict behavioural change because of knowledge is a topic that is still under heavy debate (Klepp et al., 2008) but evidence exists that improving knowledge and removing misconceptions may have potential to positively influence behaviour (Frost et al., 2012).

Though their relevance to this study is evident as noted above, the majority of these studies are situated in the west and their relevance to Africa especially SSA is debatable. Also, it is difficult to place studies conducted on young people's resources and coping mechanisms on SRH in Sub Saharan Africa.

2.2 Theoretical framework

This study employed a Salutogenic framework (Antonovsky, 1996), exploring youth's perspectives on the resources they drew on to control decisions and outcomes of stressful situations. Understanding these stressors and the resources/coping mechanisms has implications for strategies to reinforce control over young people's SRH (Folkman et al., 1992) thereby, promoting healthy behaviour and maintaining it and also creating conditions that help youth cope better with reproductive health challenges.

Antonovsky's research on Salutogenesis introduced, in the late 1970s, centers on the search for factors that keep people healthy while focusing on a movement towards health (Antonovsky, 1996). The Salutogenic approach equips us with significant lens to understand how health is realized and how it can be maintained (Billings & Hashem, 2010). From Antonovsky's original idea, it is very important to focus on peoples' resources and ability to create health rather than focusing on risks and ill health. The theory highlights the use of potential and existing resources and adaptation to stressful situations as an ideal treatment while minimizing emphasis on risk factors (Langeland, Wahl, Kristoffersen, & Hanestad, 2007). The theory, like this study focuses on the individual rather than the problem affecting them, looking at them as an open system that interacts with their environment, the environment being the source of both stressors and resources (Langeland et al., 2007).

Generalized resistance resources (GRRs) are the characteristics of the individual or properties within the environment that can facilitate effective tension management (Langeland et al., 2007). These may include physical assets, material goods, and one's own flexibility, confidence, social support, to mention but a few. Mobilized GRRs help individuals deal, avoid, define and manage stressors (Super, Wagemakers, Picavet, Verkooijen, & Koelen, 2015). The core elements of Salutogenesis point towards problem solving and, the capability to use the available resources (Fok, Chair, & Lopez, 2005). The theory notes that an individual who is able to adapt well to stress and utilize GRR has a very high Sense of coherence (SOC) (Langeland et al., 2007).

SOC can be expressed in three sub dimensions including; the ability to endure and the feeling of confidence that stressful situations are predictable and understandable (comprehensibility); for each stressful situation, there is a resource to meet its demands (Manageability); stressors are simply challenges worthy of one's investment and engagement (meaningfulness) (Langeland et al., 2007). SOC is developed through a whole life span but mostly in the first decades of life when people learn how to deal with life in general (Fok et al., 2005). It is developed in the youthful stage and considered to stabilize at 30 years of age (Super et al., 2015), the level of one's SOC determines their health status whereby the outcome of a strong SOC is movement towards health. The degree of success depends on the individual's capacity to deal with a stressful situation, (Eriksson, Lindström, & Lilja, 2007).

Figure 1: The Salutogenic model
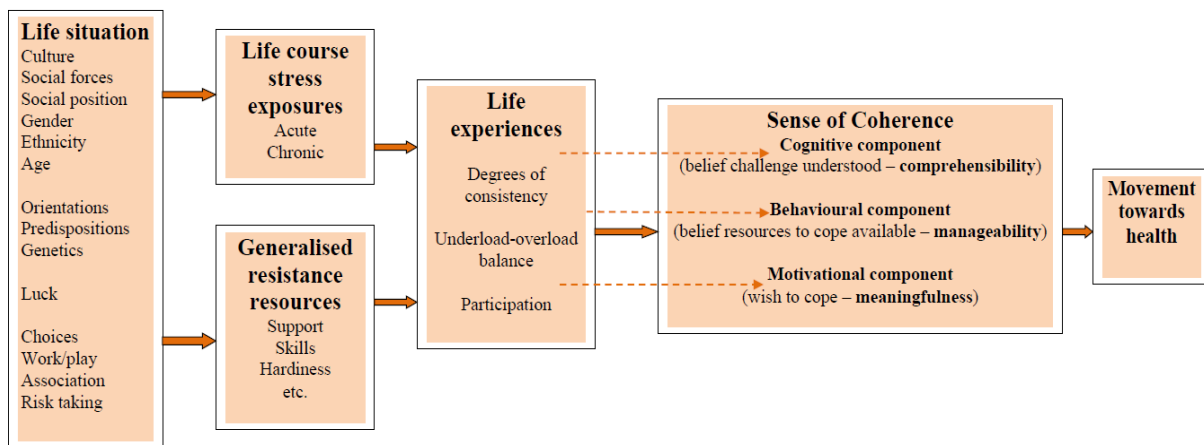
(Adaptation of Mittelmark, 2010)

Life situation are the circumstances in an individual's life which can either result into stressors or resources, therefore negotiating stability between these two is significant for one's perception of life. Aspects such as age, culture, gender, luck and also one's individual characteristics are significant in determining whether the outcome of a situation will be a stressor or GRR. The degree of consistency of the stressful situations, which means the actions that produce certain outcomes making the life course predictable, also determine whether one will be able to resist tension or succumb to it. Participation fosters understanding and adjustment which shapes outcome. The outcome is not a matter of chance but one's SOC (Lindström & Eriksson, 2008). SOC enables individuals to manage tension, to reflect on external and internal resources which helps identify and mobilize them to foster effective coping by seeking out solutions, resolving tension and moving towards health (Lindström & Eriksson, 2008).

University students in Uganda experience stressful situations in their lives including financial difficulties, social pressures coupled with negative outcomes of related unsafe risky sexual behaviour (Agardh, Odberg-Pettersson, & Östergren, 2011). This has exposed them to risky outcomes like rape, HIV/AIDS and other sexual infections, unwanted pregnancies, illegal and unsafe abortions, to mention but a few. However, some students have been able to thrive despite the difficulties. It is very important for this research to explore the students' perspectives to understand how they have been able to control extreme outcomes of risky SRH choices.

CHAPTER 3

3. Methodology

The study employed a qualitative method of data collection. According to Creswell (2014), a qualitative method of data collection focuses on the meaning an individual or a group attach to a problem with the researcher interpreting the meanings, and data collection taking place in the participant's natural setting. The reason for using a qualitative design for this study is because it is appropriate for exploring phenomena experienced and made sense of by the participants (Polkinghorne, 2005). This study therefore seeks to explore the experiences, perspectives and attitudes of university students on problems arising from sexual reproductive health and how they are able to control these problems.

3.1 Research design

The study used a phenomenological design to capture the perspectives, views and attitudes of the participants based on their experiences. The phenomenological design which has roots in philosophy and psychology, captures participant description of their lived experiences to attain a deeper understanding of the problem (Creswell, 2014). Phenomenology is also able to help the researcher understand the underlying meanings and justification for the participants' actions using their own explanation.

3.2 Study area

The study was conducted in Kampala district which is also the capital city of Uganda, at Makerere University, located in Kyadondo Sub County, Nakawa division. The reason for choosing Kampala district was because it has a big concentration of government and private universities with over 10 higher institutions of learning (UNCHE, 2015). Makerere university was the main study area because it is the biggest and most recognized university in the country with a diverse multicultural group of students, both local and international who were expected to have a variety of views concerning their sexual and social lives.

The university has a big number of hostels which are privately owned scattered around the university, these are either mixed sex hostels or strictly single sex hostels, the majority are within walking distance to the university. Within the university, there are several halls of residence owned by the university; however these are strictly male or female. Around the university, there are several institutions including biggest government hospital, Mulago

hospital and other privately owned health centers like Reproductive Health Uganda, Marie-Stopes and also the university hospital, all within walking distance to the university. Other institutions include mosques and churches.

Initially, some of the student participants were expected to be recruited from health centers, as they came in for services, however those who came in were in a fragile state of mind because they had come in to consult about an apparent concern for their sexual health, therefore I found it inappropriate to interview them in such a state. Most of the participants were therefore recruited from two other sites: one was the hostel which was mixed sex. This was convenient because the participants were introduced to me by the hostel warden. He handpicked those he knew personally because they had been living in the hostel for a year or so, explained the study to them and what they were expected to do, he also requested them to introduce me to their friends, which they did.

The second site was one of the chapels within the university, I was able to recruit several students in their second and third year of their programs who had been tasked to orient the first year students interested in joining the youth community of the church, an activity done annually to welcome new students into the congregation (It is important to note that August and September is when first year students join the university). I scheduled a meeting with the religious leader, meanwhile the youth leader in charge of the students introduced me to several of his colleagues to interview. In the end I was not able to interview the religious leader due to his busy schedule, but I interviewed another religious leader from another church attached to the university. Because I spent a good amount of time at the university, I walked up to some students, introduced myself and explained my study, they agreed to do the interview there and then.

3.3 Participants and inclusion

A purposive selection of persons with experiences of central importance on the problems of sexual reproductive health was carried out. Snowball sampling was then used for the student participant selection by identifying the initial participants from the purposely selected persons like the hostel wardens as mentioned earlier, from sites like the halls of residence and university hostels, and then these participants were asked to identify other members of the population.

Originally, the main participants were five male and five female students, however the ethical review board The AIDS Support Organization (TASO), suggested that 10 for each would be a better representation because of the big number of students at the university with unique perspectives on the topic. In the end I was only able to interview 11 students, five male and six female because ideally the selection process only continues on until the study reaches saturation; a point where no new properties or information is revealed (Creswell, 2014), which the study had reached. On the other hand, the key informants included the Dean of students Makerere university, one religious leader from one of the places of worship within the university, two hostel wardens and two health workers at the local community reproductive health center and the university hospital used by the students and the area local council one chairperson (LC1). These were selected because of their knowledge and experience concerning the sexual behaviour of the students.

The interviews were carried out in the participants' comfortable area of choice for example private offices for the key informants and a range of places handpicked by student participants that offered privacy like halls of residence, cafeterias and the shade outside the chapel. The study was originally intended to include under-graduate students between the ages of 19 and 25. This age group was not hard to find because most students enroll starting from the age of 19, however some students, most especially the male students in their final year of study were 26 or 27 years. This is because at some point some registered dead years in between and others started school late, I therefore decided to include them in the study because I felt that they may have vital information on the topic. Therefore in the end, the age range for the study was extended thus being 19-27 years.

3.3.1 Exclusion

Post-graduate students were excluded from the study. Also participants who were uncomfortable with audio recording of the interviews were excluded from the interviews.

Table 1: Overview of student participants

Pseudonym	Age	Year of study
Ivan	27	3rd
Vivian	22	3rd
Cissy	20	2nd
Mary	19	1st
Prossy	20	1st
Sarah	24	3rd
Aisha	23	2nd
Ephram	23	2nd
Charles	24	2nd
JB	26	3rd
Hillary	23	3rd

Table 2: Overview of key informants

Key informants	No.
Dean of students	1
Health worker	2
Religious leader	1
Local Council Chairperson	1
Warden	2
Total	7

3.4 Research Instruments

Individual interviews were completed with 18 participants in all, with five male, six female students and seven key informants. Interviews were used for the study because they enabled participants to share their personal feelings, opinions and experiences vividly, unlike observations. Also because of the sensitive nature of the study, they offered privacy and anonymity which focus group discussions could not have offered. In-depth interviews were

conducted using a semi structured interview guide (see appendix pg. 72) which allowed for flexibility of emerging issues where by questions were re-worded/re-phrased, re-ordered and clarified for the participants (Tong, 2007). The topics covered in the interview guide included:

1. What is known about sexual reproductive health and sources of information

2. Problems/stressors/risks related to sexual reproductive health

3. Resources and coping mechanisms

The guide was pretested on two of my contacts who were former students of Makerere university, to ensure that the language used in the guide was culturally, cognitive and emotionally appropriate. Also, the guide was presented to the review board (TASO) for the content to be validated. A few points were suggested by the review board, including:

1. Mention the chances of sensitive and embarrassing questions when seeking consent from participants.

2. Inform participants that money will not be offered (compensation) for information given.

The interviews were digitally recorded with an audio recording device and notes were taken with the permission and consent of the participants. The participants were informed that all recordings will be deleted when the study is complete. Conversations were conducted in English due to the multicultural nature of the university. Each interview lasted between 30 minutes to 1 hour.

Observation was used as an instrument and ran throughout the whole process of data collection. I was able to observe the participants' surroundings and environment for example their rooms and their way of life in there, the type of hostel one chose to live in, those around the church and the activities they carried out as they oriented the new members was very useful and gave me insight into their choice of life. I was also able to observe the billboards and posters around the university that were related to sexual health and those at the health centers (see Appendix pg.75). In this case, observation was used as a tool to enrich the information obtained from the interviews. Observation allows for the recording of extraordinary features of a phenomenon that interviewees may feel are not worth commenting

on (Green & Thorogood, 2014). Observations are reported to produce the 'purest' form of data that illustrate the truth about issues which is sometimes in contrast with what has been said or written down.

Document analysis was also used for the study, this involves reading written work or published documents related to the study that is already in existence (Rapley, 2008). For this study I looked at public documentation like the Makerere university code of conduct, Makerere university rules and regulations' book, health center magazines, leaflets and reports, posters and billboards related to the study to mention but a few. The study was not primarily focused on document analysis, but it was complementary to the study and helpful in building quality of the study.

3.5 Data Management and Analysis

All interviews were recorded using an audio recording device where after I personally transcribed the data into written text and saved it on a password protected laptop, the data were transcribed in English. A field notebook to record main points during the interviews and things I observed was used. A back-up was saved to a password protected memory stick and external hard drive. The recordings were deleted after they were transcribed. Transferring information to my supervisor was through use of a password protected memory stick to ensure safety of the information. The transcribed documents are anonymous therefore it is impossible to trace the identity of the participants; the original names have been replaced with pseudonyms. The interview transcripts will be kept for two years after submission of the thesis, in case of a follow up report; this means they will be deleted in May 2018.

Analysis of the data was done through use of Attride-Stirling's (2001) thematic network analysis which unearths noticeable themes in texts , to categorize the recurrent or common responses. This type of analysis aims to report the key elements of accounts from the respondents and identify typical responses (Green & Thorogood, 2014).

1: To get acquainted with the data, I read through interviews several times and listened to the recordings more than once to ensure accuracy of transcripts whilst referring to observational notes.

2: I coded interviews grouping similar statements into texts. Quotes were attached from the interviews to indicate were codes were deducted. Coding was done with the help of colleagues who helped with confirming similar extractions and pointing out varying

quotations. Coding was done independently and then notes were compared thereafter, picking out similar and varying texts that were collectively agreed upon.

3: Identification of themes from codes commenced whereby codes were grouped into a network of themes. Basic themes were created from the codes whereby similar texts were grouped accordingly. Research questions also guided in grouping codes under the organizing themes and global themes from the transcripts.

4: Basic themes were then grouped into organizing themes and organizing themes into global themes. Final analysis revealed that different global themes were interrelated.

Figure 2: Thematic network applied to findings
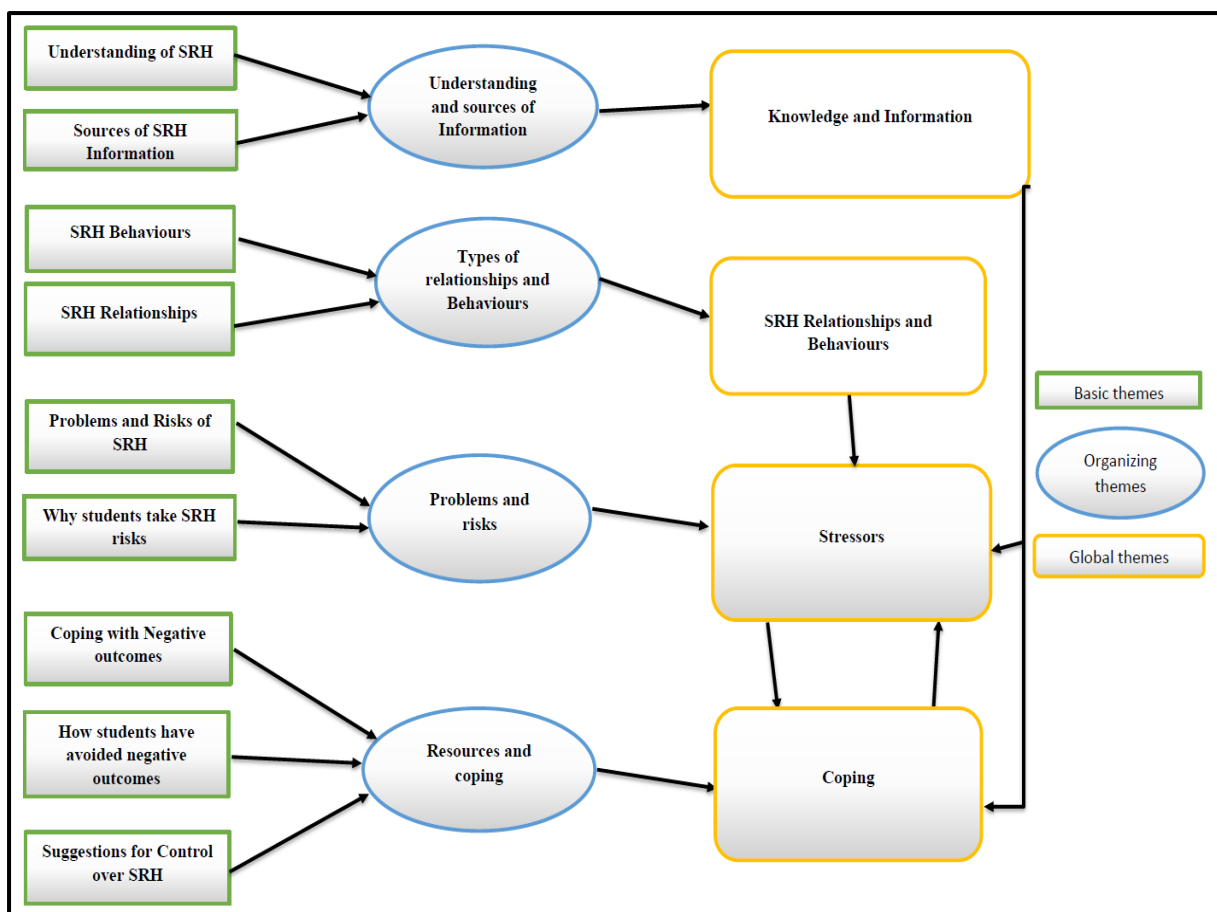
(Adaptation of Attride-Stirling, 2001)

3.6 Trustworthiness

Harrison, MacGibbon, and Morton (2001) define trustworthiness in qualitative research as the ways in which researchers work to meet the criteria of credibility, validity and believability of research. The concepts of validity and reliability, generalizability, reflexivity were originally used by quantitative researchers, that is why they are constantly scrutinized in qualitative research, some arguments state that the criteria for quantitative methods are inappropriate for qualitative studies, therefore qualitative researchers use similar concepts that are more appropriate for qualitative research, that is to say credibility, dependability, transferability and objectivity respectively (Shenton, 2004). Williams and Morrow (2009) suggested three major categories that all qualitative researchers must apply to increase quality and authenticity, these include; integrity of the data, balance between reflexivity and subjectivity and clear communication of the findings. With these in mind, I endeavored to show transparency in my findings which included descriptions of how I exercised credibility and reflexivity.

3.6.1 Validity
Validity as defined by Bowling (2002) is whether an instrument measures what it set out to measure. For validity, quantitative researchers seek to ensure that their study measured what was originally intended (Shenton, 2004), similarly, qualitative investigators ask how the findings are comparable to reality, they ask if the researcher's account is a reflection of what happened (Pilnick & Swift, 2011). According to Yin (1994 cited in Shenton, 2004), correct operational measures should be used in order to arrive at this. Credibility can be heightened by; interviewer prompts, details of the setting, respondent validation and triangulation (Green & Thorogood, 2014).

In this study, measures to insure validity included: guidance from my supervisor that kept me in line with ethics, interview guides were pretested to determine whether questions produced the intended inquiry and adjusted where necessary, also as mentioned earlier, the protocol was subjected to review from TASO and my supervisor. Triangulation of data collection was carried out in form of interview, observation and document analysis, and through this I was able to compare consistency of information between the three sources.

3.6.2 Reliability
In qualitative research, it may be referred to as dependability but we will use reliability. Reliability is the degree to which an instrument can be free from random error if it is tested

and retested, it should be able to reproduce and maintain consistency, in other words the possibility of producing the same outcomes if it is retested (Bowling, 2002). However, this train of thought is applied by quantitative researchers who assume constant nature of reality, qualitative researchers work with in context which is constantly changing (Barbour, 2001). Some examples of how to achieve reliability in qualitative research are given by Green and Thorogood (2014), they state that for the likelihood of similar research to produce the same themes, the following should be applied; there should be more than one person coding, accurate note taking or more effective, use of audio recording devices, inclusion of raw data so reader can compare how data are linked to interpretations, and constant use of interview guide.

For this study, the interviews were held in English therefore no participant meaning was lost during transcription and to increase reliability the same interview guides were used for the each category of respondents while interviews were audio recorded. More to this the data collection reached a point of saturation where respondents started repeating views and experiences another respondent had mentioned. When it came to coding, I received help from two colleagues to ensure that the codes we identified were consistent.

3.6.3 Generalizability

This is the extent to which findings of one particular study can be applied to a different situation (Shenton, 2004). It has been advised that this concept be approached with caution since it has the potential to belittle context which qualitative research operates in (Gomm et al, 2000 cited in Shenton, 2004). To enable transferability, it is vital to give a clear description of culture and context (Graneheim & Lundman, 2004). It is therefore my hope that successful findings of this study be published so that they can be helpful in matters of applying them in future reproductive health studies.

During the study some of the information I had read about in a journal article for my literature review concerning spiritual beliefs as a coping mechanism (Lazarus & Folkman, 1984; Pargament, 1990 cited in Folkman et al., 1992) was mentioned during several interviews implying that that literature applied to my study. Furthermore this study aims to gain insight into young people's own ability to manage problems and risks of unsafe sex, the results could help policy makers elsewhere and people working with youth in the field of SRH, understand this generation's shifting trend in SRH choices. Findings can also be applied to countries in SSA undergoing slow or stagnant progress in the area of SRH.

3.7 Role of the researcher

Within the broad range of approaches in qualitative research analysis, the role of the researcher is defined differently. According to Green and Thorogood (2014), in the humanist approaches, the researcher is simply a 'commodity' through which other voices can be heard. The researcher tells the story from the participants point of view, assembling it in a way that the broader meanings can be understood (Green & Thorogood, 2014).

3.7.1 Reflexivity

I am a social worker by profession with a bachelor's degree in social work and social administration. I have worked in the field of reproductive health since the first year of my undergraduate studies in three different youth Organizations; therefore, I have experience interacting with youth and I am familiar with their reproductive health concerns. However with this in mind, I had to place what I know aside and learn from the students by adopting the role of a researcher for the study and taking it upon myself to avoid interpreting and analyzing what the participants said to the best of my ability. As social workers, two of the most important principles we are taught are to avoid getting emotionally involved and refrain from being judgmental towards the people we are to help (Miehls & Moffatt, 2000). Adopting this lesson for my research was helpful in delivering what the participants were expressing without any biased interpretation to the best of my ability. As a person with knowledge about the problem, it was important that I put aside all the assumptions and preconceived ideas I harbored and walked into the interview open minded to learn from the participants. Also, it was of great importance that the participants did not view me as a social worker or as a master's student from abroad but as a student learning from them so that the information they gave was not influenced by power relations.

However because it was my first time meeting some of the respondents, the relationship was official whereby the majority did not feel comfortable revealing very personal information but rather they provided encounters from people they knew had gone through a similar experience. I believe that if I had the opportunity to create a relationship and get to know some of them before the interviews, it would have made them more comfortable but their busy academic schedules and my limited time did not permit this. Furthermore some respondents showed discomfort with being recorded therefore these particular interviews had to be cancelled and new respondents sought.

3.8 Ethical Issues

Ethical approval of the study was sought from Norwegian Social Sciences Data Services (see appendix pg.79). Our proposals were submitted to the board before the end of the semester, therefore permission was granted before we left for data collection. Thereafter, the research proposal was submitted to local institutional review board in Uganda TASO, I was informed that clearance would take up to a week but this was not the case as it took up to a month for the research protocol to be approved (see appendix pg.82). Permission was then sought from the body responsible for permitting research in Uganda, the Uganda National Council for Science and Technology (UNCST) (see appendix pg. 84) which also took a while but I eventually received an email informing me that the protocol was approved but I had to wait for the clearance letter to the study district from the research secretariat, office of the president (see appendix pg.83). I was notified that this would take up to a month too, therefore I contacted my supervisor with the issue who told me that since approval of the protocol was given, I could go ahead and start interviews because I had very little time left. Lastly, approval for conducting research in the University was sought from the Dean of students Makerere University, who forwarded me to the Academic registrar who then approved the study (see appendix pg.85).

The purpose of the study was explained to the participants prior to the interviews hence seeking informed consent from them. Written and signed informed consent was obtained from study participants with English as the language of choice. Study participants were assigned pseudonyms which were placed on the interview documents (see table 1) therefore they were not requested to disclose their real names. All interview data were confidential and the respondents were not pressurized under any circumstances to answer questions that they did not wish to answer. It was important to note and also inform the participants that there were chances of risks during the interviews and these risks included; some questions were embarrassing however participants were given an option of not answering those particular questions, some questions had potential of causing emotional distress, these were also avoided and psychosocial support was offered in case the participant broke down, however none of the participants broke down. For comfort and privacy, I took care to carry out interviews in handpicked places where participants felt secure.

The review board asked me to change a few things in the proposal that included: the number of participants from 18 to 27, it also asked me to include, in my consent form that there would be no form of monetary payment for the study so that participants were informed

beforehand, because in many cases, some participants are known to expect monetary payment for studies. Also I was asked to include psychosocial support in case participants were over whelmed by the questions. Fortunately there were no incidences of participants breaking down during interviews, however a small amount of money was placed in the community development box at the office of the Local council chairperson because this is expected from every visitor seeking consultation from the office, it is important to note that this is not a must for everyone but those willing to contribute to community development and it was clearly explained to the chairperson that the study data can be biased if money is offered which they understood clearly.

Copies of this thesis will be sent to the office of the Dean of students, the review board TASO, UNCST and the Reproductive Health Uganda, furthermore the results from the study may potentially contribute to an article published in a peer reviewed journal.

CHAPTER 4

4. Results

In this chapter, data are presented according to the emerging themes from the analysis. The data indicate the thematic analysis of the accounts given by the participants on their experiences concerning SRH. The following responses which are reflected in the text are some the researcher found exemplified the common or contrasting views.

Table 3: Structure of themes

Codes/Basic themes	Organizing themes	Global themes
Having safe sex Abstaining Being faithful Prevention and cure Ways of avoiding pregnancy Being cautious in sexual relations Sexual relations in a healthy manner How you handle yourself sexually A state of one's physical, mental wellbeing in terms of one's reproductive system	**Understanding of SRH**	**Knowledge and Information**
Modules Internships and trainings Conferences and seminars Health centers and University hospital Notice boards, billboards and posters Peers Media Parents Places of worship	**Sources of SRH information**	
Friends with benefits Sex for fame, jobs and grades Romantic relationships	**Views on SRH relationships**	**SRH Relationships and Behaviours**
Rape Buying prostitutes Sex for fun One thing led to another sex	**Views on SRH behaviours**	
Unintended pregnancies and their consequences Rape Unsafe Abortion and its consequences STDs, HIV/AIDS Emotional breakdown and Heart breaks Low self esteem Sexual gender based violence Academic drop out and failure Disowned by parents and boyfriends	**SRH problems and risks students face**	
Peer pressure Freedom Pride		**Stressors**

Low self esteem Sex addiction Attention seeking Ignorance and innocence Not worried about consequences Lack focus Poverty Need for belongingness Low self esteem Poor morals Misleading sources of information Living arrangement in some hostels Substance abuse	**Why students take SRH risks**	
Religion Health centers and University hospital Social support Dropping out and getting a Job Abortion	**Views on coping with outcomes**	
Faithfulness Abstinence Religion VCT Focus, personal values and self-respect Using contraception Institutional rules and code of conduct Time heals and lessons Sensitization Prioritizing	**Views on how students have avoided negative outcomes**	**Coping**
Patience Focus and set priorities Treatment Use protection Abstinence No compromise Discover self-worth and Identity Religion Self-control Be faithful	**Suggestions for control over SRH**	

4.1 Knowledge and Information

Two significant categories of organizing themes concerning views on the knowledge and information on SRH emerged from the data. These were participants' understanding of SRH and Sources of SRH information. Within each emerged individual classifications which are discussed in turn.

4.1.1 Understanding of SRH

For the purpose of this study, understanding of SRH is defined as participants' interpretation of SRH. Two classifications of participants' understanding of SRH emerged from the data, definitive and demonstrative interpretation of SRH.

When asked about what they understood by the term SRH, the popular responses were demonstrative interpretations of SRH, meaning that they used action words to refer to SRH. This gave the indication that the students were familiar with the term even though they did not define it in its entirety. They referred to it as; having safe sex, abstaining, being faithful, prevention and cure [of sexually transmitted diseases and infections] ways of avoiding pregnancy and being cautious in sexual relations. All the responses pointed towards conduct in a manner that ensured a safe and healthy sexual life. One student noted that:

> *"It talks about, how safe are you, I'm a Christian so we think about things like abstinence, if you're in a relationship, faithfulness, yah basically that's it, and the rest of it is having safe sex…" (Ephram, 23)*

On the other hand, some students gave definitive interpretations of SRH. They referred to it as sexual relations in a healthy manner and how you handle yourself sexually. One student was able to relate it to an individual's mental and physical wellbeing, this she explained was because she had worked as an intern at the local reproductive health center RHU, during her first year of university:

> *"According to my understanding sexual reproductive health is a state of one's physical, mental wellbeing in terms of one's reproductive system, that's how I understand it". (Cissy, 20)*

I observed that the students' interpretations of SRH may have been influenced by their personal beliefs, morals or experiences. For example as seen from the above responses, religious students leaned more towards abstinence and faithfulness, whereas Cissy, 20 understood it from her experience with working with a reproductive health center. One student who was also a volunteer youth leader at the church confirmed my observation:

> *"Of course the usual stuff they tell us, abstain, don't have sex, safe sex, generally that…" (Mary, 19)*

4.1.2 Sources of SRH information

When asked about how they learned about SRH issues, responses from the participants emerged as formal, informal and moral sources.

The student participants learned about issues concerning SRH through various formal sources which included; some modules in their school curriculum for example social sciences, Internships and trainings which are often compulsory for certain programs at the university, conferences and seminars organized by NGOs and health centers partnering with the university, student walk-ins at the health centers and university hospital for consultations and

treatment, notice boards, billboards and posters about SRH which can be found around the University. One student noted that:

> *"...through trainings and conferences about reproductive sexual health. And I also got to learn about these sexual issues through my internship, I did my internship at an organization called Reproductive Health Uganda and through that is how I got to know much more information like about sexual issues". (Cissy, 20)*

Another student added:

> *"There are talks that people hold, like pregnancy, how to prevent HIV...how is it spread? Ah posters, there are those cars which go moving around loudly, then there are notice boards..." (Vivian, 22)*

Confirming what the students reported, one health worker from the University hospital mentioned that students occasionally walked into the hospital with sexual health concerns and questions:

> *"Some come to us and ask us different questions about their sexuality, about how to keep safe...we give out leaflets and brochures, sometimes we have big posters like the one saying abstain...and then sometimes we come to the University during health week, we do HIV counselling and testing because that is also sexual health..." (Health worker 2)*

I was able to verify some of these sources through observing some students who came into the health centers and also looking at several posters that were pinned around the University and the community health centers. The posters advertised safe sex, use of contraception and various other topics of relevance.

Picture 1: Poster next to university main gate

Picture 2: Notice board at RHU

However one student believed that some formal methods, specifically posters did not deliver the message to him as well as other avenues did, he noted that:

"…I don't think you learn about sex by reading a poster, posters do not speak to me, but it imprints into you when you actually relate with people and talk to them".
(Ephram)

In line with the above quote, the majority of the students reported learning about their sexual health from informal sources. The students stressed learning something about sex from peers because as they noted, "people talk" and this was either boasting about accomplishments, talking about their experiences or discouraging sex. They also learned through the media which included television, radio or print media. One student simply noted:

"Mostly media and the peers, that's all". (Ivan, 27)

A health worker at RHU verified what the students reported by adding that students had circles where they talked about sex freely. On top of this he added that students also learned from the media and their parents back at home which the students did not mention. However he stressed that all these avenues sometimes portrayed the information negatively:

"from the peers, given the fact that there is that free lifestyle, they have friends when they are in their circles automatically they jazz about sexual health, and most of the time they are rich on information since they are not living in a vacuum, but it's also fragmented and most of the time not factual …" (Health worker 1)

However the Dean of students differed in his report by saying that students were not free in sharing their experiences.

"…so most of the sexual activities are hidden, they do not come out, first of all those who indulge in sex hide, it is a secret, those who get pregnant, it is also a secret, those who want to take risks including abortion for example, it is also a secret…" (Dean of students)

Some students also learned about sex from moral sources like places of worship that taught them that sex is a gift for marriage and they should value their sexuality and their partner's if any. One student noted:

"Here at church what we get is mainly on the abstinence level and all that, at church they preach about more of how we should value our sexual health and reserve it for a better institution which is marriage, instead of distributing, going around". (Hillary, 23)

The religious leader verified this by reporting that:

"Whenever we teach about sex in church we teach about getting involved in it after marriage not sex with anybody, anyhow. That is how the church teaches about sex". (Religious leader)

Although all sources of information were reported as being very significant in teaching students about practicing a healthy sexual life, some were also noted to be misleading, sexualized in the content they aired for example the media was reportedly influential in affecting students' negative behaviour

> *"…then I talked of sexualization, the media is one of the key avenues which has manipulated people's sexuality… for profit benefits, sex sells… so this same person wants to imitate a certain musician because that's what the media is portraying…to be ideal…they are creating a scenario where people should not appreciate whom they are…" (Health worker 1)*

4.2 SRH Relationships and Behaviours

This section is divided into two categories, types of SRH relationships and typical behaviours of students.

4.2.1 Views on SRH relationships

When asked about some of the existing sexual relationships on campus, two categories of relationships emerged from the data. Relationships for convenience and genuine relationships.

Students were involved in various relationships for convenience. For this study, relationships of convenience are those that have a beneficial factor with an aim to provide ease and effortless comfort for the students. These relationships included; sex between friends with no expectation of it developing into a committed relationship, also referred to as 'friends with benefits'. Students were reported to have sexual relationships with local celebrities for fame [this is prestigious in their circles] their superiors or much older partners in return for: better grades [lecturers], for jobs after completing their programs and for money [or expensive gifts] Relationships with older partners was evident when one student mentioned that:

> *"…some people sleep with married men and their women come and beat them up…"*
> *(Vivian, 22)*

The second category were the genuine relationships that participants referred to as boyfriend and girlfriend relationships or romantic relationships. These were popular among the students however some reported that they always end up getting heart broken or disappointed because the other person did not have the same intentions. One student was able to mention some of the above relationships.

"…not all relationships that are there are boyfriend and girlfriend kind of relationships, some people engage themselves in relationships for money, some for fame…with people like celebrities just for fame but not romantic kind of issues. Then money like I've said, others jobs, just to look for jobs, then of course boyfriend and girlfriend kind of stuff. Then others engage themselves in relationships for marks, to get marks from like say, lecturers and pass…" (Cissy, 20)

4.2.2 Views on SRH behaviours

Various behaviours emerged from the data that could not be easily classified as relationships but were relevant to the study; these encounters were either mutual or unplanned.

From the responses, it was evident that the students were sexually active and most often sex was unplanned. It emerged that some had sex because it was fun, therefore they kept doing it and for others, one thing led to another and they ended up having unplanned sex. The male students were reported buying prostitutes to satisfy their urges and on some occasions, they shared one prostitute. One behaviour that was frequently mentioned among the students and key informants was rape and this was reported to commonly occur when students were intoxicated with alcohol.

"…those boys tend to go for prostitutes in order to satisfy themselves, because those are easily got… Another thing we have is rape, rape at the University. Before it has been happening outside, you hear it is in Kikoni, Nankulabye [areas near the University] *and some other places, even girls you have a friend and she tells you "you come we have a party somewhere" then she leaves you there with some men and they rape you…"* (Health worker 2)

It was reported that some students are not afraid of the consequences of their actions, which is why sex is easy to have these days. It emerged that they walk around with the mentality of 'come what may' as one student reported. Another confirmed this by noting that:

"…A lot of girls are getting pregnant, now it is almost normal to have a child in campus, it is no longer alarming when you see someone pregnant. It has happened a lot that it is normal". (Mary, 19)

4.3 Stressors

Two categories emerged from the stressors students face; SRH problems & risks students face and why students face these SRH problems.

4.3.1 SRH problems and risks students face

When asked to mention some of the existing SRH problems among students, three categories of responses emerged from the data. Physical health problems, mental health problems and academic problems.

From the students' accounts, it was noted that some students knew the possible outcomes of sexual choices but they still went ahead to engage in risky behaviour and the reason given for this was that students assumed they would overcome the problem. One noted that:

> *"...should I say some think they are wise, for example the case of pregnancy, someone will tell you, there is protection...I can abort, you know they think about the risks at first but when the time comes when you're actually facing the risk itself, you realize you have nothing to do about it... you know the risks but you feel you can overcome them..." (Ivan, 27)*

 Students were reported to face various physical health problems as an effect of poor decision making in their sexual relationships. Both health workers reported that it was 'obvious' that students were sexually active and often times just wanted to have fun however they were never ready for the repercussions that came with this life style. The common issues the health workers reported dealing with at the centers included unwanted pregnancies resulting from unsafe sex, sometimes even rape or sexual coercion but because of the fear that comes with an unintended pregnancy for example the boys rejecting the pregnancy or being disowned by parents, students were reported to having unsafe abortions which were reported to sometimes present with complications like incomplete abortions, fistula, hemorrhaging and sometimes death. Also because of unprotected sex students reportedly got infected with HIV and other sexually transmitted infections. One health worker added that:

> *"...some get miscarriages, some get reproductive health cancers, cervical cancers, then others will present themselves with issues of misuse of contraceptives or failed family planning method, others might contract infections..." (Health worker 1)*

When asked about the physical health problems, the majority of the students confirmed what the health workers mentioned. One noted that:

> *"...Pregnancy, being pregnant; it can be a risk if at all you are not married and you're not serious and there's getting AIDS and HIV and such. STDs, candida..." (Aisha, 23)*

Mental health problems were reported to be the common problems encountered by students and these usually presented as psychological and emotional struggles. Students reported

dealing with multiple heart breaks from relationships that did not work out, development of low self-esteem and loss of confidence especially for the girls, resulting from being used for sex.

> *"...emotional breakdown, sometimes you find you've broken up and it's not in a good way and it affects you academically and socially...sometimes should I say people go in way over their heads like you go date a lecturer because you want to get marks then at the end of the day you get disappointed, you don't get what you wanted..." (Ivan, 27)*

A health worker also added that sometimes for the girls, finding out that they are pregnant is psychologically challenging because they were not ready for such a situation. Some of them struggled with the psychological effects of rape and sexual gender based violence from their partners which negatively impacted on their overall wellbeing.

> *"...just a mere knowing that this girl has become pregnant, that's an effect because psychologically she is not prepared for it, she just wanted to have fun..." (Health worker 1)*

SRH choices also presented academic problems to the students. In case a relationship with the lecturer was discovered by those in authority, it was reported that the student was automatically suspended. Furthermore, students noted that after engaging in sexual relations with the lecturers, the students were always disappointed to discover that the marks were never given in return, and because no effort was put in studying, it affected their grades negatively. It was reported by the Dean of students that pregnancy during the school year meant that one had to stop at some point to deliver the baby. The students added to this report by saying that pregnancy directly affected one's grades and most often called for registration of a dead year. Students revealed that sometimes the pregnant students were disowned by their parents and boyfriends, which meant that they had to give up on school to earn a living. One student said:

> *"...let's say for a guy, you are saying it is ok she can get pregnant, I'm in my final year I can go out and earn a living, then by the time you finish, the jobs are nowhere to be seen yah so you end up struggling there are those who deny their babies..." (Ivan, 27)*

The Dean also reported that:

> *"Our regulation is not reproductive friendly because in these regulations you will find that if you become pregnant, you are supposed to leave the hall of residence at least four months before you deliver..." (Dean of students)*

4.3.2 Why students take SRH risks

When asked about why they faced these problems, three categories of reasons emerged from the reports, these were; personal reasons, social reasons and transactional reasons.

Personal reasons emerged as the majority from the analysis and these were linked to the students' emotional/cognitive and moral experiences. Several students reported that for girls, the reasons they were prone to the previously mentioned problems in 4.3.1 were attention seeking and the need for belongingness.

> *"I think some people need a sense of belonging and they find belonging in the wrong sort of thing and with the wrong sort of friends that influence them to do those things…" (Sarah, 24)*

On the other hand they noted that boys had sexual relations with many girls because it was prestigious and doing it openly was because they were proud of their accomplishments. Collectively, students noted that sometimes students fall victim to several scenarios simply because they are ignorant and this was confirmed by the community health worker who said that:

> *"…then ignorance, and it is not only the first years because the other girl I told you was a third year* [Rape victim]*…" (Health worker2)*

More to this, it was mentioned that some students were no longer worried about the consequences of their decisions, they reportedly had the 'I don't care attitude'. Others were reportedly sex addicts who stopped at nothing to have sex and others were said to have poor morals and lack of values to keep them grounded. The majority of students mentioned that people who fell victim to SRH problems lacked focus, goals and direction, some students reported that 'they did not know what brought them to campus. An unexpected popular response from both the students and key informants was that low self-esteem predisposed the students to risky sexual behaviour. From the analysis, this emerged as a cause for behaviour and also an effect of behaviour.

> *"I believe sometimes it is esteem since you may not value yourself, sometimes people think they are not loved, so if at some point someone approaches them and they feel valued in the action of sex…it will boost your esteem really, so you think it is worth a try or something" (Hillary, 23)*

One unexpected personal reason that none of the students mentioned but was revealed by a health worker was disability. Students with disabilities were highlighted as having the same sexual needs as the other students but were usually marginalized and given little attention therefore leaving them vulnerable.

"...remember they are sexual beings, they would also love to have sex but maybe the mainstream population is not well articulate with the sexual and reproductive health concerns and the unique needs of persons with disabilities, so I believe that predisposes them..." (Health worker1)

For social reasons, the most common reason students gave was peer influence. Accounts indicated that students often did what their peers were doing and wanted what their peers had. The local council chairperson confirmed this by noting that:

"...living at home...they take responsibility because their parents are around to watch and control them, but those in hostels are living under their own will...and the habits they get, they learn from their peers... the friends are getting stuff that she would want to have too...causing her to get a sugar daddy who gives them what they are looking for so she can fit in with her friends" (LC chairperson)

In line with the LC chairperson the Dean strongly believed that besides peers, freedom was the biggest risk that predisposed students to SRH problems. According to him freedom created avenues where students were predisposed to many risks that would be avoided if there was supervision and this accompanied with peer pressure was very dangerous. He noted that:

"...if you stay in a hostel...you can lock your door and go away...there is nobody who is going to say, why didn't you sleep in your room?...but then freedom is opening risks for you, you can go late, you can stay there, you can even move with people. And when you move with people, that's where you will find drunkard-ness, you can drink..." (Dean of students)

As mentioned earlier in 4.1.2, it was reported that students' behaviour was influenced by misleading sources of information like the media that contributed to development of low self-esteem. More to this, it was also added that students were often times misled by their fellow peers who gave enticing sex stories and lifestyles, influencing their peers but also one that was mentioned the health worker of equal importance was parents who gave little, biased and fragmented information.

"...then another avenue is through parents but you find that...their parents are supposed to be the primary source of information on sexual health related issues but ...they are also ill prepared and very uncomfortable to discuss issues related to health. Those who go an extra mile bring it in a manner that is really 'ice coated' and the information given is put out in a negative perspective..." (Health worker1)

In line with what the Dean of students reported, the students were reported to carry out substance abuse which predisposed them to poor decision making and also rape.

> *"…they drink, they take drugs. Some girls also do but boys take a bigger extent and when this happens they engage in any sex whether it is protected or not, they are doing it" (Health worker2)*

As reported in 4.2.1, students engage in transactional sexual relationships and these were reported to include, sex with lecturers for grades, sex for jobs, sex with celebrities for fame but the most dominant was sex for money and this was reportedly done by girls with older men. Though poverty was given as one of the reasons, several reasons also emerged as to why girls have sex for money.

> *"…what I know about University students they fancy sex with big men because they know they earn something…Boys want to always look for 'freshers'* [first year students] *because they…know nothing, they have just come into that life of campus…when they ask out freshers for sex it is so easy…" (Prossy, 20)*

Only one student who was male mentioned that it was usually hard to control their actions with girls everywhere. He went ahead to add that sometimes it were the girls who pressured boys into sex and even though one may have had a girlfriend, he was tempted to have sex with this one girl.

> *"Sometimes you can…control yourself but it is too hard to do it…especially now we have to study, we spend most of the time with ladies who are so lovely and attractive…that comes emotionally, someone who cheats on his girlfriend, they do not really want to cheat on them but it is the lady who pressures him that now I'm here with you so it gives me feeling to do it, that gives me mood" (Charles, 24)*

In referring to previous sections in the chapter, it is evident that all sections are interconnected and linked.

4.4 Resources and Coping

Two categories emerged from the analysis, how students were able to cope with outcomes and how some avoided negative outcomes. The responses between the two categories were similar but they were addressed differently.

4.4.1 Views on resources and coping with outcomes

Religion as a resource was the most dominant in the category of moral support. It was reported by the majority of students that religion helped several students through hard times.

Even though the majority were not comfortable with sharing their personal experiences, they shared this aspect of their lives. One shared that:

> *"God. I kept a strong relationship with God" (Vivian, 22)*

The religious leader confirmed this by adding that;

> *"You see there is a way the church soothes one's mind and helps one recollect their thoughts… Sometimes for some it is God who redeems them…They know that when they run to church, they are helped immediately…we do not judge you…church is a place of rest to them, that is why they need to come to church" (Religious leader)*

Social support was also one popular resource for the students who were facing SRH problems, most dominantly peers. It was reported that students received financial support, emotional support and sometimes advice from friends. One student reported that:

> *"Most of them cannot cope with such problems but you have your friends besides you the ones who help you sometimes, because I saw one of my friends who got the same problem…he wanted to run away from the country, as long as we were there we just supported him and helped him to solve the problem" (Charles, 24)*

Besides support from friends, it was reported that students also got help from other places like the local NGOs, the University hospital and local health centers. It was reported that they received counselling and treatment from such places.

> *"…she got raped…because she was drunk. She got drunk to an extent that even when she came here, after being raped, she was still drunk…we put her on the ward because she could not even walk back…we gave her medicine, we put her on the ward…" (Health worker2)*

The other resources that students were reported to use were medical alternatives and these included emergency contraception after unprotected sex and rape. One unexpected coping mechanism that was mentioned by two female students and one male was abortion. They reported that this was one way of coping with an unintended pregnancy.

> *"Abortion…I have not encountered a friend or a lady who has aborted, but what I know, rumors had it that even in this hostel one or two abort at any given time of the semester…" (JB, 26)*

4.4.2 Views on how students have avoided negative outcomes

From the analysis, it was noted that this section was very similar to the previous whereby students used similar resources and coping mechanisms as they would if they had faced the

problem. Three categories emerged from the analysis, moral resources and medical resources and institutional resources.

When asked about how they avoided risky situations moral resources were the most dominant whereby students reported that they strengthened their relationship with God and the teachings of religion that called for faithfulness and abstinence before marriage. The local council chairperson confirmed this.

> *"Those who have been able to control themselves it is because they have religion, those hostels have students who are born again, so those students always focus on God. They counsel each other, they spend most of their time in churches. If you do not have religion or something to keep you grounded, temptation is easy" (LC chairperson)*

One student added:

> *"…I think everyone gets tempted at some point but I believe it is based on their values, personally me, I am a Christian so I definitely find it easier to keep away from such situations as compared to someone who is not saved or who is a Christian…" (Sarah, 24)*

In line with the above quote, others reported that they were able to focus on school, prioritization, self-respect and use of their childhood values and that was what they reported controlled them from making mistakes. Others reported that facing a problem the first time prepared them the second time therefore they learned their lessons.

> *"I think learning from lessons, I think they went into the relationship and it wasn't as successful as they wanted it to be and they got negative things out of it, so I think they learnt their lessons and they wouldn't do the same thing again" (Sarah, 24)*

Institutional resources were those provided by the university, the university hospital, religious institutions and any public institute that helped students control their SRH. From the reports these resources included the university code of conducts and rules and regulation of the University, sensitization and provision of information and resources like contraceptives and condoms, voluntary counselling and testing reported by the health workers, were provided by the health centers. One hostel warden confirmed some regulations at the hostels that helped students control their behaviour:

> *"The best regulation that I have seen that has worked out is closing the hostel at midnight so by midnight when you are not in, go home or go where you are from or*

come back tomorrow. So it really helps us and they are following, it is controlling both us and them. The drug use also is prohibited" (Hostel warden)

From the above accounts, it emerged that even though most coping mechanisms were positive and health promoting, some students solved their problems with alternatives that are still regarded as problems for example abortion, showing the apparent link between stressors and resources.

4.4.3 Suggestions for control over SRH

The suggestions for better control over SRH emerged as similar to the coping mechanisms in 4.4.1 and 4.4.2. They also emerged as moral and institutional suggestions.

For moral suggestions students were advised to be patient until they finished school, they would enjoy later on. Other suggestions included, setting priorities, abstinence, faithfulness, learning self-worth and learning how to control their urges and most popularly seeking God.

"To me I think it is self-esteem, you value yourself first of all…ideally they should abstain because you are young enough and life is coming so that is what we tell them, that's what the wardens tell them, that's what we expect the hostels to tell them, to abstain…" (Dean of students)

Institutional suggestions were reported to be provision of contraception for students, seeking treatment in case of STDs and sensitization of the students

"…sensitizing them but still, me I think you just offer free condoms" (Vivian, 22)

4.5 Summary of results.

In this chapter, I have presented the lived experiences and perspectives of Makerere university students and stakeholders. The data present the students' knowledge of SRH, stressors and resources/coping mechanisms. Each and every student described their unique understanding of the term and even though interpretation was individual, responses emerged as having a similar line of thought. Students gave a number of stressors with the majority of the stressors being repeated among the students indicating they experienced similar problems or were familiar with the commonly experienced problems. The stakeholders mentioned a few issues that none of the students mentioned even though they appeared to experience them, for example how students with disabilities face similar problems but are not given as much attention. This is probably because I did not get a chance to interview a student with disabilities and it is a topic that simply came up during the interview. Even though some experiences were not directly encountered, students had heard about them and knew the risks

involved. In managing stressors, although students had similar resources and coping mechanism to report, they were experienced differently, also though experiences were similar, use of a particular resource/coping mechanism was individual, whereby some ways of coping would be considered as stressors to other students. The ways to avoid risky behaviour were similar to some of the ways students actually managed a problem after it occurred. Support from close friends and religion were the most common resources to the students.

CHAPTER 5

5. DISCUSSION

In this chapter, outstanding issues from the findings will be presented in reference to existing literature and Antonovsky's theory of Salutogenesis. It is important to note that there is a link between several themes, therefore cross-reference will be used to show the interconnectedness between these themes.

5.1 The role of knowledge and sources of information

Findings indicated that students knew what SRH was, however the findings also revealed that though there was an awareness of the term, a holistic understanding was lacking as the majority of the students merely understood it as sexual conduct, reproduction, use of contraception and types of services involved. Earlier research by the Ministry of Health Uganda (2006) similarly reported that the majority of students in higher institutions of learning in Uganda had knowledge of SRH, however the report did not give in-depth remarks on the students' level of knowledge. But a comparable study carried out on adolescents in four SSA countries including Uganda established that the young group clearly had a high awareness of certain aspects of SRH but poor in-depth knowledge on the subject. (Bankole et al., 2007). Lack of a holistic understanding of SRH by the respondents in this study falls short of the 1994 ICPD definition, which declares that SRH is so much more than having a safe sexual life (UN, 1995 cited in Fathalla, 2015). The ICPD in defining SRH goes further to emphasize the rights of individuals in SRH; this was not reflected in the students' definition of the term. This implies that students are missing a very important ration of information that could be significant for decision making in their SRH lives, therefore bringing to light the challenge that lays in determining where the information gap exists within the sources of information and understanding why.

Students were more knowledgeable about the health aspects of SRH compared to SRH rights as noted above, however Fathalla (2015) emphasizes that health and rights in SRH work as a combined package whereby without the other, individuals cannot be fully healthy. (Rijsdijk, Lie, Bos, Leerlooijer, and Kok (2013)) add there is need for a holistic sexual cognizance whereby there exists three approaches to sexual education including the rights based approach which teaches rights within power dynamics, social inclusion and empowerment; morality approach which when learned enables one to develop intrinsic values for decision making while appreciating the impact of their decisions on others; health promotion approach

focusing on outcomes of SRH from the medical and technical point of view. In reference to this study, students only referenced their moral and health promotion knowledge about SRH. From the previous literature (Fathalla, 2015), it is quite clear that young people's awareness and utilization of their SRH rights is important in strengthening their overall health, but studies on the subject have brought to light the harsh reality that even though rights are significant in protecting young people's SRH, in reference to the youth in the western world; individual choices of the youth in Africa are overridingly determined by economic circumstances, social norms and religion (Rijsdijk et al., 2013). This therefore undermines the pressing need to learn about and also utilize SRH rights by young people in Africa. Earlier studies on SRH projected the high likelihood of SRH rights being veiled under the enormous umbrella of reproductive health and suffer the high risk of being left out or minimized during policy development (Corrêa, 1997).

Students appeared oblivious to SRH rights yet the sexual reproductive report by the Ministry of health Uganda (2013) declares that human rights issues have been included in the strategies meant for young people's SRH concerns in Uganda, even though this did not reflect in the students' knowledge of their SRH. In the report, the rights are proposed as the right to services and protection laws from harmful sexual encounters and practices including sexual violence and harmful traditional practices. However affirmative definition of SRH rights 'satisfaction, safety and freedom based on their own choice/decision' is seldom highlighted. Which further emphasizes the need to define the gap that lays in the type of information taught to young people and the sources of information.

Influential sources of information from the study included the media (TV, radio, internet) curriculum, posters, notice boards, hospitals and clinics, seminars, conferences, internships, religious institutions, NGOs and parents. It emerged that behavioural conduct or interpretation was highly influenced by beliefs and values, upbringing, peers and experiences. For example religious students associated a safe sexual life with faithfulness and abstinence because that is how they are taught to conduct themselves in their places of worship. Those who experimented with risky behaviour were influenced by friends. This is similar to a study carried out on contraception use among youth in America that found that contraception use was associated with behaviour whereby if peers thought it was important, the higher the odds of using it (Frost et al., 2012).

Numerous sources of information from the study cater for individual preferences while generating triangulation, if one source does not reach one student another may, whereby a single source may deliver an intended message to one student but may not influence another's behavioural change for example one student reported preferring learning from friends to posters delivering the same message. On the other hand, though one source may deliver the same message, two students may perceive or react to it differently, for example it was reported that listening to a peer's experience enticed one to try that experience but caused the other to avoid it in order to avoid risk. Also, it was evident from the responses and my own observation that even though these sources were very significant in teaching development and maintenance of a healthy sexual life, several were reported to equally cause deterioration in sexual health by providing misleading, less than factual and biased information as reported by the RHU healthworker1 who gave examples like the media, parents and peers. A study conducted on peers' role in spreading information confirms what the health worker noted about peers providing less than factual information, it found that peers usually give "non-objective and unreal" information terming it as gossip and rumors, twisted and mutated hearsay (Zhu, Liu, & Hu, 2015) However this study was carried out on peers during a crisis situation. Another similar study carried out on adolescent parent relationship in Uganda found that although parent-child relationship and communication have the potential to encourage healthy sexual behaviour (Muhwezi et al., 2015), parents are ill prepared and the discussions they have with their children are based on arousal of fear (Muhwezi et al., 2015), therefore the young people keep their issues private from parents which heightens their vulnerability (Lofgren et al., 2009 cited in Muhwezi et al., 2015, p. 2)

The media is reported as a major source of information to the youth in this generation according to the Ministry of health Uganda (2013). Results from a study carried out on Nigerian urban youths found that the media is one of the most effective communication tools in delivering SRH messages to the youth and it was found to play a role in increase of contraception use among young people (Bajoga, Atagame, & Okigbo, 2015), however this study focused only on family planning methods though the medium applies to this study as well. From the study, just as much as the media is expected to provide positive information about sexual health safety, it has also precipitated students' poor decision making as reported by the health worker1 whereby it has portrayed an unrealistic image of what attractive ought to be which has affected the self-image of many students especially girls. The majority of the

respondents reported low self-esteem and lack of self-worth as one of the leading factors for young students' vulnerability to risky sexual behaviour. And it is apparent that the media has partly played a facilitating role in affecting self-esteem and this low self-image was reported as one of the leading causes of young students' vulnerability to poor sexual decisions. Other responses related to the media were sexualization of content and easy access to pornography.

Outdated and sometimes wrong information from parents was reported as a significant factor in causing poor decision making. Health worker1 noted that parents still hold old values that applied to them while they were growing up, however these values have slightly shifted and no longer apply to the ever shifting trends of the youth today. In fact he mentioned that young people today are more informed than their parents because of the internet and access to several information sources. Besides that, parents are shy about discussing sex with their children whereby bits and pieces are taken out. Another study compliments this by adding that poor communication and relationship between parents and children causes low-self-esteem and increases vulnerability to risky sexual behaviour (Wild et al., 2004). In relation to parents, one significant finding was freedom which was reported by the Dean of students as being dangerous because students are then free to make their own decisions away from their parents, however this combined with peer influence was the leading cause of risky sexual behaviour. He believed that students under the control of their parents are more likely to control their behaviour out of fear of their parents. This contradicts the ICPD's suggestion for freedom in decision making when it comes to sexual decisions (UN, 1994) because according to the Dean, too much freedom for young people is dangerous and that is why the University employs strict rules and regulations. What is missing from the ICPD suggestion is that in order for freedom to be positively utilized by young people, it should be accompanied by other factors that regulate it without abusing it.

Despite the apparent SRH knowledge and information about risky outcomes, students still went ahead and made risky decisions. Having more knowledge is assumed to lead to adjustment in behaviour and attitudes towards health compromising decisions (EAC/EALP, 2010), and according to the results of this study, to some extent this was true, knowledge is very vital however it was not enough to influence students behavioural change, this was proved by one student's statement that seeing correct information on posters could not influence his behaviour. Nettles (2015) suggests that the reason why people go ahead to engage in risky sexual behaviour despite having knowledge about risks is that in one's social

environment, there are stressors that can possibly interact with one's personality characteristics which magnify the probability that this person, despite their knowledge of risky outcomes, will engage in high risk sexual behaviour. He adds that independent behaviour which is molded throughout one's upbringing is affected by independent forces (stressors) which despite awareness, one will be forced to act. Healthworker1 reported that knowledge alone is not enough, it needs to be supplemented with change in attitude and equipment of skills sighting an example that preaching only abstinence to young people will not equip them with coping mechanisms in case the urge to have sex arises, therefore a holistic empowerment is encouraged for example telling students to use condoms but also teaching them how to use them, and giving them out free.

5.2 Role of stressors

The majority of the students in this age group were clearly sexually active and also aware of some of the risks involved with risky sexual behaviour. Cooper, 2000 cited in Nettles (2015) defines risky sexual behaviour as sexual activity that amplifies the likelihood of negative outcomes associated with sexual contact. This group of young people are not ignorant to the risks involved with SRH, they are an elite group of people with as mentioned earlier, a variety of information sources about sex, however even with an abundance of knowledge they still faced SRH problems. It emerged that students encounter stressful situations in their lives even before decisions to take risks are made. From the experiences of the students, results indicated that students faced two types of stressors in respect to SRH decisions; stressors that influenced decision making and those that are a result of the decisions made.

Challenges in the students' lives like economic hardships, need for academic achievement, low self-esteem and the need to belong, peer influence, sex addiction, ignorance, poor moral values, substance abuse and temptation were reported to influence students SRH choices. Findings from this study coincide with a similar study carried out on University students in Uganda that found that factors that increase students vulnerability to risky sexual experimentation included financial constraints, desire for academic success, emotional distress and peer pressure (Aluzimbi et al., 2013). These stressful challenges precipitated risky behaviour which in turn created other stressful situations like unintended pregnancies, emotional break down and heart break, loss of confidence and low self-esteem, rape, abortion, STDs, sexual gender based violence, academic dropouts and some students got disowned by parents and their sexual partners.

Students were familiar with the SRH challenges even though they had not directly experienced some of them. This implies that the challenges students face are common and consistent as the students have become accustomed to them. This was reported by the students as sometimes being heard from peers' experiences. This can be evidenced by a study carried out on risk factors for unplanned sex on University students in Uganda by Aluzimbi et al. (2013), that found similar sexual health challenges. Students cited similar or closely related issues, implying that the challenges young people experience are not new or unheard of, this therefore means that they are aware of the likely outcomes of SRH decisions. However indication of likely outcomes did not stop the majority of the students from taking risks as one clearly noted that some students have a *"come what may"* temperament on risky behaviour. One health worker mentioned that students underestimated the outcomes of behaviour or sometimes miscalculated the likely outcomes, as their intentions were usually fun based but they were never prepared for consequences.

Peer influence is a challenge that gained much concern from the respondents and was reported among the reasons young people made poor decisions. Studies link peer influence and poor relationship between family and children to low self-esteem and increased vulnerability to risky sexual behaviour (Wild et al., 2004). Findings indicated that the need to fit into a certain social circle and the desire to acquire what peers had, enticed the students to try risky behaviour. A study consistent with this finding reported that during adolescence and the subsequent years, time spent with family and parents decreases and the time spent with peers increases in turn (Wild et al., 2004), so does the peer influence on emotion and behaviour. Peer relationships are noted as replacing family relationships (Wild et al., 2004), this may explain why none of the students mentioned parents as a source of their SRH information but rather peers. Also separation from family and closer relationships with peers as mentioned above bring to light freedom and lack of parental supervision experienced in the university setting, cited by the Dean of students as one of the key reasons students were vulnerable to risk. Even though it may not present as a direct stressor, it emerged as a concern, and even though it is a basic right for students, it was approached with lack of responsibility by the students. A similar study reported that independence and lack of guardian supervision is a prerequisite for participation in activities like going to night clubs and binge drinking, which were reported as increasing the likelihood of sexual

experimentation (Aluzimbi et al., 2013), whereby the sense of independence creates a feeling of emancipation but sadly also vulnerability (Aluzimbi et al., 2013).

Unplanned sex or what students referred to as *'one thing led to another'* type of sex was another shared point of concern that emerged as one of the reasons for increased risk behaviour. It is defined as sexual intercourse one decides out of free will or in other circumstances, spontaneous sex that was not thought of previously (Aluzimbi et al., 2013). It was reportedly highly associated with unprotected sex and influenced by substance abuse and a prominent cause of rape, unplanned pregnancies and transmission of STDs. Students mentioned that it is usually unexpected and in many instances it is a result of temptation from 'one thing leading to another' type of situation. Health worker2 presented rape as one of the examples of spontaneous sex commonly experienced, especially among the new students with the least experience and as an after effect of substance abuse. A similar study dependably found that it is an outstanding concern for sexually inexperienced people, usually associated with substance abuse (Hingson et al., 2003 cited in Aluzimbi et al., 2013).

Low self-esteem was one of the stressors that the majority of the students expressed as the leading cause of risky behaviour and also an outcome of risky behaviour. Low self-esteem can be defined as one's evaluation of his/her self, including feelings of self-worth (Wild et al., 2004). From the students' accounts, feelings of poor self-image appeared to arise from disappointment from previous relationships. From the accounts of the stakeholders, it was an issue that reportedly emerged from the media in regards to the image portrayed of the ideal beauty. This is consistent with a study carried out on adolescent self-esteem and risk behaviour that established a likelihood of risky sexual behaviour and substance abuse associated with low self-esteem (Wild et al., 2004). Low self-esteem was found to undermine potential protective measures like abstinence and condom use (Wild et al., 2004) This reflects what the students reported that, students took risks just to feel loved, regardless of extreme outcomes. However a debate exists that there is a protective aspect to low self-esteem especially in regards to those individuals with no sense of belonging to a peer group (Wild et al., 2004). They are most likely to spend less time with others and potential sexual partners, and are less likely to encounter opportunity to experience pressures of temptation to engage in risky behaviour (Wild et al., 2004). Unfortunately this study found compelling evidence that suggested that low self-esteem had a high likelihood to increase vulnerability to risk.

Single stressors do not always independently affect decision making, they are influenced by other factors affecting the lives of the students. Other studies confirm the same pattern noting that risk behaviour is interrelated with common influencing factors (Wild et al., 2004). Also, risky behaviour did not always emerge as a result of ill intentions, some problems arose as an individual's way of escaping another hardship, however sometimes the results were not what the students always expected. Students cited examples like having sex as a means to get money for sustenance because of financial difficulties.

5.3 Role of resources and coping mechanisms

In light of the stressors mentioned in 5.2 above, students adopted ways to manage negative outcomes of risky behaviour. Several resources and coping mechanism emerged from the study that catered for particular stressors and also worked across different stressors. It is important to note that some students relied on multiple resources at a time, research indicates that this is more likely to create better results, individuals may use a selection of coping strategies to manage stressors rather than being dependent upon a single, primary strategy. (Hulland et al., 2015). Students cited several ways of managing stress including, religion, support from friends, medical support and using contraception. These mechanisms were used as defensive tools or remedial methods, for example some students used contraception methods like condoms to protect against any risky outcomes while others used emergency contraception pills after unprotected sex.

Support from friends/peers was repeatedly reported as one the resources at the students' disposal. They mentioned that without the support of friends, they did not know if they would have survived their challenges. This finding matches one from a study carried out on peer relationships in development of active coping and self-esteem among adolescents that found that friendships and peer groups create a safe haven which signifies a tremendous setting for learning problem solving skills and development of self-control (Mota & Matos, 2013) which predict coping ability including seeking information, advice and emotional and social assistance. Communication and trust in peer relationships are associated with development of self-esteem and coping because here, one is free to express their feelings and ask for help (Mota & Matos, 2013). From the study, students mentioned receiving advice, financial support from friends, and learning from their experiences.

Religion emerged as a very significant aspect in the lives of the students in regards to helping them deal with stressful situations. Research agrees that religion is crucial in coping with stressful events (Bakibinga, Vinje, & Mittelmark, 2014). The majority of the students mentioned creating a relationship with God and because of this, they were able to avoid risking their health, citing examples like faithfulness and abstinence as taught in their places of worship. The religious leader also added that students, frequented the church when they were overwhelmed with a challenge and they were able to receive spiritual and emotional comfort in addition to getting advice. Religion emerged as a symbol of strength to the students. In Uganda, Spirituality has been revealed as the most common and main way of coping with HIV/AIDs (Bakibinga et al., 2014). Support from fellow believers and the belief that God provides sustenance have been found to be enabling factors. A study on over worked and under paid nurses in Uganda showed that they were able to stay at work because of their faith in God that helped them accept their situations and through prayer and meditation, they gained strength and the ability to cope (Bakibinga et al., 2014). The Local council chairperson and the hostel warden mentioned that those students who had a relationship with God, were unlikely to get involved in risky behaviour.

Knowledge was considered a protective tool in instances of potential risk. As mentioned in 5.1, students displayed knowledge of SRH including possible risks, methods of protection and services involved. Even though it was not mentioned directly, observations indicate that some students were able to protect themselves from poor decisions because they were informed about the consequences. Similar studies agree with this by noting that information is important to young people and youth need protective information and skills, preferably before they are sexually active in order to be prepared for the risks involved (Bankole et al., 2007). However it should also be noted that those that got involved in risky behaviour were also aware of the possible consequences. Studies suggest that even though knowledge equips people with preventive mechanisms and the ability to cope with a difficulty (EAC/EALP, 2010), the ability to predict behavioural change because of knowledge is a topic that is still under heavy debate and one cannot only rely on knowledge but rather complement it with skills (Klepp et al., 2008), but evidence strongly holds that improving knowledge and removing misconceptions may have potential to positively influence behaviour (Frost et al., 2012).

Not all coping mechanisms were positive and healthy, as one would expect from a typical management tool, some emerged as stressors but were resourceful from the students' perspective. This is similar to a study carried on suicide as an escape from self that found that in some circumstances, young people may turn to risky behaviour as another way of coping with stress (Wild et al., 2004). When asked about how they managed an unintended pregnancy, several students revealed abortion as their first option. One student, Vivian stated abortion as the only choice if she was ever to be faced with the problem of an unintended pregnancy while in school. Reports from Uganda make known that abortion is illegal under normal circumstances (Guttmacher Institite, 2013), however multiple studies reveal that unplanned pregnancies and the need to prevent them are a leading cause of abortion among young people and the shame that arises from pregnancy by unmarried young people (Singh et al., 2005). Though the students did not reveal in-depth reasons as to why abortion was their first option, studies suggest that young people may opt to abort because of financial difficulties, they are not emotionally prepared, they do not have good and stable relationships with their partners, the prospect of a baby would interfere with new opportunities and influences from friends and family (Biggs, Gould, & Foster, 2013). All these reasons apply to the living situations of the students in the study. Abortion as a coping mechanism is a good example of how to deal with the outcome of risky behaviour by resorting to another risky behaviour.

It was found that most of the coping mechanisms worked alongside each other, whereby a student would use more than one resource for a certain stressor. It was found that using multiple resources helped yield better results for example as the church provided spiritual and emotional restoration, the hospital and health centers offered physical treatment and psychological help through counseling, while friends offered social support and encouragement. However this does not mean that one cannot get help from one available source.

5.4 Salutogenesis Theory

The relationship between the stressors, resources and coping mechanisms emerging from the study is discussed in this section in reference to the Salutogenic theory. The purpose of this study was to gain insight into how university students are able to cope with stressors in their SRH lives. As mentioned earlier the study employed Antonovsky's theory of Salutogenesis which focuses on the search for factors that keep people healthy (Antonovsky, 1996) and the

equipment of significant lens that helps to understand how health is realized and maintained (Billings & Hashem, 2010). It is important to emphasize problem solving and to highlight people's capability to use the available resources to create health and concentrate on the movement towards health (Lindström & Eriksson, 2010) rather than focus on risks and ill health.

Figure 3: The Salutogenic model applied to this study
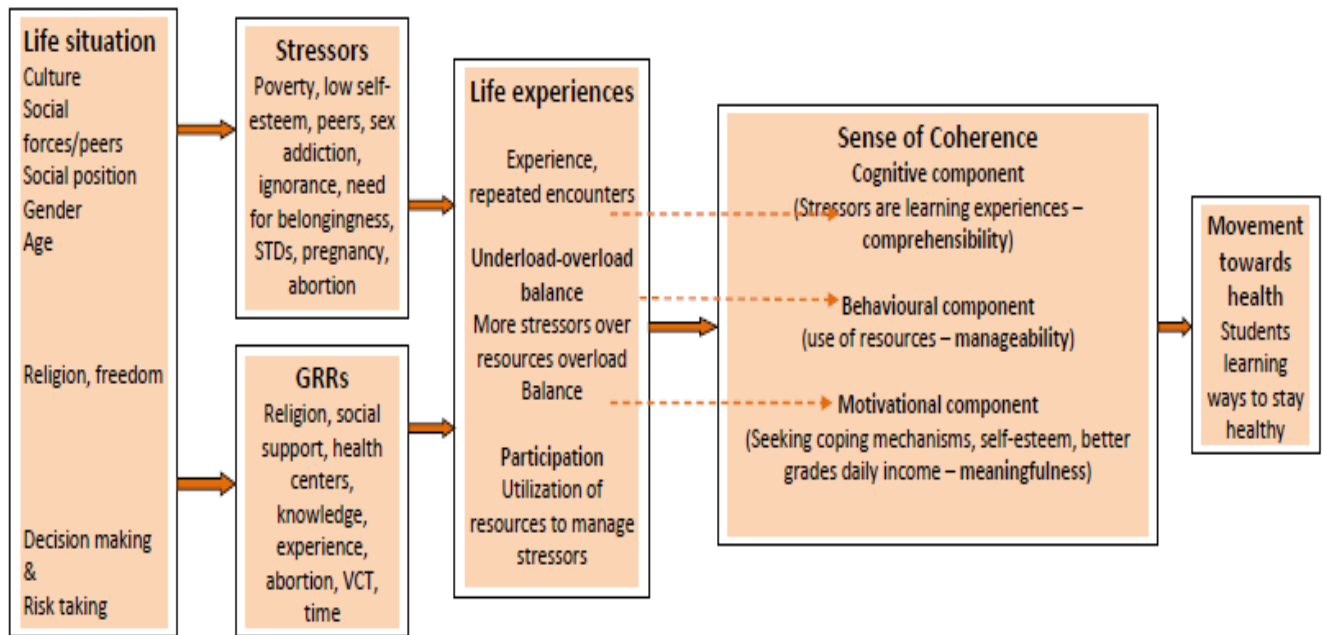
(Adaptation of Mittelmark, 2010)

5.4.1 Life situation

According to Antonovsky, life situation comprises the experiences in the lifespan of an individual that can either result into a stressor or a resource (Antonovsky, 1996). An individual is an open system who is in constant interaction with their environment, this environment can either be a source of tension or resistance resources (Langeland et al., 2007). Aspects of life with in one's environment for example age, culture and social forces to mention but a few play a significant role in influencing outcome of a situation. The outcome is not a matter of chance, it depends on the engagement of SOC and GRRs within one's environment (Lindström & Eriksson, 2008). When faced with potential tension an individual will be motivated to either cope, understand the challenge, and identify available resources or succumb to tension (Antonovsky, 1996).

The life situation of the students is first and foremost influenced by their age group as youths which is characterized by the behaviour of experimentation and discovery. The stakeholders reported this age as a point when the students leave their parents' homes and utilize their freedom in the university environment. Accounts revealed that the desire to experiment with risk and learn new things coupled with freedom, created opportunities for risk. Social forces including peers as the most commonly cited source of information, financial status, gender, values, beliefs and religion they experienced in the environment of the university reportedly influenced decision making and outcomes of the students' behaviour. For instance from the students' reports, poor decision making was sometimes influenced by peers and giving in to poor advice was highly possible in instances where one had low self-esteem and a desperate need to belong. On top of this, some students came from poor economic backgrounds and poor decisions simply meant a way of making ends meet, for example they risked involvement in sexual relationships with older men who provided financial favors in return. All these vulnerabilities led them to succumb to tension. However on the other hand these same aspects acted as resources depending on how students chose to utilize them, for example students reported receiving social support from peers when overwhelmed with stress and some students overcame potentially risky situations by reflecting on their individual values, beliefs and religion. Interaction with these aspects within the students' environment swayed decision making and determined whether interaction would create a stressor or a resource for the students.

5.4.2 GRRs
GRRs can be the characteristics within an individual, property and assets within the environment or a situation which can facilitate successful coping with inherent stressors (Lindström & Eriksson, 2008). They can be any resource that can enable effective tension management (Langeland et al., 2007). They foster repeated life experiences which are significant in helping one have better understanding of the world (Lindström & Eriksson, 2008). Food, clothing, accommodation, knowledge, self-identity, flexibility and culture (Langeland et al., 2007) are some examples of GRRs. Having the resources at one's disposal is not enough but the ability to utilize them is very significant (Lindström & Eriksson, 2010)

Students were found to be empowered enough to recognize and utilize resources and coping mechanisms in their environment to cope with stressors. Some of the resources that were revealed include religion, knowledge and information, support from friends/peers, learning

from experience, time, VCT and abortion. Though abortion may not appear as a resource given the risk involved with it, it was a coping mechanism many students mentioned as the best option in case of an unintended pregnancy. From the students' accounts, it was evident that abortion in the long run generated a shift from a stressful coping mechanism to its outcome being a movement towards health because it contributed towards eliminating students' fears and building mental health. Mental health is vital to the overall health of an individual therefore abortion created such an opportunity for the students undergoing stress from unintended pregnancies. Research notes that at least four resources must be available to an individual for them to develop a strong SOC (Lindström & Eriksson, 2010).

5.4.3 Sense of coherence

SOC is an individual's assurance that stimuli in the environment are controllable, foreseeable and justifiable, resources are available and challenges are worthy of engagement (Lindström & Eriksson, 2010). SOC means having an inner trust and confidence to identify resources within self and the environment and being able to use and reuse these resources. SOC is usually conveyed in three sub dimensions; comprehensibility, which is the ability to endure and the feeling of confidence that stressful situations are predictable and understandable; manageability which suggests that for every stressful situation, there is a means to meet its demands; meaningfulness, which considers stressors as simply challenges worthy of one's investment and engagement (Langeland et al., 2007). All these three sub dimensions of SOC are connected but meaningfulness is the most vital as a motivational factor because it pushes one to seek out resources, it strengthens the other two sub dimensions (Lindström & Eriksson, 2010). The level of one's SOC determines their health status whereby the outcome of a strong SOC is movement towards health with the point of success being the individual's capability to deal with a stressful situation, (Eriksson et al., 2007).

From the accounts students were evidently under various forms of stress in their SRH lives. But their need and ability to overcome and thrive was evident in some of the various resources they identified and were willing to utilize. The risk of utilizing coping mechanisms that were potentially harmful to their health that's is to say abortion, indicated their level was of assurance was existent.

Comprehensibility

As mentioned earlier, student's accounts indicated that the challenges they encountered were not new to them, students were familiar with the typical SRH problems. This from even some of the students who had not directly faced the problems, implying that these problems had been repeated overtime and therefore become predictable. This gave the students a chance to also become familiar with counter resources for these problems that is why it was possible for students to cite possible solutions in case they were faced with a SRH challenge.

Manageability

For every stressor students mentioned, there was a resource that could manage it, either before the problem occurred or after it was encountered. This meant that the problems students confronted were solvable. Once students were aware of a problem, they sought out various alternatives to solve their problems. Sometimes using more than one resource at a time, for example accounts indicated that in case of an unintended pregnancy students sought out help from health centers for medical support, friends for social support and places of worship for spiritual and emotional help. Also in cases of unprotected sex, students sought emergency consultation from medical personnel or purchased emergency contraception to avoid getting pregnant.

Meaningfulness

From the students' accounts, for example getting pregnant at school was cited as getting in the way of future opportunities, therefore they used this as a motivational factor to avoid risky sexual behaviour or to seek out resources that would help solve an unintended pregnancy. Some students chose to use contraception, others used abortion as a solution and others chose to drop out to work in order to sustain the pregnancy. The belief that these challenges could be managed and the desire to protect their health and future opportunities motivated them to seek out solutions and utilize them. Even where students felt too overwhelmed to handle problems on their own, they sought help from friends and religious leaders.

5.4.4 Movement towards health

As mentioned above the students' SOC was evident in their ability to comprehend and manage their problems through knowledge and experience, and the willingness to recognize and utilize resources. The facilitation, likelihood and outcome of health depends on a good SOC (Lindström & Eriksson, 2008). The students' ability to manage tension, identify,

mobilize and utilize resources to promote coping indicates a movement towards health in their SRH lives.

6. Study limitations

Because of the delay in permits, student participants were interviewed in a short period of time and even though saturation was reached, it cannot be ruled out that some vital information was missed because of the hastiness of the interviews, which may have affected quality of data.

During the interviews, most of the participants were reluctant to express personal experiences which limited the conversations. This I suspect was because the topic was very sensitive and also I had not met the students prior to the interviews, sensitive questions from a stranger might have made them shy and uncomfortable. However they were willing to give accounts about their peers' experiences.

Because the semester had just began and there was a strike by the administration, many students were late to return to the university, therefore it cannot be ruled out that some eligible students were not included in the study.

Suitable respondents who were highly knowledgeable about the topic of the study had to be excluded because they were uncomfortable with recording. So it would be difficult to rule out that I might have missed a few good accounts for the study. However they were replaced with similar respondents in the same field.

Very few peer reviewed literature from Uganda relevant to the study was found. It may be possible that this literature is still at operational level and not yet peer reviewed. However, research from other countries were used and several unpublished government reports relevant to the study were referenced.

These limitations should however be considered in light with the strengths of the study. It in contrast to some of the available literature in Uganda, explored experiences of students' control over sexual reproductive health

7. Conclusion

The aim of this study was to identify the experiences, perspectives and attitudes of university students, on their control over sexual reproductive health. The study addressed three objectives; to explore what is known about SRH and sources of information, to explore main stressors related to SRH and to explore what generalized resistance resources help university students take control of their SRH. All students had experienced at least one challenge in

regards to their SRH making them a suitable group to interview. The students formed a unique group in that they were an elite and informed section of the population within favorable age range that defines youth 19-24, with an active sexual life as emerging adults struggling with pubertal maturation, identity realization on top of socioeconomic pressures.

Students were empowered enough to make their own decisions based on any challenge they encountered, be it before, during or after a difficult situation. They all demonstrated knowledge of SRH citing general services and activities involved, typical risks, problems, including ways to manage these problems and what part of human health it affected. This can be greatly attributed to exposure to education and other related sources of information. They were able to cite various sources of information where they had learned about SRH, giving examples like the electronic and print media, peers and so forth. However despite the demonstrated high levels of knowledge, important aspects of SRH as a whole were excluded from their accounts, that is to say, knowledge of SRH rights. Also despite understanding of the term and risks involved, students still got involved in risky sexual behaviour. It was noted that even though SRH rights and knowledge have a significant role in possibly preventing risky decision making, the lives of young people in SSA are to a superior extent determined by social and economic hardships.

Students were sexually active, some demonstrated use of contraception and VCT to avoid risks, but the majority encountered the extreme challenges involved with unsafe sex. Students revealed a relationship between the majority of the challenges in their SRH, that is to say academic/economic hardships and transactional sex and low self-esteem and peer pressure, the need to fit in and unplanned sex. The majority of the problems appeared to be familiar to the students even though some had not directly encountered them. It emerged that they were greatly influenced by lifestyle, social circles and trends including the media, unlike in the past; however, even though some made conscious decisions to get involved in risky behaviour for example those who had sex for fun, majority of the decisions made were influenced by independent forces in their life situations that interacted with individual behaviour and vulnerabilities. Distressing to discover is that a few young people are not worried about the potential outcomes of unsafe sex, this is because they are not afraid of outcomes and know of ways to cope, however this lack of fear can also be attributed to the stressful life situations that push them to take risks regardless of the outcomes.

The students sought out and utilized resources like religion and spirituality, friends and colleagues, knowledge and information of SRH, medical/professional support and services, while taking advantage of morals like faithfulness and abstinence for those who had the will to manage them. Some students accepted their circumstances and believed that time would heal any emotional problems. It emerged that for every stressful situation in the lives of the students, there was a resource to manage it. Students had resources and mechanisms to avoid involvement in risky behaviour and also to deal with outcomes of risky behaviour. Not all coping mechanism appeared healthy at first however in the long run, they contributed towards promoting the mental health of students for example abortion. Resources complemented each other, with students using more than one to help with their situations.

It emerged that students had a strong S.O.C when the theory of Salutogenesis was applied to their experiences. It can be appreciated through their understanding of their challenges and believing that time would heal them alongside other resources. It is also seen through their ability to recognize, access and utilize the resources in their environments for the challenges. And lastly it is recognized in their willingness to recognize the challenges in their lives and the motivation to seek and utilize the available resources. Being able to have resources to help with challenging experiences emerged as very significant to the students, being able to solve their problems made their lives manageable and gave them a chance to potentially make better decisions in the future.

This study has contributed to empirical evidence in regards to exploring experiences, perspectives and attitudes of university students on their control over SRH. The findings may apply to young people elsewhere, especially those in SSA.

SRH challenges are part and parcel of young people's lives, and these challenges are going to continue evolving overtime. However the health promoting nature of this study has the potential to keep extreme outcomes in check, so that health balances out ill health. Results could therefore potentially be helpful in policies and initiatives made for youth SRH, since it has been proved that effective interventions have based their fundamentals on existing experiences as opposed to generalization. The existing gaps in knowledge and coping with SRH reflect potential entry points for policy enhancement.

8. Recommendations

This study brings to light the significance of mental health on young people's sexual decisions, since it has not been given much attention in SSA like in the western world. This emerging from the students' experiences about low self-esteem and risky behaviour. Students thought that working on one's self-image would help reduce this problem, my suggestion is that policy makers develop support systems and programs specifically targeting young people's mental health in regards to sex.

Health workers hinted that students do not show much interest in seeking information about risks before they occur and utilizing the free services at the clinics. They only do this when problems arise and this partly contributes to why they constantly face the same problems. It would be significant to create more youth friendly programs to attract their attention.

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Appendices

Informed consent form:

Control over sexual reproductive health: stressors and resources for University students in Uganda. An exploratory study.

This study is about exploring University students' perspectives on sexual reproductive health, focusing on how they are able to control and cope with the outcomes of risky sexual relations. The overall expectation from this study is to use this information to help create appropriate and effective preventive measures with the expectation of contributing to promoting the health of young people in Uganda. If you agree to participate, you will be asked to answer a number of questions in about an hour long interview. The information obtained will go towards writing of my master's thesis.

Your view on sexual reproductive health can give important information for the study. If you agree to participate in the study, your own name will not be used in the written report, results will be presented anonymously and it will not be possible to trace who said what. Whatever you said in the interviews will not be passed on to other people in the community. Recordings will be destroyed after they have been transcribed (written down).

The interviews are voluntary and if there are any questions posed to you during the study that may cause any discomfort or embarrassment, you are free to withdraw at any time or you may refuse to answer them.

If you agree to participate, please read and sign the statement below.

If you have any questions about this study you should feel free to ask them now or anytime during the study by contacting me.

Thank you for your co-operation,

Marion Ebuge

Contact mobile number +256775582745/ +4748681973

Written consent:

The purpose of this study has been explained to me and I understand what it is about. Participation will involve an hour long interview.

It has been made clear that if I agree to participate in the study, my own name will not be used and, in the written report, it will not be possible to trace who said what. Whatever is said in interviews will not be passed on to other people in the community. Recordings of the interviews will be destroyed after they have been written down.

I am free to with draw at any time or may refuse to answer any of the questions asked of me.

Name:

Signature:

Date:

Interview guides:

I want to thank you for taking the time to meet with me today. My name is Ebuge Marion and I would like to talk to you about your experiences about sexual reproductive health. The interview should take about an hour.

I will be taping the session because I don't want to miss any of your comments. Although I will be taking some notes during the session, I can't write fast enough to get it all down. Because we're on tape, please be sure to speak louder so we don't miss any comments. All responses will be kept confidential. This means that your interview responses will only be shared with supervisor and I will ensure that any information I include in the report does not identify you as the respondent.

Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

Interviewee   Date

Key Informants (students):

1. Tell me what you know about sexual reproductive health.
2. How do people at this University spread information about sexual health?
3. What are the common sexual related behaviours among students here?
   (Besides romantic relationships what other sexual relationships are there?)
4. Tell me what you know about the typical risks of sex that students face.
   (What fears do people have around sexual relationships?)
5. Why do you think they face these particular risks?
6. Tell me about the risky situations you have faced.
   (What made you decide to do that? What did you fear when you encountered these risks?)
7. How often have these risks happened?
   (Tell me why you think they reoccurred)
8. How do students avoid getting involved in risky sex? (Have you experienced any of these things?)
9. What are the resources to strengthen them?
10. How were you able to avoid encountering some of the risks other students face?
11. How did you overcome the ones you encountered?
12. How would you approach the same risks in case they resurfaced?
13. What advice do you have for other students who may potentially face the same problems?

Is there anything more you would like to add?

Stakeholder1 (Dean of students):

1. Tell me what you know about the sexual health of the students in this University.
2. How is information about sexual health spread around the University?
   (How do students learn about this information?)
3. What are the common sexual related behaviours among students here?
   (Tell me what you know about the typical risks involved)
4. Why do you think they face these particular risks?
5. What has the university done to help with student vulnerability to these risks?
6. How does vulnerability to sexual risks vary across student groups?
7. How are they able to overcome these problems?
8. What resources do they draw on to have more control of their sexual health?
9. What do you think the students could do to be more in control?

Is there anything more you would like to add?

Stakeholder2 (Local council chairperson):
1. How do students in your community learn about sexual health?
2. Tell me about the common sexual related behaviours among students in your community?
3. What are the typical risks involved?(What are the fears related to these risks)
4. Why do you think the students in your community face these particular risks?
5. How do you think the students manage to take control of these risks?
6. What resources does the community offer to help students improve their sexual health? (What activities have been carried out to help them in the area of sexual health)
7. What suggestions do think they could use to manage their sexual health better?

Is there anything more you would like to add?

Stakeholder3 (Community health center):
1. How do students in this community learn about their sexual health?
2. What are the typical risks concerning sexual health that students come in with?
3. What are the common risks they may face but do not usually know about?
4. Why do you think they are involved in these particular risks?
5. Describe the sexual related services the health center offers to students.
6. What do you think of the services? (How effective have they been)
7. Why do you think some students still encounter the same problems despite the availability of these services?
8. How do you think the students manage the risks in sexual relationships?
9. What do you think they could do to take control of their sexual health?

Is there anything more you would like to add?

Stakeholder4 (Hostel warden):

1. What sexual related behaviours do you commonly hear about among the students in this hostel?
2. What are the risks involved with these behaviours?
3. How do you think living away from home affects the students' decisions?
4. What are the regulations in the hostel to help the students control their sexual health?
5. How do the students relate to these rules?
6. Why do you think they face these particular risks?
7. How do they manage to overcome the risks they face?
    (What resources do they draw have?)
8. What suggestions do you have for the students to improve their sexual health?

Is there anything else you would like to add?

Stakeholder5 (Religious leader):

1. How is information about sexual health spread to students in this institution?
2. What sexual related behaviours do you commonly hear about among the students in this institution?
3. What are the typical risks you hear about?
4. What fears and concerns do they have?
5. Why do you think they are involved in these particular risks?
6. Why do you think the students choose to come here with these concerns?
7. Describe the services and information this institution offers to students to help improve their sexual health.
8. What do you think of the services? (How effective have they been)
9. How do you think the students manage the risks in sexual relationships?
10. What do you think they could do to take control of their sexual health?

Is there anything more you would like to add?

Closing remarks

Thank you for your participation. I believe your input will be valuable to this research and in writing of my master's thesis.

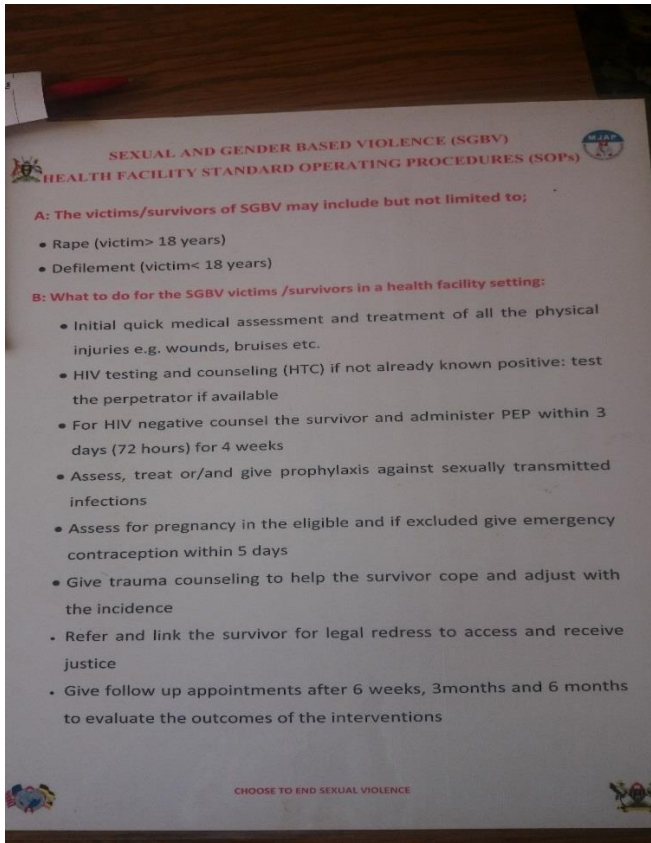Confidentiality of responses is guaranteed

Approximate length of interview:

Pictures:
Billboards next to the University main gate

Signs at the university hospital showing services offered

SEXUAL AND GENDER BASED VIOLENCE (SGBV)
HEALTH FACILITY STANDARD OPERATING PROCEDURES (SOPs)

A: The victims/survivors of SGBV may include but not limited to;

- Rape (victim> 18 years)
- Defilement (victim< 18 years)

B: What to do for the SGBV victims /survivors in a health facility setting:

- Initial quick medical assessment and treatment of all the physical injuries e.g. wounds, bruises etc.
- HIV testing and counseling (HTC) if not already known positive: test the perpetrator if available
- For HIV negative counsel the survivor and administer PEP within 3 days (72 hours) for 4 weeks
- Assess, treat or/and give prophylaxis against sexually transmitted infections
- Assess for pregnancy in the eligible and if excluded give emergency contraception within 5 days
- Give trauma counseling to help the survivor cope and adjust with the incidence
- Refer and link the survivor for legal redress to access and receive justice
- Give follow up appointments after 6 weeks, 3months and 6 months to evaluate the outcomes of the interventions

CHOOSE TO END SEXUAL VIOLENCE

Sexual & Reproductive Health Unit

COUNSELLING ROOM

Posters at RHU about SRH rights

Study permissions:

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Marguerite Daniel
HEMIL-senteret Universitetet i Bergen
Christiesgt. 13
5015 BERGEN

Vår dato: 18.06.2015   Vår ref: 43518 / 3 / MHM   Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 20.05.2015. Meldingen gjelder prosjektet:

43518	*Control over sexual reproductive health: Stressors and resources for makerere university students Kampala, Uganda. An exploratory study*
Behandlingsansvarlig	*Universitetet i Bergen, ved institusjonens øverste leder*
Daglig ansvarlig	*Marguerite Daniel*
Student	*MARION EBUGE*

Etter gjennomgang av opplysninger gitt i meldeskjemaet og øvrig dokumentasjon, finner vi at prosjektet ikke medfører meldeplikt eller konsesjonsplikt etter personopplysningslovens §§ 31 og 33.

Dersom prosjektopplegget endres i forhold til de opplysninger som ligger til grunn for vår vurdering, skal prosjektet meldes på nytt. Endringsmeldinger gis via et eget skjema,
http://www.nsd.uib.no/personvern/meldeplikt/skjema.html.

Vedlagt følger vår begrunnelse for hvorfor prosjektet ikke er meldepliktig.

Vennlig hilsen

Katrine Utaaker Segadal

Marianne Høgetveit Myhren

Kontaktperson: Marianne Høgetveit Myhren tlf: 55 58 25 29
Vedlegg: Prosjektvurdering
Kopi: MARION EBUGE marionebuge@yahoo.com

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Based on the information we have received about the project, the Data Protection Official cannot see that the project will entail a processing of personal data by electronic means, or an establishment of a manual personal data filing system containing sensitive data. The project will therefore not be subject to notification according to the Personal Data Act.

The Data Protection Official presupposes that all information processed using electronic equipment in the project is anonymous.

Anonymous information is defined as information that cannot identify individuals in the data set in any of the following ways:
- directly, through uniquely identifiable characteristic (such as name, social security number, email address, etc.)
- indirectly, through a combination of background variables (such as residence/institution, gender, age, etc.)
- through a list of names referring to an encryption formula or code, or
- through recognizable faces on photographs or video recordings.

Furthermore, the Data Protection Official presupposes that names/consent forms are not linked to sensitive personal data.

Please keep in mind that the project is entailed to follow general guidelines for research ethics. Read more here: https://www.etikkom.no/en/research-ethical-guidelines/general-guidelines-for-research-ethics/

UNIVERSITETET I BERGEN
Det psykologiske fakultet

Department of Health Promotion and Development
The Faculty of Psychology
University of Bergen
PO Box 7807
5020 Bergen
Norway

25 March 2015

To Whom it may concern,

I am the academic supervisor for Marion Ebuge who is currently doing an International
Master's in Health Promotion. I confirm that she will be travelling to Uganda from mid-June
until mid-September 2015 in order to carry out fieldwork. The data she will collect in Uganda
will be an essential part of her Master's thesis.

Yours sincerely,

Marguerite Daniel
Director, International M.Phil. in Health Promotion

The AIDS Support Organisation
(TASO) Uganda Ltd.

TASO Headquarters
Mulago Hospital Complex
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Tel: +256 414 259 555
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E-mail: mail@tasouganda.org
website: www.tasouganda.org

28th July 2015

Our Ref: TASOREC/36/15-UG-REC-009

Ebuge Marion,
marionebuge@yahoo.com
University of Bergen

Re: RESEARCH APPROVAL "CONTROL OVER SEXUAL REPRODUCTIVE
      HEALTH: STRESSORS AND RESOURCES FOR UNIVERSITY STUDENTS IN
      UGANDA: AN EXPLORATORY STUDY"

Thank you for submitting your responses to queries raised by the reviewers dated 15th July 2015.
This is to inform you that your responses dated 28th July 2015 met the requirements of the TASO
REC. TASO REC annual approval has been granted for the above-referenced new study.

This approval is valid until 27th July 2016 after which you will be required to make a request for
extension to the Chairperson, TASO REC in case of continuation with the research.

The review and approval includes the following:
1. The study protocol.
2. Informed consent form.
3. Data collection instruments.
4. TASO REC Research Review Application and Declaration of Conflict of Interest form.
5. Letter of introduction and approval from University of Bergen and Makerere University

Amendments: All proposed changes to the study (including personnel, procedures, or
documents) must be approved by the REC in advance through the amendment process.

Adverse Events/Unanticipated Problems: You must inform the REC of all unanticipated
problems and adverse events that occur during your research study – these include, but are not
limited to, events and/or information that may have physical, psychological, social, legal, or
economic impact on the research participants or others.

It is a requirement by the TASO REC that you submit the timely annual progress reports.

We recommend that you proceed with the registration of your study by the Uganda National
Council of Science and Technology (UNCST).

Continuing Review application due date (60 days prior to expiration date).

Sincerely,

27 JUL 2016

Mr. Bakanda Celestin,
Chairperson, TASO RESEARCH ETHICS COMMITTEE (REC)
    CC: Executive Director, TASO (U) Limited

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THE REPUBLIC OF UGANDA

OFFICE OF THE PRESIDENT

PARLIAMENT BUILDING P.O. BOX 7168 KAMPALA, TELEPHONES: 254881/6, / 343934, 343926, 343943, 233717, 344026, 230048. FAX: 235459/ 256143
Email: secretary@op.go.ug, Website: www.officeofthepresident.go.ug

ADM 154/212/01

March 4, 2016

The Resident City Commissioner
Kampala District

RESEARACH CLEARANCE

This is to introduce to you **Ebuge Marion** a Researcher who will be carrying out a research entitled **"CONTROL OVER SEXUAL REPRODUCTIVE HEALTH, STRESSORS AND RESOURCES FOR MAKERERE UNIVERSITY STUDENTS KAMPALA UGANDA. AN EXPLORATORY STUDY"** for a period of **three (3) months** in your district.

She has undergone the necessary clearance to carry out the said project.

Please render her the necessary assistance.

By copy of this letter **Ebuge Marion** is requested to report to the Resident City Commissioner of the above district before proceeding with the Research.

Alenga Rose
FOR: SECRETARY, OFFICE OF THE PRESIDENT

Copy: Ebuge Marion

Uganda National Council for Science and Technology
(Established by Act of Parliament of the Republic of Uganda)

Our Ref: HS 1873   29ᵗʰ April 2016

Marion Ebuge
Makerere University
Kampala

Re: Research Approval: Control Over Sexual Reproductive Health: Stressors and Resources for
                               Makerere University Students Kampala, Uganda. An Exploratory Study.

I am pleased to inform you that on **19/08/2015**, the Uganda National Council for Science and Technology (UNCST) approved the above referenced research project. The Approval of the research project is for the period **19/08/2015** to **19/08/2016.**

Your research registration number with the UNCST is **HS 1873**. Please, cite this number in all your future correspondences with UNCST in respect of the above research project.

As Principal Investigator of the research project, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the research protocol or the consent form (where applicable) must be submitted to the designated Research Ethics Committee (REC) or Lead Agency for re-review and approval **prior** to the activation of the changes. UNCST must be notified of the approved changes within five working days.
3. For clinical trials, all serious adverse events must be reported promptly to the designated local REC for review with copies to the National Drug Authority.
4. Unexpected events involving risks to research subjects/participants must be reported promptly to the UNCST. New information that becomes available which alters the risk/benefit ratio must be submitted promptly for UNCST review.
5. Only approved study procedures are to be implemented. The UNCST may conduct impromptu audits of all study records.
6. A progress report must be submitted electronically to UNCST within four weeks after every 12 months. Failure to do so may result in termination of the research project.

Below is a list of documents approved with this application:

	Document Title	Language	Version	Version Date
1.	Research proposal	English	N/A	June 2015
2.	Informed Consent	English	N/A	June 2015
3.	Interview Guide	English	N/A	June 2015

Yours sincerely,

Hellen. N. Opolot
for: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

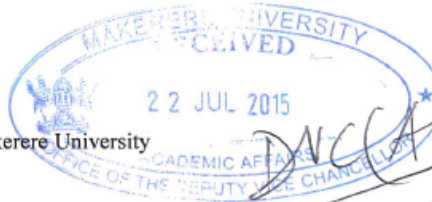cc. Chair, The AIDS Support Organization, Research Ethics Committee

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LOCATION/CORRESPONDENCE   *COMMUNICATION*

Plot 6 Kimera Road, Ntinda   **TEL: (256) 414 705500**
P. O. Box 6884   **FAX: (256) 414-234579**
KAMPALA, UGANDA   **EMAIL: info@uncst.go.ug**
                                                     WEBSITE: http://www.uncst.go.ug

21.7.2015
Dean of students Makerere University
P.O.Box 7062
Kampala, Uganda

RE: Permission to conduct research study.

Dear Sir,

I am writing to request permission to conduct a research study at your institution Makerere University. I am currently enrolled in the Master's of philosophy in health promotion at the University of Bergen, Norway and in the process of writing my Master's Thesis. This study is entitled Control over sexual reproductive health: Stressors and resources for Makerere University students Kampala, Uganda. An exploratory study

I hope that the institution will allow me to select at least 20 students (10 male, 10 female) between the ages of 19 to 25 from the University to anonymously complete a one hour interview session with each student (copy of interview guide enclosed). Due to the nature of the study, I hope to recruit the Dean of students, 2 hostel wardens, one religious leader, one local council chairperson and 2 health workers to complete their own interviews (copy of interview guides enclosed). Stake holders who volunteer to participate will also be given consent forms to be signed and returned to researcher (copy enclosed).

If permission is granted, participants will complete the interviews in a place of their own choosing that is comfortable for them during their free time. The interview process should take no longer than one hour. The interview results will be pooled for the thesis project and individual results of this study will remain absolutely confidential and anonymous. Should this be published, only pooled results will be documented. No costs will be incurred by the University.

Your approval to conduct this study will be greatly appreciated. You may contact me at marionebuge@yahoo.com and +256775582745

If you agree, kindly sign below and return the signed letter to researcher. Alternatively, kindly submit a signed letter of permission on your institutions letter head acknowledging your consent and permission for me to conduct this study at your institution.

Sincerely

Marion Ebuge
University of Bergen Norway

Approved by:

Signature: Date