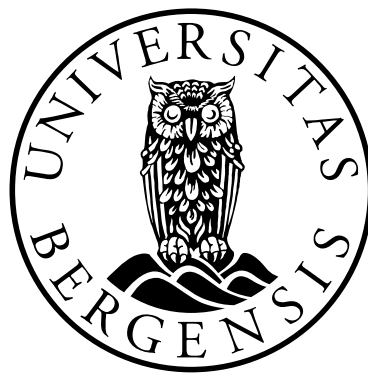


VOICES OF MALE AND FEMALE UNIVERSITY STUDENTS ON  
YOUTH-FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH  
SERVICES IN KAMPALA, UGANDA

EMMANUEL KAMYA



Master of Philosophy in Gender and Development

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Faculty of Psychology  
Department of Health Promotion and Development

## ACRONYMS AND ABBREVIATIONS

AAAQ	Availability, Accessibility, Acceptability of Quality care
ABC	Abstinence, Be faithful and Condom Use
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ASRHS	Adolescent Sexual and Reproductive Health Services
SRHS	Sexual and Reproductive Health Services
STI	Sexually Transmitted Infection
RHS	Reproductive Health Services
RHU	Reproductive Health Uganda
ECP	Emergency Contraceptive Pill
ERHC	Essential Reproductive Health Commodities
HIV	Human Immunodeficiency Virus
HCP	Health Care Providers
HRM	Human Resource Managers
IRO	International Relations Office
ICPD	International Conference on Population and Development
MOH	Ministry of Health
MUBS	Makerere University Business School
MUK	Makerere University
MDG	Millennium Development Goals
NTIHC	Naguru Teenage Information and Health Centre
PEP	Post-Exposure Prophylaxis
UDHS	Uganda Demographic Health Surveys
UBOS	Uganda Bureau of Statistics
UOB	University of Bergen
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organizations

## **ABSTRACT**

This study explored the experiences and expectations of male and female students at Makerere University's main campus and the campus of the University's Business School towards youth-friendly sexual and reproductive health services. It also explores the attitudes and perceptions of health workers and parents towards young peoples' sexuality and compromising health challenges including the risk of contracting STIs/HIV and unwanted pregnancies that can lead to unsafe abortions. The study was guided by one human rights framework for professionalism in health care, which postulates that all health care services must be Available, Accessible, Acceptable and of good Quality for all. Furthermore, a theoretical perspective on gender as well as the three bodies approach guided the analysis and discussions of the empirical data.

Since the study was explorative, primary data were generated using focus group interviews, in-depth interviews and observations. Research findings indicate that greater access and availability of treatment and drugs for STIs/HIV infections like Antiretroviral (ARV's), Post-Exposure Prophylaxis (PEP) and Emergency Contraceptive Pills (ECP's) have created laxity and false confidence amongst male and female university students. Perceiving HIV like any other disease has made young people engage in unprotected sex with multiple sexual partners. For instance, female university students in this study feared pregnancy more than STIs/HIV in fear of social stigma and early child-care responsibilities, misinformation and access to pornographic material from social media like WhatsApp, Internet, sexualized images displayed in some tabloids and frequent uncensored videos on televisions, have impacted greatly on young peoples' attitudes and perceptions of their own sexuality.

The gender and power imbalances concerning females' capacity to negotiate safer sexual relations is significant, as male dominance in decision-making and control in sexual relations prevails. Finally, failure to recognize young people as clients for sexual and reproductive health (SRH) services by some health care providers and parents shows a gap between young peoples' needs and service utilization, and therefore, their voices need to be represented.

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# **INTRODUCTION**

## **Introduction**

Qualitative studies pertaining to the voices of male and female youth in regards to youth-friendly sexual and reproductive health services in Uganda are still limited. Therefore, this study is about male and female university students' experiences and expectations towards youth-friendly sexual and reproductive health (YFSRH) services, their needs and the challenges they face in accessing such services. The study also explores the attitudes and perceptions of health care providers (HCP) and parents towards youth sexuality and the negative health compromising outcomes young people are grappling with as a result of increased sexual activities that have put many young people at risk of contracting STIs and HIV/AIDS and unwanted pregnancies. How these university students make decisions about relationships, participate or abstain in sexual activities or protect themselves and others from STIs/HIV and from falling pregnant, is explored across an array of factors ranging from social-economic, to power disparities pertaining to inequality in gender relations as well as in same-age and cross-generational relations. How health care providers, parents and peers, influence these negative health outcomes young people are grappling with is also included in this qualitative inquiry.

## **Statement of the Problem**

In Uganda, statistical reports from the Ministry of Health (2013), UDHS (2013), and Uganda Aids Indicator Survey (2011) have highlighted the need and urgency for sexual and reproductive health services as a major concern among young people aged between 15-24 years. Government recognizes the underlying causes of young people's reproductive health challenges are closely linked to issues such as ignorance, misguidance as opposed to proper information, desire for quick material gains which makes young female university students engage in risk-taking sexual behaviors including same-age and cross-generational sex (UDHS, 2013, p. 108). Proportionately small numbers of male and female youth receive adequate preparation for their sexual lives as a majority is left potentially vulnerable to sexual coercion, sexual abuse and

exploitation (ibid). Statistical reports from the Ministry of Health Uganda (2012) indicate that 41 percent of young females aged 20-24 have experienced sexual violence. Furthermore, the prevalence rate of infectious diseases particularly HIV/AIDS is high among young females at an estimation of 4.8 percent, as opposed to 2.3 percent among males of the same age group 15-24 years (Hervish, 2012).

Furthermore, the Uganda Bureau of Statistics (2013) reports indicate that young females were often left with the consequences of unwanted pregnancies such as unsafe abortion with severe complications, while others experienced maternal deaths. Early childbearing is also high among young girls with a 12 percent of female adolescents aged 15-19 giving birth each year (UNFPA, 2014). Additionally, young people are faced with conflicting and confusing messages from different sources about sexuality and gender during their transition from childhood to adulthood. This situation not only renders young male and female vulnerable for uninformed choices on their reproductive health but also threatens the realization of Millennium Development Goals (MDG's) and the quality health life of the entire population.

In spite of various measures taken by health care providers, non-governmental organizations and the state at large, to ensure that a safe avenue is created for both male and female youths, limited access and utilization of reproductive health services by a majority of young people is common; a factor that increase their risk of exposure and vulnerability to reproductive health challenges. On the other hand there is little evidence that sensitization efforts have increased service utilization or have improved the quality of reproductive health outcomes among the youth. This study therefore seeks to assess the experiences and expectations of male and female university students of age cohort 18-24 towards SRH services, as well as health care providers' and parents' perceptions and attitudes towards young peoples' sexuality and the provision of youth-friendly SRH services.

## **Aim of the Study**

My motivation for conducting this research was guided by the overarching goal to give voice to male and female university students as to their specific SRH needs and the challenges they are faced with while seeking access to youth-friendly reproductive



health services. Therefore my main objective for this study was to explore young male and female students' expectations and experiences with youth-friendly reproductive health services, including the perceptions and attitudes towards the provision of these services by health care providers and parents. In achieving this aim, male and female youth students aged 18-24 currently in university were approached. In order to achieve the main objective of this study, the following issues were explored relating to different groups influencing youths' sexual and reproductive health needs and access to services:

- Young male and female university students' sexual and reproductive health needs and their expectations and experiences of youth-friendly services and the barriers they encounter to these services.
- Health care providers' and parents' perceptions and attitudes towards young peoples' sexuality and youth-friendly SRH services.
- The ways in which young people negotiate power disparities in sexual relations, and in relation to service providers and the parent generation.

Compared to other regions within the country, Kampala has the highest number of health care centres with public and private hospitals since it is the capital city with the highest population of young people. In other places youth-friendly SRH services are rarely accessible and available due to facilitation challenges which forces most of youths to seek them from Kampala city. Youth-friendly sexual and reproductive health services are provided and accessed from two prominent reproductive health youth centres including, Reproductive Health Uganda (RHU) and Naguru Teenage Information and Health Centre (NTIHC) both situated in Kampala with affiliates in other districts. However, the Ministry of Health Uganda has recently included youth corners on public health hospitals in Kampala (Ministry of Health Uganda, 2011). According to the Ministry of Health, all Kampala capital city authority health facilities have to secure designated youth centres to specifically cater for SRH needs and challenges of young people (Namakula, 2009). Although this is stated in the policy, all the available 13 facilities in Kampala are still strained by the immense number of clients and thus lack adequate resources to avail quality health care services that are acceptable and accessible by all young people irrespective of age and gender differences (ibid, p. 6).

In regards to the nature of SRH information shared in the public domain, the Ministry of Health Uganda takes the initiative to monitor and evaluate all health programs, carry out health sensitization and awareness on bill-boards, chats, mass media and campaigns around the city. Depending on the specific agenda, this arrangement is done with the assistance from donor partners. Research by Namakula (2009) on adolescents, also emphasised other sources of obtaining SRH information for young people that included peer-peer, social / media prints, pornographic materials, which are displayed and sold by street vendors in Kampala, internet computers, TV shows and programs, relatives and domestic maids among others.

### **Organization of the thesis**

Chapter 1 highlights the policy and legal frameworks on youth's sexual and reproductive health services in Uganda as compared to global frameworks. The aim of this chapter is to provide the basis for understanding the rationale for providing youth-friendly reproductive health services to young men and women of particular age and gender. Chapter 2 presents the conceptual framework and theoretical perspectives used in the analysis and discussion of research findings, while chapter 3 presents Sub-Saharan studies that have been carried out on young peoples' sexual and reproductive needs, and barriers to accessing services. Chapter 4 presents the methodological considerations for this study and methods that were used to generate data. The last three chapters of the thesis focused on empirical findings that were obtained from the field. Chapter 5 explores young male and female university student's SRH needs and their expectations and experiences towards youth-friendly SRH services and the barriers they encounter in accessing these services. Chapter 6 presents perceptions and attitudes of health care providers and parents towards young peoples' sexuality and provision of youth-friendly SRH services. Lastly, chapter 7 of the thesis presents the power disparities young people face when negotiating sexual relations and access to services amidst gender and age, including in relation to service providers and the parent generation.

# **CHAPTER 1: BACKGROUND AND CONTEXT OF THE STUDY**

## **1.0 Introduction**

The World Health Organization of (2002) defines reproductive health as a state of emotional, physical, mental and social wellbeing related to sexuality (quoted in Edward, (2004).Sexual health is not merely the absence of disease, dysfunction or infirmity but requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. In this chapter I will give a general overview of young peoples' sexual and reproductive health concerns in Sub-Saharan Africa and Uganda in particular. This includes an understanding of the SRH concept, defining who young people are and why addressing their SRH concerns are imperative.

## **1.1 Youth Sexual and Reproductive Health needs**

Knut-Inge, Flisher and Kaaya (2008) note that a majority of young people in Africa aged 18-24 years are experiencing numerous reproductive health challenges leading to contraction of sexually transmitted infections (STIs) including HIV/AIDS, early child births and unwanted pregnancies that can end in unsafe abortions (Knut-Inge, Flisher, & Kaaya, 2008, p. 6). Statistics from some parts of the Sub-Saharan region and Uganda inclusive, as presented in the UNFPA by Hervish and Clifton (2012) on *Opportunities and Challenges*, estimated high rates of HIV prevalence among male and female youth aged 20-24 years, with 1.4 percent among males and 3.4 percent among female youth (UNESCO, 2013).According to these authors, young females are twice more likely to be infected with HIV and other STIs than males due to gender disparities and power relations in relation to their SRH needs and services. Additionally, this paper refers to evidence that young females increasing indulge in risky and unplanned sexual activities that can result in unprepared responsibilities relating to unwanted pregnancies that might end in unsafe abortion. According to the authors of this paper, several factors account for such existing challenges among this age cohort, part of which stem from young people's under-utilization of the sexual

and reproductive health services and barriers limiting their accessibility to RH needs and rights.

Demographic country surveys as reflected by UNFPA (2012) emphasized that a large number of young people are sexually active during this stage in life which requires attention to their SRH needs and access to accurate information regarding to their sexuality. The circumstances for engaging in risky sexual activities are varied. As Mutebya and colleagues (2011) noted, for a majority since their first sexual experience is clandestine and chaste, they are often limited opportunities for precautionary measures. Additionally, as Prata, Weidert and Screenivas (2013) noted, a wide range of modern contraceptives is needed among female youth than adults. According to these authors, in Zambia 33 per cent and in Mali 7 per cent of sexually active youth use modern contraceptives Adolescent birth rates per 1,000 girls aged 15 to 19 ranges from 68 and 70 in Uganda and Ghana, to 190 in Mali respectively (UNFPA, 2012).

Several authors have noted that despite policy makers and program managers recognizing the importance and need of addressing the sexual and reproductive health concerns of young people in Sub-Saharan Africa, high levels of unwanted pregnancies that end in unsafe abortions and the prevalence of STIs including HIV/AIDS in the region show that young people continues to be faced with numerous SRH challenges starting from their early adolescents (10-19) to young adulthood (18-24) (L. R. S. Bearinger, Ferguson, & Sharma, 2007; Knut-Inge et al., 2008; Sidibe, 2009). Chief among these authors' concerns is that programs concerned with young peoples' reproductive health challenges are still not adequately articulated to their peculiar needs; an issue highlighted during the Cairo International Conference on Population and Development (ICPD) of 1994 and reaffirmed during the Accra Ghana ICPD beyond 2014 (ICPD, 1994, 2013; Sawyer et al., 2012).

In the review report of the Abuja declaration of April (2008), it was noticed that youth called on governments to accelerate the implementation of the conference resolutions by allocating 15 percent of national budgets to health, with specific attention on SRH programming for all young people as a priority (Fatusi, 2010).The ICPD Program of Action holds governments accountable for the strengthening of programs

that should suitably address youth reproductive health needs. Emphasized at the Accra Ghana ICPD beyond 2014 (ICPD, 2013) was the need for youth to participate actively in planning and implementation of programs, and a tracking of progress of national health budgets in the 159 participating countries, Uganda included.

The group of youths taking part in this study belong to the age cohort 18-24 at universities since they comprise the most at risk population in Uganda; not only grappling with their sexuality as such but also with the most severe consequences of risk-taking sexual behavior and its outcomes. Some of the reasons for this age cohort of youth at universities becomes important because, majority tend to move away from the guidance and control of parents to leave by themselves with new peers in hostels of different home/social backgrounds, others get more excited to try on new different experiments in their sexual lives due to peer pressure and new social groups at universities.

Thus the access to RHS are considered to be in much more need for university youth, given the fact that this age cohort remains vulnerable to engage in risky sexual behavior such as having frequent unprotected sex with multiple partners. Even among the youth, gender is an important consideration because girls are considered to be more sexually active as compared to the males. Meanwhile, the males seem to have more control over power to negotiate sex and mode of having it, that is to say whether to use a condom or not and females seem to be compelled to go by the will of the men (Ministry of Gender, Labour and Social Development, 2014). This makes the youth and gender factors to be an important subject of consideration for YSRH services in this study.

There is a need to recognize the distinctive differences between adolescents and youth age groups. This categorization within age brackets bares distinctive features in relation to male and female youth's sexual and reproductive health needs, services and challenges faced also in terms of gender issues. Globally, adolescence is defined as that period of transition from childhood to adulthood, characterized by emotional, biological and psychological changes 10-19 age, Berry and colleagues (2000); as cited in Namakula (2008). 'Youth' is a gendered component that comprises male and female though not a fixed category, thus definitions may vary accordingly

from different social contexts.

This study therefore adopts the definition by the United Nations Educational, Scientific and Cultural Organization UNESCO (UNESCO, 1949) which spells out that, “youths” are those persons between the age cohort of 15-24 years without prejudice to other definitions by member states. “Youth” is therefore understood as that period of transition from the dependence of childhood to adulthood’s independence and awareness of our interdependence as members of a community, thus youth is a more fluid category than a fixed age group (UNESCO, 2013). The group of youths taking part in this study belong to the age cohort 18-24 since they comprise the population most at risk; not only grappling with their sexuality as such but also with the most severe consequences of risk-taking sexual behavior and its outcomes.

## **1.2 Context of Study**

Geographically, Uganda is situated in the East African region commonly known as the country with the source of two major tributaries of river Nile waters namely the blue and white Nile. Uganda is a land-locked country bordered by Southern Sudan in the North, Kenya in the East, Rwanda and DRC in the west and Tanzania in the South. Churchill once described Uganda as the pearl of Africa because of its strategic geographical location.<sup>1</sup> The country has an area of 241,039 square kilometres and is administratively divided into 112 districts. Uganda has a decentralized system of governance and several functions have been relegated to the local governments. However, the central government retains the role of formulating policy, setting and supervising standards and providing national security.

The recent population census carried out in Uganda revealed a total population of 34.9 million, an increase of 10.7 million from the 2002 census (UBOS, 2014). The National Population and Housing Census (UBOS, 2014) estimated that if Uganda’s population maintains a growth rate of 3.03, its population would increase to 46.7 million in the year 2025, an increase of 11.8 million persons in 11 years. Uganda

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<sup>1</sup> Churchill, S. Winston. 1908. *My African Journey*, in The Strand Magazine, <http://www.churchillbooks.com/guidePDFs/g9.pdf>

being a multilingual state with over 53 ethnic groups, English is chosen to be the main official language followed by Luganda, Runyakole-Runyakitala and Kiswahili, among others, as the most dominant local languages. The literacy rate of Ugandans aged 15-24 is 77.1 for males and 75.2 for females with an average total of 76.1 (UDHS 2011). The main capital city of Uganda is Kampala with a population of around 1.5 million according to the most recent Population and Housing Census (2014).

The UDHS (2013) reports that youth is a challenging stage in life where a person is in transition from childhood to adulthood. This stage is associated with lots of experimentations and risky behaviors that might result in contracting STIs and HIV/AIDS. It has been acknowledged that female youth are the most vulnerable as they continue to bear the consequences of early and unwanted pregnancy which forces them to carry out unsafe abortions. Rubina (2013) asserted further that Uganda has one of the highest and escalating rates of youth pregnancies and abortions in the world estimated at 43 percent among the 15-24 years. The UDHS (2011) also indicated that 14 per cent of young women and 16 per cent of young men had their first sexual encounter before the age of 15, while 57 per cent of young women had their first encounter before the age of 18. Early initiation of sexual relationships and limited knowledge/information contribute greatly to the cause of unwanted pregnancies among female youth and other negative health outcomes for young people in Uganda. Thus the need for an increase in the utilization of YFSRH services in Uganda. The assistant country representative to UNFPA, Ochan Wilfred claimed that limited access to accurate reproductive health information supported with adequate services steers young people into risky sexual practices in Uganda (Agatha, 2011).

### **1.3 Policies and Legal Frameworks: YFSRHS in Uganda**

Uganda has a Policy Guideline on Adolescent Sexual and Reproductive Health (ASRH) concerns that encompasses the SRH needs and services of all young people according to the Ministry of Health Uganda (Ministry of Health Uganda, 2011). The aim of this policy is to mainstream the adolescent sexual and reproductive health concerns in the national development process with a main focus on improving young people's quality of life and standards of living. The emphasis for this ASRH policy further highlights the provision and increase of availability and accessibility of

appropriate, acceptable, affordable, quality information and health services to adolescents and youths in the country.

Additionally, Uganda has ratified a number of global and regional conventions on youths SRH services including, the re-affirmation to its commitment to the full implementation of the ICPD Programme of Action and the key actions for its further implementation beyond 2011 (Ministry of Health Uganda, 2011). Uganda also ratifies its commitment to the Addis Ababa Declaration on Population and Development in Africa Beyond 2014, in accordance with national laws and policies and the Abuja Declaration of 2008 in Nigeria towards the elimination of HIV/AIDS in Africa by 2030 (ICPD, 2013). Furthermore, the national policy guidelines and service standards for sexual and reproductive health and rights recognize the relevance of providing adolescent-friendly health services as a way of increasing service coverage for reproductive health amongst adolescents (Ministry of Health Uganda, 2011).

Furthermore, the Health Sector Strategic Plan II (2010/11-2014/15) highlights the need for increased reproductive health service provision for adolescents and young people through environments that are supportive and conducive (Ministry of Health Uganda, 2011, p. 9). Article 16 under section (c) of the African Youth Charter (2006) supports the provision of YFRHS including contraceptives, antenatal and postnatal services (ibid, p. 9). The continental policy framework for Sexual and Reproductive Health & Rights in the Maputo Plan of Action 2007-2010 are all regional policy frameworks that recognize the need to provide youth-friendly services in order to improve sexual and reproductive health for young people. According to Girard (Girard, 2014), in Uganda there is currently ministerial commitment to comprehensive sexuality education and SRH services for adolescents.

#### **1.4 Youth unwanted pregnancies / abortion, STIs and HIV in the context of YFSRHS.**

In circumstances of unwanted pregnancies, it is the young females who bear the related consequences of unsafe abortion, shoulder the child bearing, if unmarried or still at school they face stigmatization or are dropping out of school. Young females especially the aged 18-24 university students are particularly at risk of unwanted



pregnancies as a result of premarital sex, which is common among youth in Uganda. According to the UDHS(UDHS, 2013), more than one in three female youth aged 15-24 has had sex and nearly one in five female youths in that age group reports currently being sexually active. Braeken and Rondinelli(Braeken & Rondinelli, 2012)noted that Gender based violence including coercive sexual practices with young females is high and increasingly in Uganda. UDHS (2013) statistics have revealed that a majority of the girls that end up with unwanted pregnancies, resort to unsafe abortion due to multiple factors. Chief among them is the abortion law based in the current legal frameworks.

### **1.5 Interpretation of the abortion policy in Uganda**

Abortion in Uganda is legal and permissible when a pregnancy endangers a woman's life or her physical and mental health. However, the Ugandan Constitution prohibits abortion in general, according to Article 22(2); "No person has the right to terminate the life of an unborn child except as may be authorized by law." From this article it can be observed that there is no absolute prohibition on the termination of pregnancy in Uganda, but the indications for abortion is narrow. Abortion is only permitted on grounds of preserving life and health of the pregnant woman (Constitution, 1995).Accordingly, the 2006 National Policy Guidelines and Service Standards for SRHR provide access to termination of pregnancy services in cases of, severe maternal illnesses threatening the health of a pregnant woman for instance, cardiac disease, renal disease, and severe preeclampsia(Ssewanyana & Okidi, 2007). More still, severe foetal abnormalities that are not compatible with extra-uterine lifeand cancer of the cervix and HIV-Positive woman requesting for termination are accepted. With such a strict policy young females might be denied their freedom to exercise their sexuality life.

Unsafe abortion is defined by WHO (2004b) as a procedure for terminating an unwanted pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both (Shah, Åhman, & Ortayli, 2014). According to Patton and colleagues (2009), unsafe abortion among young females, is estimated to account for around 15 per cent of all maternal mortality deaths in the age group of 15-24. Similarly, a study by Ahman and Shah

(2011) on trends regarding unsafe abortions revealed that unsafe abortion is both widespread and a significant cause for maternal deaths in developing countries. In the UDHS (2011), it was found out that transactional sex is closely associated with high risk of contracting HIV and other sexually transmitted infections due to compromised power relations and the tendency to have multiple partners which is a common practice among young people at university settings in Uganda today.

In the case of sexually transmitted infections (STIs) and HIV/AIDS, the ASRH policy and the Ministry of Health Uganda (2011), emphasised the fact that no adolescent living with HIV, or any other related STI, shall be discriminated based on the health status (Ministry of Health Uganda, 2011, p. 19). The policy points to the fact that HIV counselling and testing is the entry point to HIV/AIDS services thus encouraging all adolescents to take the responsibility of testing. However, the policy emphasises adolescent's consent before access to services. Furthermore, this policy emphasises the fact that adolescents living with HIV/AIDS shouldn't be mistreated at schools, homes and in communities thus availing them with equal opportunities to participate in youth programs and any other health concerns.

The above statistics, information and situation surrounding young peoples' SRH concerns in Uganda today have informed my study about existing challenges within the service delivery, and the health status of young people as a starting point for my investigation. This review further shows that the HIV/AIDS epidemic continues to spread more among younger age groups than older people and worst of all amongst the educated youths whom are assumed to possess more knowledge about the virus and other negative health compromising risky sexual activities for their lives. The same applies to the challenge of unwanted pregnancies and other related reproductive health concerns such as family planning, condom use and Other STIs. Perhaps, having education and being at universities does not necessarily guarantee youth a safe a venue to enjoy their sexual rights and freedom, including accurate knowledge on proper sexual activities as the case might be assumed to be for several reasons which this study focuses on. My study therefore intends to unearth and address these SRH concerns from a gender sensitive perspective, by giving youth a voice to these concerns.

## CHAPTER 2: CONCEPTUAL FRAMEWORK AND THEORETICAL PERSPECTIVE

### 2.0 Introduction

Creswell (2009) stated that the word ‘theory’ refers to a particular explanation of a given phenomena under specific circumstances. Worthy of noting, there are several sets of concepts that are produced within a theory, in which, as Silverman has noted, “theory provides both a framework for critically understanding the phenomena and a basis for considering how, what is unknown might be organized” (Silverman, 2010, p. 110). In his understanding, theoretical frameworks help to arrange sets of concepts that can define and explain the empirical findings of data generated from the field. To achieve this goal, I adopted the rights-based “AAAQ” framework for health provision as suggested by Hunt & De Mesquita (2008) and Yamin (2009), the three bodies approach by Scheper-Hughes and Lock (1987) and Connell’s (2009) perspective on gender relations in the reproductive arena, that helped me to understand and explain the empirical findings of this study. Emphasis in this chapter is laid on specific aspects of the theories and perspectives that are particularly relevant for this study. The main purpose is to show how the theoretical considerations can provide a deeper understanding of my empirical findings.

### 2.1 AAAQ (Availability, Accessibility, Acceptability and Quality)

The United Nations for economic and social council introduced during its meeting in Geneva (2003) the ‘AAAQ’ framework as a possible umbrella goal to assess the provision of health care services in the post-2015 development agenda, mainly in maternal health and general reproductive health services, from a human rights perspective (Evans, 2013). Hunt & De Mesquita (2008) has emphasized that the thrust of the AAAQ framework is that health care products and services must be *available* for utilization, *accessible* in terms of physical and non-physical structures, designed in an *acceptable* manner for the target group of clients, appropriate and of good *quality*. In this current study, the AAAQ framework was considered relevant for understanding how youth-friendly sexual and reproductive health services are

provided and utilized by male and female students at the university in Kampala.

The first 'A', *availability*, relates to a functioning health system and health care facilities, goods and services, as well as programs in sufficient quantity within a country. Relating this to my current study, this first A in the framework was useful in assessing the availability of SRH facilities and services for young people. This also means designing gender and age sensitive youth health corners that must be available for users, as in my study, at the University, with skilled youth health care professionals and adequately supplied with essential reproductive health commodities such as emergency contraceptive pills (ECPs), condoms, sanitary towels, adequate SRH information and materials. This first A therefore links to how SRH services in Kampala are availed to different young people in relation to age and gender in my study.

The second 'A' in the framework represents *accessibility* of facilities and services. Hunt & De Mesquita (2008) suggested that all health care services must be accessible for everyone without discrimination even to the most vulnerable people. Accessibility is not only limited to health care facilities but also to adequate SRH information to enable anyone making his/her own informed decisions on their sexual and reproductive health lives. This also means that health services must be designed in a responsive way to suite young people. Young people in Uganda need access to not only comprehensive sexuality information but also access to accurate and gender sensitive details for both male and female youths. Access encapsulates almost all aspects of health system including service delivery, health financing, human resources for health and essential medicines among others.

The third 'A' in the framework is *acceptability* of health care services. The framework postulates that health services including SRHS must be respectful of medical ethics, culturally appropriate and gender sensitive in Hunt & De Mesquita's (2008) understanding of the framework. Additionally, before administering medical treatment to clients, Health Care Providers (HCPs) must explain exhaustively to clients in an understandable manner with a cultural sensitivity consciousness to build trust in the utilization of services. In regards to young people especially female youths, HCPs should endeavor to understand the type of clients they are dealing with in respect to their age and gender when, for example, recommending contraceptives.

Male and female youth need much information on these products to demystify the misconceptions and negative social sentiments affecting such products utilization.

The 'Q' in this framework refers to *quality* of sexual and reproductive health services. It postulates, as Hunt and De Mesquita has noted, that all reproductive health care services, including the essential reproductive health commodities, must be scientifically and medically appropriate and of good quality. This applies as well to the manner in which clients seeking services are treated at health centers in Uganda including the manner in which young people are received and treated during routine medical examinations and checkups. The quality of health care commodities will also enhance service utilization among the consumers. The AAAQ is therefore useful in explaining if male and female SRH needs are satisfied, and for understanding the barriers young people face in accessing health related services; issues that were explored and addressed in Chapter 5 of this thesis.

## **2.2 The Three Bodies approach**

The three bodies' approach by Scheper-Hughes and Lock (1987, p. 6) represents an attempt to integrate an anthropological theorizing of the body and simultaneously challenge the assumptions of Cartesian dualism found in medical anthropological understandings of the body. Scheper-Hughes and Lock illustrated that dualist ideas rigidly separate "mind from body, self from matter and real from unreal" (ibid, p. 6). The three bodies' approach interprets the body as a physical and symbolic entity that is biologically and culturally constituted. This theoretical approach therefore represents three levels of analysis by which the body can be understood that include, the individual body (phenomenology), the social body (structuralism and symbolism) and the political body / body politic (post structuralism) (ibid, p. 7). Scheper-Hughes and Lock doesn't assume these levels of analysis as being mutually exclusive but rather as interconnected.

At the first level of analysis lies the individual body, which is understood as the lived experience of the body-self. At this level, Scheper-Hughes and Lock demonstrates how the individual body experiences life in health, illness, happiness, joy and sorrow although these experiences are influenced by social, political and

cultural factors. This level of analysis was used to explain the ways in which young people receive and experience reproductive health treatment, and in the case of young females, when it comes to managing unwanted pregnancies. Male and female youth's scope of reproductive health knowledge on managing bodily infectious STIs and unwanted pregnancies can be best explained and understood using the individual body as a basis for analysis.

At the second level of analysis, Scheper-Hughes and Lock identifies the social body (the body as a symbol). In their theory, they discuss the representational uses of the body as a natural symbol by which one thinks about as nature, society and culture. Douglas, as cited in Scheper-Hughes and Lock (1987, p. 7), suggested that the physical experience of the body is always modified by the social categories by which it is acknowledged and sustains a particular view of society as a whole. For instance, in the African social context, young people are expected to be chaste and sex among unmarried youth including adolescents is therefore commonly clandestine. Society dictates the good and the bad for young people by drawing on to their bodies as social symbols attached to different meanings. In circumstances of unwanted pregnancy out of wedlock or official marriage, girls' individual bodies are stigmatized and covered with shame, a factor that might be forcing majority to seek unsafe abortion. Hence, the cultural dimension of the social body has relevance for sexuality and reproduction.

In light of Foucault's work on power, Scheper-Hughes and Lock identified the third level of analysis in terms of body politic, referring to the regulation, surveillance and control of the bodies in reproduction and sexuality, in work and leisure, sickness and other forms of deviance and human difference (ibid, p. 8). Foucault illustrated that the body as "docile may be subjected, transformed, used or improved" (quoted in ibid, p. 103). In his work on power, Foucault asserted that power is everywhere; thus it is neither an agency nor a structure. He therefore signifies that power is constituted through accepted forms of knowledge, scientific understanding and truth (Foucault, 1998, p. 63). In a similar way, Scheper-Hughes and Lock (1987) stated that, a beautiful, strong and healthy body is that which is culturally and politically "correct" though the indicators may differ accordingly. This level of analysis, therefore, enables an understanding of the power dynamics young people experience when negotiating safer sex in their relationships. This perspective also encompasses power differentials

at play in the sexual and reproductive health services from health service providers as well as in relation to parents. This theoretical approach was useful for this research as it gives an understanding on how young peoples' bodies can be understood and how different connotations are attached to them; what is considered acceptable or undesirable in the Ugandan society as control and power are exercised on these young people's bodies.

The three bodies' approach is helpful to understand perspectives at individual, community and structural levels. In relation to my study, the concept of the individual body helps me to analyze the ways in which male and female youth's bodies receive and experience the sexual and reproductive health services from HCPs, how their bodies are viewed by society for instance in terms of unwanted pregnancies or if infected by STIs in relation to cultural constructions of a normative body. The social body is relevant to understand the society's views on young people's sexuality lives, their concerns on SRH needs and services and how young people themselves perceive their SRH services in relation to their expectations. Further still the social/symbolic body perspective is also important to understand the different representations and meanings attached to young people's expectations of sexual behaviors by parents, health care providers and society as a whole. The political body was helpful in understanding the power hierarchies / disparities and dynamics influencing young people's sexual behaviors and practices that consequently lead to most of their reproductive health challenges. Furthermore, it was useful to ascertain the socialisation, gender relations and reproductive decision-making of young people when experiencing all the sexual aspects of life.

### **2.3 Social embodiment and the reproductive arena**

Connell (2009, p. 11) asserts that, gender is a specific form of social embodiment that encapsulates almost all human practices. Noticeably, from this perspective, we begin to understand gender if we understand how closely the social and bodily processes mesh in our daily lives. These bodily capacities and the practices that realize them constitute an arena, a bodily site where something social happens. Connell recognizes the distinctive binary features within gender, that not only is used to refer to the bodily structures and processes of human reproduction but also, gender involves

clusters of human social practices including child care, birthing, sexual interaction which deploy human bodies' capacities to engender, to give birth, to give milk, to give and receive sexual pleasure. Connell defines gender as a structure of social relations that becomes especially distinct as binary categories based on biological sex in the reproductive arena, despite being based on socially conditioned sets of practices. However, Connell also recognizes that bodies have agency. The biological and social analysis of bodies is therefore inseparable in Connell's writings. This argument is similar to that of Scheper-Hughes and Lock (1987) when they were challenging the dualist ideas that rigidly separated the mind from body, self from matter and real from unreal in their three bodies approach.

To relate Connell's and Scheper-Hughes and Lock (1987) writings, the three bodies' approach by Scheper-Hughes and Lock examined three perspectives from which the body can be viewed. In this case understanding what male and female youth under go through during challenges of unwanted pregnancies and dealing with STIs/HIV, can be analyzed using the experienced individual body-self. These young people's scope of reproductive health knowledge on managing STIs including unwanted pregnancies, determines the fate for their health lives. However societal structures already have their expectations in regards to how one's social actions and behaviors are perceived. In regards to this social challenge Connell (2009) perceived people to be influenced by social structures when they act but that they can also act counter to social structure (and hence, that it is not entirely predetermined how people will act) a factor that coincides with young peoples' attitudes and expectations in relation to their experiences and sexual behaviors. University youths are not only perceived by society to be important icons but also strong symbols of knowledge for which society draws upon, and this is what Scheper-Hughes and Lock identified as social body. In this, society ensures that the individuals' conducts and behaviors are set under an artifact of social and political control (body politic), a factor related to what Connell (2009) viewed as bodies being both objects of social practices and agents in social practices. This level of analysis, therefore, enables an understanding of the power dynamics young people experience while negotiating safer sex in their relationships. This theoretical approach helps to understand how young peoples' bodies can be understood and how different connotations are attached to them.



In relation to Connell's (2009) perspective on gender relations in the reproductive arena, which understands gender as closely related to the social and bodily processes mesh in our daily lives. These bodily capacities and the practices that realize them constitute an arena, a bodily site where something social happens. The biological and social analysis of bodies is therefore inseparable in both Connell's and Scheper-Hughes and Lock (1987) writings when they were contemplating on the dualist ideas that rigidly separated the mind from body, self from matter and real from unreal in their three bodies approach.

Gender constitutes an arena, a bodily site where something social happens. Among the things that happen is the creation of the cultural categories 'women' and 'men'. Connell calls this the reproductive arena in social life. Bodies are transformed in social embodiment. The transformation of bodies is structured in part on gender lines. Many gender processes involve bodily processes and capacities that are not sex-differentiated, that are in fact common capacities of women and men. It is possible for social practice to move gender orders in different directions, and create different relations between bodies and social structures despite the strong link to biological sex in the reproductive arena.

Services must be available for utilization, accessible in terms of physical and non-physical structures, designed in an acceptable manner for the target group of clients, appropriate and of good quality. They also encompass power differentials at play in the sexual and reproductive health services from health service providers as well as in relation to parents. Thirdly, what is considered acceptable or undesirable in the Ugandan society as control and power are exercised on these young people's bodies. As human beings, we are socialized to perceive gender as an idea of difference between women and men. The reason for the difference between male and female bodies will be discussed through the local understanding of gender in the reproductive arena. It is possible for social practice to move gender orders in different directions, and create different relations between bodies and social structures. It is in this manner the conceptual framework and the theoretical perspectives adopted for this study will help to analyze and discuss male and female university students' SRH needs, and their experiences and expectations towards YSRH services. It is also useful for analyzing and discussing the attitudes and perceptions of health care providers and parents towards young peoples' sexuality and youth-friendly SRH services.

## CHAPTER 3: LITERATURE REVIEW

### 3.0 Introduction

Young people, both male and female, have distinctive sexual and reproductive health needs from adults. These needs are not limited to gender differences but include as well age differences within the category youth. For example, according to *Adolescent Health Policy Guidelines and Service Standards* in Uganda the SRH needs for youths in age groups 10-19 and 20-24 vary significantly (Ministry of Health Uganda, 2011). In addition, it is noted that youths in schools and those out of schools face different challenges in accessing SRH services whether from health care centers or obtaining information at home. Given the importance of quality health services for young people as the future torch bearers in our societies, scholars have been burning the midnight oil carrying out studies on SRH needs and services offered to young people. In this chapter, I will draw specifically on literature that refers to studies carried out in Sub-Saharan African countries and Uganda in particular. The selected literature addresses youth's SRH needs and barriers to services in three main sections as follows; (1) studies related to how young people envision their needs and SRHS in relation to the barriers encountered, (2) studies conducted on how health care providers' and parents' attitudes affect young peoples' utilization of SRHS, and (3) studies on how young people negotiate sexual relations and access to services amidst power disparities and dynamics across gender and age.

### 3.1 Male and female YSRH needs and barriers to services

According to some large-scale studies conducted in Africa by Bankole and Malarche (2010), Biddlecom and colleagues (2007) and Erulkar and colleagues (2005), a majority of young people in Sub-Saharan African countries frequently mentioned a need for having affordable SRH services to meet their reproductive health needs. In these studies, it was noticed that young people are faced with a challenge of high costs attached to SRH services, costly reproductive health commodities as well as the inability to afford transport costs to health centers. Additionally, a study by Muhangi and Ninsiima (2011) on Ugandan adolescents found that lack of accurate knowledge and information prevents young people from effective utilization and access to

services. In line with studies conducted by Nobelius and colleagues (2010) among young people in the western parts of Uganda, it was reported that young people do not only prefer sexuality information and education that is accurate and easily accessible, it should also be in line with their ideal life experiences. Nobelius and colleagues noted also that this information has to be non-judgmental, non-authoritative and positively framed. However, young people identified health care workers as potential sources for this accurate and reliable information. In Amuyunzu-Nyamongo and colleagues' (2005) study from Uganda, this was because information from peers was reported to be unreliable and sometimes conflictual.

Surveys conducted on the SRH needs of male and female adolescents aged 12-19 in Burkina Faso, Ghana, Malawi and Uganda indicated that, contraceptive and STI services, including HIV testing, by Bankole and colleagues (2007) found that such services are still underutilized. Study findings indicated that a majority of these youth lacked comprehensive knowledge on existing contraceptive methods including condoms and their proper usage. In addition, these youth were found to be unaware about where to obtain such relevant services whenever required. Noteworthy, the findings of this study showed that limited knowledge affects SRH service utilization especially on contraceptive use and STI services such as HIV testing and counseling.

In a qualitative study conducted by Taffa and colleagues (2002) in Addis Ababa, Ethiopia on young peoples' perceptions, beliefs and sexual risk-taking, it was noted that the majority were depended on information from their peers instead of accessing SRH services. This information from peers is more often than not inaccurate and superficial. The challenge with limited knowledge and information on sexuality concerns, identified in this study, is that it increases the risk-taking behaviors such as unprotected sexual practices that can result in contracting HIV, and in unwanted pregnancies that end in unsafe abortion (Taffa et al., 2002). In this study from Addis Ababa, it is concluded that, relying on peers for SRH information and services might result into misguidance since a majority of them are in fact ill informed.

In a similar study, Bankole & Malarcher (2010) found that the proportion of young people with detailed and accurate knowledge is low and percentages of young people with such knowledge varied from country to country. However, Uganda was

one of the leading countries with the highest percentage of young people with SRH knowledge, which was estimated at 32% followed by Ghana and Malawi on 28%, and finally Burkina Faso with 9%. This study concluded that the provision of detailed and accessible information on SRH is of paramount importance. Additionally, these authors noted that, it is not enough to provide sexuality information to young people without considering the appropriateness and accuracy of the information.

Studies by Marston and colleagues (2006) revealed, furthermore, that youth commonly respond reluctantly to questions concerning their sexual relationships or having contracted an STI, especially in situations where they feel suspected of being sexually active. Smith and colleagues (2006) concluded that failure to disclose such information might strongly influence whether or not young people are willing to comply with testing or seeking care for any in fear of shame and being stigmatized. Similarly, research by Dloski (2013) on Zambian youths aged 15-24 in several districts of Lusaka, found that young people are heavily stigmatized if caught accessing SRH services and information. As a result young people rarely access SRH services in fear of being chastised, stigmatized and punished for sexual involvement (L. H. Bearinger, Sieving, Ferguson, & Sharma, 2007; UNESCO, 2013).

From a gender perspective, young females frequently reported experiencing shame and embarrassment when accessing the most needed essential RH commodities such as contraception and condoms. For example, research by Mashamba (2002) in Bulawayo district of Zimbabwe concluded that even in places where clinics are spatially accessible stigma and fear of shame about having contracted an infectious STI or being pregnant influences the way they perceive reactions to disclose their sexual behavior to a health care provider (HCP). Whereas young females are often powerless in negotiating condom use or any other methods of contraception with partners, they nevertheless bear the brunt of social condemnation and stigma if they become pregnant. As (Bankole & Malarcher, 2010) have noted, they feel afraid and embarrassed. In fact shyness was the most common barrier mentioned among sexually active female youth. In fact, lack of privacy and youth friendly SRH centers have been identified in a number of studies as a major barrier for the utilization of such services. A study by Boltana and colleagues (2012) among youths students of Mbarara University in Uganda and that of Erulkar and colleagues (2005) conducted in

Kenya and Zimbabwe, illustrated this point well. These authors found that young people in these two countries envisioned SRH services that guarantee confidentiality and privacy. These young people wanted stand-alone youth-friendly SRH centers separate from adults, and staffed by young professionals who are closer to their needs and concerns and probably less judgmental than adult health staffs.

Biddlecom and colleagues (2007) found that most of young people consider confidentiality and privacy to be their center of attraction to the health care providers. This was revealed by a majority of the adolescents in Burkina Faso, Malawi, Ghana and Uganda in their study. Their findings pointed to the fact that young people prefer obtaining SRH information from service providers who are willing to secure their privacy without linking to their parents. Once young people have identified an attractive separate youth-friendly center and indicated their confidence and trust in the system, they will increase their utilization and access to relevant information and services. Furthermore, Bankole and Malarcher (2010) found that, young people, especially female youth, have a high unmet need for contraception in Sub-Saharan Africa. This study puts the statistics of the unmet need of contraception as follows; 39 per cent of married adolescent females wish to avoid pregnancy for two or more years of which almost two thirds of 25 per cent are using no form of contraception.

## **3.2 Health Care Providers and Parents attitudes towards YSRHS**

### *3.2.1. Health Care Providers*

According to Rickwood (2007), the existing climate of intimidation at health centres during service delivery scares most young people seeking reproductive health services. In his study on young people's SRH challenges in Nigeria, Rickwood (2007) revealed that most of the health care providers lack the professionalism to deal with young people. Furthermore, results from country surveys in Kenya, Laos and Zambia by (Godia, Olenja, Hofman, & van den Broek, 2014) documented that one half to two thirds of health care professionals were unwilling to provide contraceptives to adolescents based on the negative attitude that young people are not capable of making substantial life choices for themselves so early. Whereas young people claim that they are able to make proper decisions on their sexuality lives, Hobcraft and

Baker (2006) illustrated that health care providers have a patronizing view of their young clientele assuming to know whatever care and treatment is suitable for them.

Additionally, the country surveys conducted by Godia and colleagues (2014) revealed that health care providers possess mixed feelings based on cultural and religious values in relation to their professional work. Besides some of the health care providers intentionally deny delivering reproductive health services to young people especially contraception and condoms with an attitude that they are not potential clients for such services. These authors concluded that youth seeking SRH services might be disproportionately subjected to discriminatory behaviors from health professionals due to age preferential and gender.

A study on adolescents SRH services in Tanzanian health facilities by Mbeba and colleagues (2012), found that the inadequate staffing and stocking of equipment with less logistical supplies of materials, remained a major challenge. In this study, findings indicated that frequent shortage of commodities and supplies along with financial resources constrain the health care providers' capacity to administer youth-friendly services separate from adult patients. Out of the 38 health facilities visited in Mtwara district of Zambia, it was noticed by these authors that none of them had designated areas for the provision of youth-friendly services and the available services were suitable only for adults. Major essential RHS such as information, contraceptive commodities and curtains before the windows were missing.

Although government policies strive to provide youth friendly SRHR services, research by (Warenius et al., 2006) in Kenya and Zambia revealed that making the health care providers follow the policies is still a challenge. For example, as Koster-Oyekan (1998) has noted, even where abortion is legal like Zambia, adolescents undergo illegal abortions because legal abortion services are inaccessible and unacceptable. Similarly a study conducted by (Neema, Ahmed, Kibombo, & Bankole, 2006) in Uganda found that the policy exempts young people to pay some of the costs associated with SRH services in principle but in reality and on ground there is weak implementation and a few health care providers hardly know about this policy due to less access. Bufumbo (2011) during his assessment study on young people's perceptions on SRHS in Uganda, found that most health care providers lack access to

policies and guidelines related to adolescents' reproductive health services. Bufumbo noticed that in relation to the poor remunerations of health staffs, coupled with the poor working conditions under which they operate, most health care providers lack access to adolescent SRH guidelines; an issue which continues to hamper effective service delivery.

### *3.2.2. Generational issues of power*

A study conducted in three Zambian districts of Lusaka, Chibombo and Katwe, Dloski (2013) found that restrictive traditional cultural norms and practices limit young people's choices over their sexual and reproductive health rights. In this study, young people reported that restrictive traditional cultural norms actively discourage communication around sexuality health issues. Additionally, during a qualitative survey among adolescents in Ghana, Kumi-Kyerem (2007) noticed a strong negative relationship in regards to effective communication between parents and adolescents on sexuality-related matters. According to Dick and colleagues (2006) one prominent reason for withholding sexual and reproductive health information from young people was the conviction that such information would encourage them to engage in sexual activities prematurely.

Whereas studies by Martina and colleagues (2012) revealed that most parents were aware of adolescents' secret sexual relationships between male and females, they hardly discussed any sexual issues related to this. Conclusions in this study indicated that lack of communication between parents and adolescents over sexuality matters is as a result of shyness and the perceived notions that providing sexuality information to young people encourages sexual activities. However, Akim (2001) during his qualitative research on parent' attitudes to adolescents sexual behavior in Lesotho, South Africa, showed that discussions on sexual sexuality education in families and at schools not only reduced the chances of risk-taking sexual behaviors among young people, but reduced rates of unwanted pregnancies and unsafe abortions as well as prevented the contraction of STIs, including HIV/AIDS. Although this author notes that some parents felt obliged to share relevant information on sexuality health concerns with children, the majorities are faced with a dilemma on who should be responsible to take up the challenging task of education at home.

Whereas a study from Zambia by Dloski (2013) points to a lack of dialogue between parents and youths on sexuality issues, a study by Bantebya and colleagues (2013) and Muhanguzi and colleagues (2011), noticed that conversations on sexuality concerns between parents and children were often prompted by unpleasant events such as death, suspicious infection of an STI, pregnancy, or suspicion of being sexually active. Furthermore, Bantebya and colleagues (2013) noted that sex among young people is often clandestine since they are expected to be chaste. In their study on adolescent girls and gender justice in Uganda, these authors concluded that silencing of meaningful discussions about sexuality pose a major threat to young people's health, and that information about sexuality from parents is commonly sketchy and stigmatized.

In addition to that, a study conducted in Sierra Leone by Kathy (2012) in regards to understanding major barriers limiting young people's access to SRH services, revealed that the society's tolerance of transactional sex and abuse of young people by powerful people in authority is a distinct challenge. Kathy further noticed that most adults blame young people for living a materialistic life and become pregnant as a consequence of wanting to keep up with their peers. Counter to this presumption, Herschderfer (2012) noted that young people expressed their dissatisfaction for living in a society where parents turned a blind eye to transactional sex by letting older men exploit the poverty and ignorance of young females; creating a culture where abuse is accepted until the young girl becomes pregnant and then is ostracized and marginalized for her transgression of norms.

### **3.3 Negotiating sexual relations and power disparities**

In a study by Jewkes and colleagues (2009) that aimed at empowering male and female young stars in preventing unwanted pregnancy in South Africa, it was found that the majority of young people, especially young females, had less power to negotiate safer sexual relations. In their study, these authors revealed that age difference and gender norms extending from provision of gifts by male partners to females manipulate economic transactions in exchange for sex were at issue. As Bearinger and colleagues (2007) have noted, compared to males, female youths are far less likely to have negotiating power in the intergenerational relationships with



older men. In return this constrains the young females' agency in sexual encounters as evidenced by Dunkle and colleagues (2007; 2004) in their study on transactional sex among young South African men. With the growing practice of transactional sex, studies from Kenya, South Africa, Cameroon and Nigeria have found that young people, especially females, exchange sex for education-related expenses and as a means of gaining connections in the social networks (e.g. Calves et al., 1996; Barker & Rich, 1992; Kaufman et al., 2001; Meekers & Calves, 1997; Mensch et al., 1998). On the other hand, other qualitative studies conducted in Uganda, Zimbabwe, Ghana and Sierra Leone, suggest that peer pressure to obtain luxurious items, such as expensive clothes, jewelry, designer hairstyles, accessories and makeup, influences young females to engage in transactional sex (see also Ankomah, 1998; Longfield, 2002; Temin et al., 1999; Bledsoe, 1990; Hulton et al., 2000; Nyanzi, 2001; Gregson et al., 2002).

In relation to the above constraint, a study conducted by the Ministry of Health in Kenya (2011) found that gender disparities in sexual relationships among young people are also significant with young females feeling obliged to respond positively to men's sexual demands especially after accepting gifts and other offers of money also when engaging in sex with peers. This report noticed that such an inclination of power dependency may reduce young females' ability to negotiate safer sex from partners, and as a result a majority of young females are unable to prevent pregnancy and indeed many find the manipulation of a same-age boyfriend hardest to resist. Furthermore, studies by (Jewkes, Morrell, & Christofides, 2009) illustrated that condom use depends on a woman's right to demand for its use. In this case insisting on condom use is perceived as a woman's responsibility. Nevertheless in other studies, like the one conducted by (Christofides et al., 2014) among young south African women, power inequities were found to reduce the women's ability to influence protected sex and regard their body and sexuality as a domain over which they should ultimately exert control. There is therefore no assurance that women have the ability to exercise agency in any sexual relationships per se.

The power disparities noticed are reflective of the different perceptions surrounding condom use, from both male and female youths, who insist that condom use is a way to protect against HIV and other STIs while others view condoms as

protective mechanisms only for sex workers. More still, other misperceptions, noted by Amuyunzu-Nyamongo and colleagues (2005), suggested that many young people think sex is more enjoyable without condoms. This endangers many young people's lives in Uganda. It should also be noticed when addressing the issue of power that women and young girls are greatly disgraced by the courts of law when having demonstrated and testified acts of rape and sexual violence committed against them by male perpetrators. Considering the cultural context of African girls, the acts of rape and sexual violence strongly stigmatize and marginalize them more than males. During court proceedings that require victims to provide evidence based on medical examinations, most of the girls including women shun away in fear of shame and embarrassment by the society.

When women fail to provide evidence and illustrate how male perpetrators conducted the rape, or comment on other acts of sexual violence against them, justice cannot prevail. As a result young women's sexual and reproductive health rights are compromised, since they cannot seek legal address from the authorities. Besides in many cases, the perpetrators connive with the victim's parents to withdraw cases of sexual violence and rape against them from the police in exchange for money. This clearly demonstrates the loopholes within the legal framework that have failed to recognize gender equality and equity by taking into considerations the social cultural circumstances and contexts that fail to secure women's, including young females', SRH rights.

While young females are often powerless in negotiating condom use or any other methods of contraception, they also bear the brunt of social condemnation and stigma if they become pregnant, as in Bankole and Malarcher's (2010) study. These scholars noticed that feeling afraid and embarrassed while obtaining contraceptive pills and condoms at the health care centers and clinics was a challenge commonly faced by sexually active youths. Additionally when (Mashamba & Robson, 2002) were conducting a study in Bulawayo district of Zimbabwe they illustrated further that even in places where clinics are spatially accessible, stigma and fear of shame to seek a treatment on an infectious STI, or obtain information in relation to an unwanted pregnancy was almost impossible.

### **3.4 Situation in Uganda**

Due to limited knowledge and information on SRH services, including proper use, as indicated by some data from the above studies, statistical evidence from UDHS (2013) indicate that young people are increasingly engaging in risky sexual practices. According to Nobelius and colleagues (2010), this is shown by prevalence rates of STIs including HIV/AIDS among the 18-24 years (4.3% for females and 2.3% for males) and a high rate of unwanted pregnancies (23 per cent) that end in unsafe abortion. Additionally, studies conducted by Muhangi & Ninsiima, (2011) emphasized Ugandan adolescent youth's own need for sexuality education to be objective, explicit, clear and in-depth, thus enabling them to make their own decisions. Furthermore, young people in schools indicated that such information should be in line with their real life experiences, non-judgmental, non-authoritative and positively framed. Worthy of note here is also Muhangi and Ninsiima's (ibid) emphasis on that the information obtained from health workers is, not only accurate, but that hearing such information from reliable sources builds trust that can contradict ill-informed accounts from peers and the media.

In Bankole and Malarcher's (2010) study, young people in Uganda especially female adolescents, have identified the need for accessing essential reproductive health commodities such as contraceptives to protect themselves from unwanted pregnancies. In line with the unmet need for contraceptives, these authors have noted that some SRH experts have cautioned that, particularly sexually active adolescents need access to appropriate and effective contraceptives to protect themselves against unwanted pregnancy and condoms to prevent STI infectious diseases (Bankole & Malarcher, 2010). This SRH concern for young people was not only revealed in Uganda but also in other studies in sub Saharan African countries (Biddlecom et al., 2007; Erulkar et al., 2005).

A study conducted by Nalwadda and colleagues (2010) on the underutilization of SRH services by young adolescents in Uganda, revealed that perceived misconceptions and social sentiments on most SRH products was found to be a strong barrier for service utilization. This study conducted on persistent fertility rates in

Uganda, discovered that fear and shame among young people to utilize certain SRH services like contraceptives and condoms is related to the pervasiveness of misconceptions and myths surrounding SRH commodities. In a similar study on reproductive health services among young females in sub Saharan Africa, the World Health Organization (2011) observed that a majority of the young people were sharing social sentiments on contraceptive use among which increasing rates of fibroids and infertility for women was among the most common ones. Misconceptions and myths limit young peoples' ability to utilize reproductive health services thus rendering them vulnerable for contracting STIs as well as having to deal with unwanted pregnancies.

As noted in this review of research literature above, most of the sexual and reproductive health challenges faced by young people in the Sub-Saharan African region in general is similar to those faced by male and female youth in Uganda. However, not much qualitative research has been conducted on the age group 18-24 years where most of the youth are crossing from high schools to tertiary institutions and universities. Some gaps have been identified from the existing studies conducted in Uganda such as the involvement of young males in the SRH programs, an area that has not been explored much by researchers, and a strong need for more research on the provision of emergency contraceptive pills, as well as cheap and quality sanitary towels to keep girls in school during their menstruating periods.

### **3. 5 Research contribution**

While most of the studies discussed above have focused on adolescents' needs and barriers to accessing sexual and reproductive health services in the age cohort 10-19, my research will contribute to the existing qualitative literature on young male and female university students' expectations and experiences towards their sexual and reproductive health needs and available services in the age cohort 18-24 years. Besides another reason as to why I am focusing on the 18-24 youth age, is that this is the time when the majority are in a state of confusion characterized with much excitement, exploration of risky sexual practices for several reasons while crossing from high school level to higher learning institutions of education. Especially universities students are expected to be knowledgeable and versatile at this stage and

capable of avoiding negative health outcomes and associated risks of bad sexual activities, and more so than out of school youth or those on lower levels of education.

This research also contributes to knowledge on whether youth in this age group with higher educational status, face different challenges with the sexual and reproductive health services; an area that has not been much explored in Uganda. Furthermore, the literature commonly addresses male and female youths SRH needs and services in a gender-blind fashion, without recognizing the existence of gendered differences among young people. Consequently, there is a need to explore young women's and men's expectations and experiences of SRH services from a gender perspective. This is based on recognition of power disparities and the need to analyze these dynamics as they are faced and experienced by young male and female university students in Kampala, Uganda.

## **CHAPTER 4: RESEARCH METHODOLOGY**

### **4.0 Introduction**

Denzin & Lincoln (2011) claimed that the aim and function of qualitative inquiry is to understand the meaning of human actions by describing the inherent characteristics of social objects and human experiences. Furthermore, Yin (2010) has noted that qualitative research involves studying the meaning of peoples lives under real world conditions to represent the views and perspectives of participants in a study. In addition to that, Silverman (2013) has stressed that qualitative methods have proven to be the most appropriate approaches in exploring the complexity of peoples experiences, their stories and what they do in practice.

The main aim of this study was to explore the extent to which sexual and reproductive health services in Kampala accommodate young people's needs particularly university students, by way of exploring their reproductive health life experiences and expectations, and how HCPs' and parents' perceptions and attitudes influence their accessibility to services. Being exploratory, Creswell (2002) affirms that qualitative methods are more interactive and humanistic in nature thus rendering the researcher an opportunity to interact with participants on an investigated phenomenon.

In order to accomplish my research objectives, I adopted qualitative research techniques to generate data that could not easily be quantifiable using quantitative methods in the field under the phenomenon that was investigated. This chapter therefore highlights the data collection methods, study area, recruitment processes, data analysis, ethical considerations and reflexivity. The choice of methods used during data generation, were made mindful of the research questions as Maxwell (2006) emphasized. In addition, Charmaz (2014) considers qualitative research as the most flexible methodology of data collection which a researcher may opt for new emerging leads in the field. During fieldwork, several methods were used for purposes of data triangulation. I conducted focus group interviews (FGIs) with youth university students, in-depth interviews (IDIs) with youth health care providers at the health

centers where I also did observations, and held individual interviews with some parents.

#### **4.1 Study Area**

The study was conducted in two boroughs of Kampala district, which include Nakawa and Kawempe. Despite having several reproductive health service centers in the country, I concentrated on Reproductive Health Uganda (RHU) and Naguru Teenage Information and Health Center (NTIHC), because these are the most prominent centers for delivering both male and female youth SRH services in the country. Further to that, these centers have knowledgeable and experienced personnel that were resourceful in providing information and materials concerning young people's SRH concerns and who agreed to participate in my study.

Higher institutions of learning were selected to gain access to university youth students of age 18-24 years. Two education institutions selected for this study included Makerere University (MUK) and Makerere University of Business School (MUBS). Makerere University was selected on grounds of my study background and familiarity with the place and is situated within Kawempe borough, within the study area. Makerere University of Business School (MUBS) is located on the outskirts of the city within Nakawa borough and was chosen for comparative reasons. This made it possible to ascertain whether there are differences as to youth's experiences and expectations SRH services in different environments.

#### **4.2 Recruiting and gaining access to informants**

I had to obtain an official letter from the Uganda National Council of Science and Technology (UNCST) as a requirement for any foreign and domestic research. Additionally, I introduced myself with an official letter from the University of Bergen (UoB) to the respective international relations offices at the universities for purposes of authorization and recruitment of study participants in the two universities' compounds. As a requirement, I further sought clearance from Local Area Authorities (LAO) within the divisions/communities where I interacted with parents and community members. I also presented the introduction letter from my study University of Bergen to the human resource managers at the youth health centers as a

way of gaining permission to youth HCPs in charge of SRH youth programs. It was not until I had obtained these permissions that I started approaching study participants.

## **4.2 Research Assistants**

I appointed one male and one female youth from two different universities as research assistants. The male research assistant was identified during the Pre-Youth Family Planning Conference on sexual and reproductive health rights and services (SRHRS), which I attended on 24 July 2014, in Kampala. During this conference, I created rapport with this male youth participant who was a peer educator working with university students in the study area. I kindly requested him to identify and mobilize interested male and female university young students of 18-24 years for my research and setting up interview venues with participants for the scheduled FGIs; a role he accepted.

The second research assistant was my cousin, a 3<sup>rd</sup> year Bachelor's student at Makerere University. Her role was to identify and mobilise female youth participants in a range of 18-24 years at the University and identify a convenient venue for holding interviews with group participants. Since these research assistants were students, sharing similar characteristics like education, age and sex with the participants, it was easier for them to identify and mobilise fellow participants suitable for my study. Sometimes I was able to use convenience sampling to meet some students to recruit for my FGIs, and they responded positively.

Furthermore, I purposively identified key individuals who were experts on both male and female youth SRH services and had hands-on knowledge surrounding the topic I was investigating. Identifying these particular male and female key health care providers (HCPs) within the reproductive health centers dealing with youth friendly SRH services, was made possible with the assistance of the human resource managers (HRMs) who introduced them to me. Parents were identified and accessed through a former female workmate. The parents were included in the study for purposes of exploring their perceptions and attitudes towards youth on SRH concerns.



### **4.3 Data collection methods**

The fieldwork study adopted three primary methods of data generation for purposes of triangulation and analysis. Several authors consider triangulation as a method used by qualitative researchers to check and establish validity in their studies by analyzing a research aim from multiple perspectives (Flick, 2004; Given, 2008; Yin, 2010). Therefore in order to enhance the validity, credibility and trustworthiness of my research findings, I adopted data triangulation to understand the male and female university students' needs as well as their experiences and expectations they have with the SRH services from different perspectives. Since I had employed a voice recorder to elicit opinions in the FGIs and in the IDIs, these recordings were transcribed under the themes of the study and provided a systematic way of identifying the responses in line with the objectives. In this manner I managed to capture the key opinions in verbatim and pick-up the forceful ideas from the rest of the recorded data.

#### **4.3.1. Focus Group Interviews (FGI)**

In line with (Krueger & Casey, 2002; Parker & Tritter, 2006), I opted for focus group interviews with male and female youth due to my full involvement and role in explaining some particular concepts that seemed hard for participants to contemplate. According to Krueger & Casey (2002), during group interviews the interviewer adopts an 'investigative' role by asking questions, controlling the dynamics of group interviews, often engaging in dialogue with specific participants that are assumed to possess knowledge on the investigated theme as compared to focus group discussions where the role of the interviewer is more in the background listening and observing a small number of participants' exchanging views and opinions over a particular issue. However, the interviewer ensures that the group boundaries are kept, and that participants stay on the track, a role I assumed.

Sixteen females and ten male university students aged 18-25 years were selected for FGIs. A pilot test was carried out with six females to test the research guide before scheduling further FGIs. During the pilot focus group interview, salient features such as silence and fear among informants were observed. This implied that nothing much would be yielded in terms of information unless I changed my

interview strategy. Subsequently I realized that students in focus groups needed elaborative explanations on particular SRH questions and reproductive health terms that used to confuse the majority. After noticing this challenge, I tried to soften / rephrase my research questions as much as possible by breaking down any health term that seemed unclear so that every one would understand.

My interest was in capturing male and female university students' group voices in relation to their perceptions, attitudes and their experiences and expectations of SRH services, and thought this would make the youth more relaxed to talk if they were gathered in groups. By using focus group interviews, I was convinced that selecting study participants based on their relevance and relationship to the topic under study would generate real life data/information from an informed point of view as this method was considered cost effective in terms of time invested. This is what makes it unique from a focus group discussion.

During group interviews, projective techniques were used since they allow unstructured and indirect ways of questioning. Ritchie and colleagues (2013) suggests that projective techniques allow the participants to project their covert feelings to third parties while explaining their experiences. For example: "*Do you have a friend who has ever been denied pills/condoms/information in the health centre?*" This meant that instead of questioning participants directly on situations that involved much privacy, I would ask them to refer to a third party. This encouraged participants to share about their underlying reproductive health challenges, needs and experiences more explicitly.

For convenience purposes and gender sensitivity, male and female participants were organised in groups depending on their choice of preference in accordance to sex, thus those who felt comfortable in a mixed focus group were interviewed under one group whereas the ones who wished to be identified with same sex group members were organised in different groups particularly for males and females alone. However, some male and female participants did not have a problem participating in a mixed group. Each group comprised of six participants, as Krueger (2009) has contended that smaller groups are easier to recruit, host and hence more comfortable for participants to share opinions. Furthermore, Morgan (1997) emphasised that, the

separation of groups based on gender is significant if a researcher is to generate varying opinions that circumvent issues of power and inequalities. During the course of the interviews, study participants were encouraged to freely use concepts in local languages to express and stress their opinions and suggestions better.

#### **4.3.2. In-Depth Interviews (IDI)**

According to Creswell (2013) qualitative interviews allow the researcher to conduct face-to-face interviews with study participants using open-ended and follow up questions to explore their experiences. Therefore the face-to-face interviews gave me insight into the health care providers' and parents' perceptions and attitudes towards the SRH concerns of young male and female university students. The in-depth interviews were held with four male youth health experts at the reproductive health centres (RHU and NTIHC). Although I happened to see some young female peer contacts and other female officers at the centres, I hardly interviewed any because all the identified key youth trainers and councillors were unfortunately men for the reasons best known to the health centres.

However, the over representation by male trainers as compared to females did not affect the study findings. This is because the study equally, already had more females, such as the sixteen females as compared to ten male university students of 18-25 years selected for FGIs. Besides, male key youth trainers and councillors also handle female clients; therefore these were able to give representative views and experiences of both males and female (youth) students. This helped my study to explore the extent to which sexual and reproductive health services in Kampala accommodate young people's needs, by way of exploring their reproductive health life experiences and expectations and how HCPs' and parents' perceptions and attitudes influence youth's accessibility to services.

Using data from these different sources, that is to say, trainers and students, differences as to youth's experiences and expectations SRH services in different environments were obtained in detail. Data triangulation to understanding the male and female university students' needs as well as experiences and expectations of SRH services from different perspectives encouraged participants to share about their

underlying SRH needs and experiences towards the SRH services. My interest was in capturing male and female university students' group voices in relation to their perceptions, attitudes and their experiences and expectations of SRH services. Furthermore, youth health experts included the gender/youth coordinator and youth manager working with RHU, head-manager of training and head youth counsellor working with NTIHC.

All the IDIs were conducted and recorded in English. Each interview lasted for approximately from 60 to 90 minutes including the time spent in building rapport. IDIs gave me the opportunity during the discussions to learn more whilst listening and hence probe the informants based on their understanding. Kvale (1996) considers this type of interviewing an effective method in exploring individuals' experiences and opinions through conversations, while the validity and unstructured talks are crucial aspects in research. Because of the organizations' working schedules, I met the identified key health experts only once for a scheduled interview from their work places.

These parents included four females and one male whom I interviewed individually depending on their convenient time and venue. After having been introduced to them by my former workmate and explained to them my research interests, I was able to arrange appointments for interviews successfully. Unlike the health care providers' tight working schedules, some parents gave me an opportunity to meet them often whenever I felt to inquire about anything.

### **4.3.3. Observations**

During my regular visits to the SRH youth health centers, I made some observations that were significant for data triangulation. The permission I obtained from the HRMs at the centers, granted me full access to most of their operations related to youth SRH programs; sexuality education trainings and seminars that were organized within and outside the centers. I managed to carry out observations on three organized sexuality education workshops that were scheduled at Reproductive Health Uganda (RHU). The interactions with some youth peer educators, counselors and other officers, granted me the opportunity to get insight into the theme being investigated. In

addition, I got the opportunity to look at the SRH materials, analyze most of the information on charts that were designed and used, and how they conducted workshops and trainings with the young people.

#### **4.3.4. Secondary Sources**

Government policy documents and programs related to young peoples' SRH service and rights were readily available from the Ministry of Health, Ministry of Gender, Labour and Social Development from the youth department libraries. The information obtained from these sectors included brochures, magazines, charts, documents and reports from UNFPA department for the youth. Significant the materials and information which included socio-demographic statistics were also retrieved from the Uganda Bureau of statistics (UBOS) and the reproductive health centers visited, The secondary sources are used to place the interview data and the other primary sources in the appropriate local context during analysis.

#### **4.4 Challenges to data generation**

Unfortunately the field research was carried out from June-August, when most of the participants were on second semester recess holiday at the University. However, employing research assistants who were tasked to identify particular individuals within their social networks of age, gender and experience, mitigated this challenge. Making appointments with the participants became cumbersome, however, since some students would not come to the group interview on time or even not come at all. I had anticipated this challenge, and had noted their contact information and kept following them up through telephone calls. In certain instances where a few students turned up and I could not form a quorum, I rescheduled the appointments with apologies to those who had made it to the venue.

Obtaining permission from the RHS centers was complicated since the directors of the centers viewed the study more as an audit than an academic study, and thought that the findings of the study would greatly affect their service delivery. However, I presented my official letter from University of Bergen and detailed my research aim and background to the directorate committee of the RHS centers which enabled the building of trust and confidence. They later on granted me permission

with reservations and on the condition that I forwarded a copy of my research final report; which I of course agreed to do.

Identifying parents was more challenging because many seemed to shun away on the theme under investigation. I decided to consult and rely on my former female workmate at the public service (Uganda Management Institute, Kampala) for assistance in identifying parents that was willing to participate; a responsibility she accepted. Most of the parents I talked to seemed busy with no time to offer for the interviews, and besides many were uncomfortable with sharing their views with me on the investigated phenomenon since I am young, have not married and have no children of my own at the moment. They thought I could not understand the dilemmas involved in raising children although some seemed to understand the situation. But, it was not until I consulted this previous workmate, who is a mother to three children (2 boys and a girl) to assist me in identifying parents that parents accepted to participate. Both male and female parents (participants) were not very receptive to the questions I was asking them, especially female parents because of my marital status and gender issues.

#### **4.5 Research Ethics**

Research ethics are complex set of values, standards and institutional guidelines that regulate research. Davies (2008) asserts that an ethically sound research is one that involves obtaining informed consent, guaranteeing confidentiality and anonymity for both the researched and the researcher. This section details the gathering and treatment of information from study participants so as not to cause any harm to them.

Informed consent and anonymity was done according to the Norwegian Social Science Data Services (NSSD) guidelines for ethical research procedures. After sharing my study background and purpose for carrying out the investigation, I obtained informed consent and gained permission from all my participants before conducting interviews with them. The participants were assured confidentiality and privacy by using pseudo names. Similarly they were expected to not share the group information outside our discussion; a promise they vowed to honour. I explained to my study participants why I was specifically interested in their opinions, ideas and

experiences on the investigated phenomenon. The study participants were briefed on their freedom to discontinue the discussion at any point they wished in case one felt uncomfortable. I also spelt out the research objectives and benefits of participation such as to contribute successfully to my completion of the degree and for learning purposes. Their participation was based on personal choice rather than coercion during recruitment. Subsequently, they all consented freely and willingly some by verbal consent particularly parents and young university students, whereas the signing consent was done by the HRMs of the health centres on behalf of the HCPs.

Information obtained from the field was treated with utmost confidentiality. On the informants' side, it was necessary for me to remind them as well on the ethical considerations of keeping shared information amongst themselves, as anonymity to their group members was vital and necessary to be observed. This also applies to the safe storage of field notes and information obtained from the fieldwork as Wax (1980) emphasized.

#### **4.6 Reflexivity and Positionality**

Research by Finlay (2002) illustrated that, in order to increase the integrity and trustworthiness of qualitative research, researchers need to evaluate how inter-subjective elements influence data collection and analysis. Therefore reflexivity operates in a way that enables researchers to engage in explicit, self-aware analysis of their own role in the field that offers one tool for such evaluation. It was upon this self-awareness that as a social researcher in the field, studying abroad with multiple reflections could influence data generation to a certain degree. In spite of the fact that I am a Ugandan, my newly acquired status bore significant implications on my fieldwork process throughout. Access to the National Council for Science and Technology (NCST), a body presumed to issue research permissions, especially for foreign researchers, became an uphill task. But later on after having cross-examined my objectives, I was given a "green light"; though it had consumed more time than I expected.

Based on my previous education background, data generation at the University seemed obvious given the fact that I was a former student at the undergraduate

studies. But during inquiries I felt like a total stranger to a place I once belonged. The red tape bureaucratic processes characterised by missed appointments to meet with the officials concerned with endorsing my research became a common occurrence at the international public relations office. Unlike in the affluent countries where appointments are honoured, I was sent back and forth and it became a “goose-chase” in futility. It was not until I met an officer in the Senate building at Makerere University whom I narrated my ordeal to, and who advised me to go ahead with my research after looking at my introductory letter satisfactorily. I followed his advice and successfully conducted my FGI’s on campus as I waited for the official authorisation from the officers in charge.

Based on my previous background as Makerere alumnae, I felt that associating with university youth would enable me to build trust and confidence because of similar related characteristics and interests that we shared such as old university hall slogans, jargons, age brackets, and gender. Nevertheless, at certain points I had to use my female research assistant to rephrase specific gender questions for females. Their positive response can also be attributed to many expectations in terms of networking and allowances among others. Additionally, I visited Naguru Teenage Information Health Centre (NTIHC) and Reproductive Health Uganda (RHU), which are prominent youth SRH centres in Kampala and Uganda as a whole where I was received with a warm reception. Perhaps this was due to the fact that my research was investigating a phenomenon that was part of the centres’ missions. I was given time to introduce my research objectives and spelt out the ethical consideration in order of priority, which further secured my status as an academic researcher.

#### **4.7 Data Analysis**

Scholars such as Hsieh & Shannon (2005), Zhang & Wildemuth (2009) have defined content analysis as a research method for the subjective interpretation of the content of the text data, through the systematic classification process of coding and identifying themes or patterns. However Holsti (1969) argued that the use of latent content analysis makes it a complimentary qualitative process, which refers to not only coding and identifying of patterns but to the interpretation of content. It should be noted here that I carefully went through the descriptive responses given by



participants to each question in order to understand the meaning they communicated. From these responses I later developed broad themes to reflect these meanings encompassing the fact that participants sometimes used different words and language to express themselves. It was important to select the wording of the themes in a way that precisely represented the meaning of the responses categorized under the research objective. These themes became the basis for analysing the text of all the interviews (FGI and IDI).

It was also critical to allocate codes to the main themes to count the number of times a theme had occurred in the different interviews. Following this kind of arrangement, I selected a few responses to an open-ended question and identified the main theme. In the same way I continued to identify other themes that emerged prominently from the same question till a saturation point was reached. These themes were assigned codes by using key words. Responses were clarified under the main themes and having identified the themes, the next step was to go through the transcripts of all the interviews and clarifying the responses under the different themes.

This was done to maintain coherence in data findings and build each theme based on the depth of responses obtained. Having identified responses that fall within the different themes, responses were integrated into the text of the thesis while discussing the results that emerged from the study. More so, verbatim responses were employed to keep the individual feel of the response itself. There were other themes that frequently emerged in the process of analysis, which would necessitate the researcher to provide a sample of the response in order to emphasize a given argument. The above methodology helped me to achieve the set objectives for my study, rather successfully.

## **CHAPTER 5: YOUTHS' EXPERIENCES AND EXPECTATIONS OF THE YSRHS: NEEDS AND BARRIERS TO SERVICES**

### **5.0 Introduction**

Drawing on focus group interviews (FGIs) with male and female university students aged 18-24 years, this chapter represents the voices of young people towards their SRH needs in relation to their experiences and expectations of access, including barriers to these services. The chapter is presented on the following subthemes; Male and female youth's expectations and experiences of YSRH services, the first A: "Availability" of services and commodities, the second A: "Accessibility" of accurate SRH information, the third A: "Acceptability" of service delivery, Provision of "Quality" health care services and commodities, Barriers to accessing and utilizing SRH services, and discussion: AAAQ.

### **5.1 Male and female youth's expectations and experiences of YSRHS**

As data from the FGIs indicate, there are distinct differences in the level of understanding between male and female youth when it comes to interpreting their SRH needs and accessing services. When I asked the young students in a mixed FGI, which comprised of both males and females, about how they expected these SRHS to be delivered, a majority of the five out of the six participants in this mixed group shared similar views, as represented by the selected voices below:

*Shame: Those are the services keen to cater for our sexuality lives! I expect them to be served in confidential and in private settings to avoid linkage to our parents! I also think that such services shouldn't be discriminative. Meaning they cater more for the girls and less attention is offered to the males which I have seen in most health service centres in my locality. (Female student aged 20).*

*Sarah: I think such SRH services have to be about condom usage, family planning and pregnancy related issues. I also expect such services to include a package of issuing free products like condoms, sanitary towels, HIV counselling, testing and treatment services because we need them more than any one. (Female student aged 23).*

*Ben: You guys you seem to be forgetting about sex education because many of us don't exactly know how to use condoms very well so I guess sexuality education is equally important and part of the SRH services (Male student aged 22).*

Given the above contributions from some young people, both male and female youth seem to encompass their expectations to SRH services as including sexuality education, family planning methods including condom use, HIV testing, counselling and treatment among others. Similarly this perceived notion of SRH understanding was shared by several participants in other separate FGIs that reflect a positive level of understanding among the youth. However, the female students in a separate FGI went ahead to anticipate that regardless of gender and sex, they expected such SRH services to encompass youths living with disabilities since such people hardly express their special needs because of their disabilities in societies. On the other hand, the males in a separate FGI, their expectations of the SRHS did not vary much from those earlier echoed by youth in the mixed FGI as presented above.

## **5.2 The first A: “Availability” of services and commodities**

During focus group interviews with both male and female university students, the concern and need for separate youth-friendly sexual and reproductive health corners with adequate materials and services were frequently raised. When I asked male and female participants in a mixed FGI to elaborate on the ideal situation of the existing RH services, and what would work for them, the views below reflect the concerns of most of them:

*Bryan: There are fewer RH centres administering YFRH services in our region! Unfortunately, these centres cater for the adult RH concerns including longer waiting hours in queues! Imagine you're examined in front of people who are you're your parents' age! (Male student aged 22).*

*Jessica: I have a similar concern on our female needs! Sanitary towels are expensive and cheaper ones are of poor quality, they burn and become unbearable, yet at this age you fear to ask from your own parents! (Female student aged 21).*

*Rachael: That's true especially to us who are living with single parents like fathers where you can hardly mention such needs. (Female student aged 24)*

Given the above contributions from some university students as stated above, majority from other FGIs attested to the fact that they are fewer designated health facilities within reachable distance. Especially the voices of young people from Nakawa region indicated this concern because at least the students from Makerere University have an option of a university hospital though it is not properly gender mainstreamed according to the voices of some youth students. To compound on this health concern, the availability of youth friendly reproductive health corners with adequate resources within workable distances around the university settings is still a challenge. Additionally the voices of many female students affirmed that they are unhappy with the quality of RH commodities supplied at the few available health centres.

When I asked female participants in a female FGI to elaborate on the ideal situation concerning emergency contraceptive pills (ECPs), whether contraceptives are available at health centres and surrounding clinics and how such needs are sought for precautionary measures of preventing unwanted pregnancies, and what would work for them, majority elaborated on this issue as illustrated below:

*Phionah: Many times we (girls) are coerced into sexual acts by boy friends and other men! This always happens when maybe you have just gone to visit your boyfriend at home, drinking alcohol or as a result of persuasive language men use with attached benefits! By the time you realize, this man has sexually used you and you're not sure whether he used a condom or not! As you try to access such pills, most of the health facilities don't have them and those with such pills hardly issue them! (Female student aged 23).*

*Marry: I think it's the HCPs who deny giving out such products to you! And besides you fear to exactly ask for them when you reach to the health centre in fear of intimidation and shame! Immediately you tell a health care worker to give you those tablets, he/she becomes inquisitive as to how you have ended up having sex and asking you other embarrassing questions which makes you shy away and leave the centre altogether! (Female student aged 24).*

*Hadijja: I stay in the hostel in Kikoni, but I observe all most every girl struggling to have contraceptive pills with her! This is not because everyone is into sex but you never know because fun is fun and comes at a cost sometimes! In spite of this being our major concern, you have to find a strong excuse for obtaining the pills from the health centres of which sometimes you buy them at night covering your face! You're not even sure about whether these pills work or not because some girls get complications with them! (Female students aged 22).*

From the contributions obtained from the above female university students, many seem to find challenges with accessing their major concerns particularly ECPs *postinor-2*, in case your in a dilemma after unsafe sex. Access to health care services is a necessity to all human beings as emphasised by the world health organization in the second 'A' of the health provision frame work discussed in chapter two of the thesis. According to the findings as reflected above from female students in FGIs, ECPs like *Postinor-2* were so popular among the youth and yet they are not readily accessed due to limited provision/availability. However, the male students did not agree *per se* that contraceptives are hardly accessed by females, because as some stated that selling pills on the open market has become a hot cake for clinics and other health centres due to their demands by both young and adults.

It was later understood, that failure to easily access to ECPs like *Postinor-2* is not only limited by lack of availability in the health corners, such as health centres, pharmacies and health clinics, but also by lack of finances to buy the drugs. This was noted from one student, who was asked what limits her accessibility of ECPs like *Postinor-2*, where she remarked as follows:

*Hadijja: Although ECPs like Postinor-2 are now available in many clinics and pharmacies, they sold at expensive prices and some of us can not afford to buy them...they may be accessed in government health facilities such as health centres we are also discouraged by the long cues of clients in need of similar or related reproductive health services. Sometimes, the health workers will write or prescribe and refer you to a health clinic or pharmacy to buy the same items buy we don't have the money to buy them... (Female students aged 22).*

This implied that many students fail to access ECPs not only because lack of availability, but also due to lack of money to buy them. The effective and full involvement of male and female youth at different levels during designing, implementation and evaluation of SRH programs emerged as an important need for both the male and female students participating in the FGIs. When I asked male and female university students suggest possible ways on how they would wish to contribute towards effective distribution of SRH service delivery of their needs and what works out for them, both males and females expressed their expectations as follows:

*Tom: The existing campaigns and programs focus mostly on girls with less interest on males' SRH concerns; we need to be given priority in SRH programs as well! There is a need for equity and equality what makes those HCPs think that girls need to be involved in much SRH programs more than boys if we face almost the same challenges! For instance, 'Educate a girl and educate a nation', this implies that we are less relevant but remember we stay with these girls! (Male student aged 22).*

*Teddy: We need to get involved in our own SRH programs, which HCPs claim that are designed for us! It hurts to see only adults and older people seated in youth's conferences addressing our SRH concerns instead of young representatives who share similar experiences and challenges like us! We have distinctive needs as boys and have totally different challenges than adults! (Male student aged 19).*

*Nabatanzi: Thanks (Teddy), there is no point coming up with a reproductive health program addressing female issues or boys issues but pioneered by an adult your fathers' or mothers' age! We perceive such programs being authoritative and suitable for adults for example condom adverts with married couples, images and posters with family planning programs targeting married adults! (Male student? aged 21).*

Both male and female university students emphasized the need for full involvement into the YFSRH existing programs as the best way to attract others for service utilization, and as platform to voice out young peoples' needs from their own experiences with the situations many are undergoing. Regardless of gender, all young

stars pointed to this concern of getting more involved with knowledgeable youth representatives at all levels to eliminate the gender blindness that might seem to appear in the already designed programs.

### **5.3 The second A: “Accessibility” to accurate SRH information**

University students both male and female had concerns about accessing and obtaining RH information to be able to manage their SRH needs, especially in relation to STIs and unwanted pregnancies that might end in unsafe abortions. The United Nations (1995) has emphasised that complete SRH information covers a wide variety of sexual and reproductive health topics ranging from information on gender relations and equality to responsible sexual behaviour and the prevention of STIs including HIV/AIDS. This right to accessing complete and accurate information on SRHS is a fundamental right for young people as enshrined in the convention on the rights of the child and the commitments made at the ICPD meetings (1994, 2009, 2012). Most participants’ male and female alike raised this need for accurate and comprehensive knowledge from valid sources. Below are some excerpts from different interviews of FDIs:

*Moses: You can find yourself in a health compromising situation to deal with an infectious STI! When you try to administer treatment based on your knowledge you risk worsening the situation! When we’re taught about existing STIs in schools, we’re only limited to HIV/AIDS, gonorrhoea and syphilis, yet they’re various infectious diseases affecting our health especially on your private parts! Remember that not all of us are bold enough to seek advice because it’s a shame somehow!’ (Male student aged 24).*

*Peter: I agree with what my colleague says! In reality one of my friends nearly lost his girlfriend in the process of inducing an abortion! This guy was convinced that some funny local herbs and tealeaves could help to induce an abortion since we wanted matters to remain secret! In due course the girl bled almost to death! But remember that we acquire this superficial knowledge from friends and other guys! This girl nearly lost her life because when the herbs reacted, she was abandoned in her room in fear of the consequences. (Male student aged 21).*

*Shamim: That's true, in most cases I have seen friends ending up in trouble after following superficial information on RH concerns! Even using a condom is alone a challenge...I have seen friends getting pregnant yet claim to have used condoms! One of my girlfriends in second year was misled to enjoy sex in what we consider as "safe days" and she ended up getting pregnant! I'm sure a majority of youth experience this kind of challenges! (Female student aged 20).*

From these discussions held with young people, it can be concluded that both male and female youth expect accessibility to essential comprehensive sexual education on managing UTIs, STIs including HIV, proper prevention of unwanted pregnancy, and in case it happens, they need knowledge on how to acquire treatment. Many young females have lost their lives after inducing abortions due complications and lack of post abortion treatment and care.

The concept of accessibility was not only limited to tangible services but also SRH information that was distributed through various means. When I asked these university students, how information related to their sexuality education and knowledge about reproductive health services were obtained, both male and female youth attested to the fact that mass media has contributed significantly to information distribution. This was elaborated further in the discussion that took place in the mixed FGI as illustrated below from different students:

*Moses: We fear parents and are also too shy to ask health workers but however if you want to find out what you want you can watch pornographic movies and many times some TV stations broadcast erotic love stories where most of these things are included! (Male student aged 23).*

*Sheila: But not everyone watches porn! I remember teachers used to tell us a bit about our reproductive health during biology classes at schools and in strait talk newspapers were experiences of adolescent's sexuality life styles is published. (Female student aged 23).*

*Jackie: To some extent I agree with (Moses), you can purchase any porn movie and magazine from the street vendors or gazetted newspapers like Red paper were you*



*normally find interesting sex stories and nude pictures! And still I hear my elder sister listening to a night radio talk program for lovers so I listen attentively (Female student aged 21).*

*Sheila: At times you can ask the house caretakers, especially the women at home! Even if you need information on abortion or treatment for a STI, these ladies, since they're mature they know a lot of things! You can also try out clinics far from your area of residence where you won't be noticed about your whereabouts!*

*Anne: 'But you guys sometimes they are education workshops organised at health centres on sexuality education I often see some youths going over (Female student aged 24).*

*Robert: How many do you think have time and resources to facilitate themselves in workshops on sexuality education unless they're giving out allowances as attractions for participation? I accept the fact that majority of us are influenced by friends (Male student aged 23).*

In the normal social settings, male and female live together and learn from one another. However, while information concerning SRH services and knowledge about sexuality issues commonly prioritizes females, as noted by the male participants above, the result might be that males might prejudice the SRH information which they do not have access to (which I will return to in chapters 7). In most communities that are still patriarchal, girls, including women, depend greatly on the males / men for decision-making. Empowering a girl without involving males might compromise the effect of the designed programs. This is observed from the existing sexual and reproductive health programs for females which are based on 'girl child education', 'educate a girl, educate a nation', and 'let a girl be a girl' among others, to enhance the knowledge flow to all and as a means of equipping young girls with the necessary sexual and reproductive health skills because they are considered more vulnerable than boys in sexual relations. When the males are not supported, sensitized and recognised as change agents in the process in SRH service programs, progress on these issues might be hampered.

## 5.4 The third A: “Acceptability” of service delivery

Skilled peer educators and trainers at youth health corners were cited during the FGIs with male and female students as a centre of attracting majority of young people to SRH service utilization and making them comfortable to share their private SRH needs and experiences as illustrated from their voices below:

*Peter: You feel encouraged to disclose your secrets to someone who is not much older than you! Just imagine you have an infection in your private parts, how would you feel to be examined by an adult almost your parents' age! In such circumstances where this health staff is older or perhaps is a female, you can feel shame and rather walk away with confidence that you will be fine! (Male student aged 19).*

*Ivan: You see when you find a peer educator who is almost your age and the same sex, you're prompted to discuss at length and share your experience because you assume that this guy understands your situation! Besides they are not so serious and tough on you compared to adults (Male student aged 22).*

*Joan: I agree with what these guys are saying! Many times you happen to seek advice on a serious health challenge such as abortion or having a STI disease, you feel the need for treatment but feel shy and shameful to tell an older person who will probe you more (Female student aged 20).*

With designated RH corners young people are enabled to seek related health materials with more confidence. Their desire was to obtain RH services from designated youth corners, administered by trained youth health personnel. Recognizing the much-needed essential SRH commodities among young people, youth corners should also be stocked with adequate materials to avoid disappointments. Based on the above views and experiences of both male and female students, there is a need to recognise the pathways to SRH service which might circumvent the health clinics. There is also a need for skilled health personnel to that can execute deliver services in a flexible and youth-friendly manner. This calls for the training of both state and peer health providers to fill this gap. For example, during an interview with the head youth counsellor at Naguru Teenage Health and Information Health Centre (NTIHC) it was

revealed that communication and assistance was given by way of phone call services with the use of toll free lines across all networks to offer counselling, guidance and information services to the hard to reach youths. However in terms of availability, accessibility and acceptability of SRH services for young people, different challenges were taken note of.

### **5.5 Provision of “Quality” health care services and commodities**

The need for provision of quality health care services and commodities from health centres including clinics and drug shops was frequently mentioned as a major concern for both male and female university students during interviews held with them. When I asked young people to share their experience with and explain what they meant by need for quality health care services and products in relation to their expectations of available services, many explained as follows:

*Sam: You get disappointed with the number of patients lining up for a similar service from one health care staff! The fact that this one staff is seeing many clients he/she starts talking badly and if you're not patient enough you might give up! Sometimes if you need proper guidance, you have to sit and wait for longer hours until the doctor comes although not all in health centres! (Male student aged 23).*

*Shame: I am so disappointed with the quality of sanitary towels that are found on the open market! I will not say that all, of course the good ones are quite expensive for which majority can't afford! Here am talking about the normal ones which seem affordable, they are burning and make you feel unease! How I wish those responsible for dumping such poor products could be held accountable! (Female student aged 20)*

*Joseph: Thank you shame, in relation to a similarly issue, I don't know whether some guys here have experienced scenarios with bad condoms that burst so easily! And these are the mostly supplied ones on the market and easily accessed on open markets! And remember it is very hard to walk out of pleasure and go out looking for extra condoms! They're good ones however, but extremely expensive! (Male student aged 24).*

*Josephine: The same applies to some family planning methods particularly contraceptives pills! You can buy pills expecting that they're working well yet expired or elicit on the market! With evidence I saw a girl who suffered consequences of fake pills until she died after some time! I wonder why such commodities are administered on the market! (Female student aged 23).*

Based on the above voices from young university students, it can be observed that the quality of some SRH services and commodities are unpleasant to the majority an issue contradicting with the human rights basis for professionalism as earlier discussed in chapter two of the thesis. When health services and commodities are doubted as these young people were heard saying, this compromises not only on the service utilization but also on the bodily health of individuals. This leads to unacceptability of services in a long run with other factors together.

#### *5.5.1. Uniqueness of the SRH needs by age and gender*

In a same sex FGI by male and female university students, youth highlighted a need for differentiated SRH services based on their age and gender for some particular reasons as some detailed below.

*Maculate: Our RH needs are quite different from those of males! As I'm agitating for sanitary towels to be given out free, a male is urging for condoms with nice scents and so forth! Even with gender our services are different! Take an example of the young people with disabilities or lesbians or sex workers or homosexuals! We have different SRH needs so you can't assume that our packages should bare similar characteristics! (Female student aged 23).*

*Joy: Yes I think I agree with Maculate, I personally I was born with HIV! I'm always seeking special treatment for my virus! I'm happy that I come out to speak loud on this but many hardly believe me especially men and other male friends! So my SRH needs and many out there are quite different and we are challenged with different SRH services! (Female student aged 24).*

It can be noticed from the above contributions although not many commented from the FGI where this response was given that, young peoples' SRH interests and needs

vary accordingly thus not a vertical scale as majority might assume. To compound on this issue further, young persons are diverse, thus the needs of a 10-15, 16-18 year olds might be distinctively different from those of 19-24 years as well. However, this distinctive variation might depend on the status of education, society of residence and on challenges encountered in the ideal life. University students for this matter might be experiencing same challenges as faced by other youths in different environments, but in a different way which later on changes their perceptions, experiences and expectations towards most SRH services and needs.

## **5.6 Barriers to accessing and utilizing the SRH services**

The challenges faced by young people in accessing the SRH services, including information range from are multifaceted. Male and female university students are faced with several distinctive factors that limit them from proper usage and access to RH services. Therefore this section presents youths' experiences with the RH services including sexuality information in terms of the barriers they encounter.

### *5.6.1. Limited number of RH centers and shortage of RH materials*

Young people, both male and female students, identified a challenge of having limited SRH centers in their communities or youth corners close to where they spend their days; as to the participants in this study in the University. This challenge was identified as one of the major limitations to accessing and utilizing services. During focus group interviews participants also noted the shortage of RH commodities as a challenge to actual utilization of services:

*Nathan: With the few available and existing RH centres there is a constant shortage of RH commodities! I remember a time when my friends and I visited a certain RH centre to obtain condoms and they weren't available many times! You know that it requires braveness to walk into a drug/clinic shop to ask for a condom! If you miss out on it the first time, then you lose your moral. (Male student aged 19).*

*Maculate: Some centres are less facilitated with necessary products! Take an example of our university hospital it has less equipment! If you require better quality health care services you need to go to the private health care centres that are expensive! Within our settings you hardly find facilities; that becomes a challenge to us*

*especially girls! Female condoms are also very scarce, you can only hear information about it but it is not available in health care centres. (Female student aged 20).*

*Moses: You can't imagine that I grew up knowing only RHU and NTIHC as the only youth health care centres offering RH services for the young people! But other than that the rest are shared clinics and drug shops where you don't expect a full package of services! (Male student aged 22).*

Both male and female representational voices from discussions pointed to the fact that whereas there is two major prominent reproductive health centres in the whole region of Kampala, majority's SRH concerns cannot be accommodated from only these centres. Almost half of the population in Kampala is comprised of the young generation, in and out of school, adolescents and youths, thus with such huge numbers of clients, service delivery has to be compromised in terms of resources and management.

#### *5.6.2. Uninformed sexual choices / social media and peer influence*

Young people are continuously faced with a challenge of ill-informed sexual choices some emanating from the media and peer influence. Young people, both male and female students, attested to this fact that some media information continues to avail people with nude pictures and sex stories that misguide them. In their voices, this is how participants commented on the media and information acquired from peers:

*Jane: I have always observed most of my friends when we're heading to school in the morning standing on streets to peruse through nude pictures of prominent people in the country including sex stories which attract them to read! On the other hand you can access any porn movie from street vendors in town since they display them on streets and in corridors without hassles! Imagine the kind of image depicted from such pictures! (Female student aged 20).*

*Marry: Yes that is true! I have also observed that most television stations apart from the Christian TVs and radio channels, today are more of broadcasting uncensored movies without minding about the parental guidance of the scenes and including*

*video songs that are full of seductive sexual scenes that influence our attitudes and behaviour! (Female student aged 20).*

*Peter: That wouldn't be a big issue guys, but media presenters who are perceived as role models to many sometimes they make ill-informed statements on RH matters let's say on manhood, becoming infertile, avoiding pregnancy without condoms, among others! (Male student aged 24).*

*John: Sometimes you take a wrong choice on a certain action based on your friends experience and information! I remember one day when my friend convinced me that sex with a virgin girl has no significant consequences since she hasn't slept with anyone! I did that at the first time but later on I realized that I was stupid when this girl spent almost a month plus without having her period! (Male student aged 21).*

As shown above, some participants admitted that ill-informed sexual choices are affecting most young people. The nude and sexualized images pervading the [social] media (e.g. Television, music videos, the Internet, and others), are increasingly more explicit in sexual content, whereby more than half of all television shows in Uganda contain sexual content averaging more than three scenes with sex per hour. With such shows with sexual content, a few might include possible risks of sexual activity or any reference to contraception, protection or safer sex. This challenge might also be attributed to lack of adequate information that later on compromises their sexual and reproductive health attitudes for both male and female youth. On the other hand, although media images of sex and sexuality may be socially perceived to bare negative influence on youth sexual decision-making, there is a considerable potential for the use of media in conveying messages about responsible sexual behavior.

### *5.6.3. Stigmatization, shame and judgement*

Young people experience fear of being shamed and stigmatized by their families and the community, including the clinical staff at health centres when seeking SRH services. Young females feel more ashamed to ask for contraceptives, such as pills and condoms as compared to males. Over this challenge to accessing needful RH services and commodities in confidentiality, one female student said during a FGI:

*Jane: I don't trust most of the clinical staff due to the fact that immediately you obtain contraceptives or condoms or test for any STI from the centre; you risk this information falling into the hands of your guardians! If not, some have a tendency of questioning you in a rude way as if you're the first one to utilize such services! You feel shame and guilt when you tell this health worker that you might be pregnant and she blames you for being irresponsible and is asking you why it happened! If the health care centre is within your community they will tell your parents how promiscuous and sexually active you are! (Female student aged 21).*

Furthermore, in another FGI the female youth participants admitted facing stigma and shyness from health care providers as elaborated below:

*Stella: When you ask for protection from a drug shop, the shop attendant stares at you like a murderer. If you're not bold enough, you run away! (Female student aged 23).*

*Josephine: Leave alone that, but you can't imagine asking for condoms even if they were distributed for free during sexuality workshops. Your fellow peers look at you with this attitude that you are promiscuous or sexually active, which makes you shy (Female student aged 21).*

*Mary: It takes a lot of confidence and self-esteem to walk into a shop/clinic to ask for a male condom. Even if they are distributed for free at the university hospital you feel ashamed to ask for them! Even your fellow female students' look at you in a bad way; yet everyone needs them (Female student aged 18).*

Together with lack of confidentiality, shame was identified as a major impediment in accessing reproductive health services and commodities. As observed in the two youth health centres, condoms, contraceptive pills and other SRH services are available. However, gaining the courage and confidence to gain access to these services requires a lot of boldness, especially for females. Hence, the shame and stigma involved in obtaining male (or female) condoms is unbearable; by marshalling the confidence to walk into pharmacies or drug shops or even when distributed around university halls or student residences, becomes too difficult. When I probed further as



to how they face discrimination while seeking SRH commodities, one female youth participant in a same-sex focus group interview explained:

*Sarah: When you visit a drug shop/clinic you're subjected to embarrassing questions as to why you need condoms or pills! I remember one day I was even denied a pregnancy test kit as I was examined heavily on why I needed it, moreover loudly in public and everyone in the queue, including older people, were staring at me! I had to run away and opt for other means (Female student aged 21).*

Noteworthy here is a study conducted by Patton and colleagues (2009) where it was noticed that factors that are unwelcoming or hostile to young people, especially females, involving mandatory spousal or parental consent further alienate these girls from access to SRH services. Data generated from HCPs' and female youths has proved that majority of young people seeking SRH services might be subjected to discriminatory behaviors and intimidation from health care professionals. Further still, youths may be reluctant to seek SRH services where extensive physical examination is required. Remember that during SRH service delivery, privacy and confidentiality are key principles to young peoples' secret lives and SRH needs. It is therefore important to note here that services cannot be considered youth-friendly if the young people are underutilizing them due to discrimination.

Still the majority of youth in my study attested to the fact that they are treated with contempt during visits at the health clinics and centres. This was attributed to the negative attitudes and perceptions held by some health workers that young people are not considered as potential clients for certain SRH products and services, as this was addressed by one female student as follows:

*Sheba: Many times we are denied certain reproductive health services like condoms, contraceptive pills and sexuality information with an attitude that we shall get spoilt! In cases where some health personnel open up, they also give us inadequate details. (Female student aged 20).*

Freedom and full rights to access reproductive health services, including positive attitudes and proper education will encourage both male and female youth to freely

utilize services that might eventually curb the rate of unwanted pregnancy, STIs and HIV infections.

#### *5.6.4. Economic factors such as high costs for RH services and products*

The female participants observed with concern that essential reproductive health commodities (ERHCs) such as sanitary towels are expensive to acquire, especially the quality ones. Even the contraceptives that are recommended by doctors are expensive. In one focus group interview with some female participants, they stated as follows:

*Jackie: We have a need for good quality products such as sanitary towels and pills that can be trusted! Some of these products are not good and always sold on the market! The good ones are so expensive that unless you're financially stable or from good families, you can't afford them! So this is a major RH concern for us girls! (Female student aged 23).*

*Peter: I don't know whether other members here will agree with me or not but we have a need for quality condoms! You can get shocked that the condoms distributed to youths for free are not durable! That's why you see that the ones in pharmacies are so expensive meaning that they are of high quality! (Male student aged 24).*

As noticed from some voices of young students, majority are challenged with the costs of services and commodities. Whereas majority come from poor families and some are breadwinners by their own, high costs attached on health services such as consultation fees, counselling and testing including costs for affording commodities hamper their ability to continuously obtain a service. Not every everyone can afford the prices as observed from the interviews.

A majority of the young people attested to the fact that they have limited resources to sustain themselves with the basic necessities. This was almost every ones' concern both male and female youth:

*Maddie: Most of us come from poor backgrounds, so if your parents can afford tuition you don't expect them to cater for your SRH needs as they think that you can do away with them! So in cases where you acquire a serious STI, treatment becomes a challenge because you can't afford payments! (Male student aged 24).*

*Jane: what my friends are saying is true but you realize that we have a need for health clinics to subsidize the costs of treatment and testing for some diseases in hospitals! This challenge affects our purchasing power for RH products as well! Take an example of ECPs, especially for girls. (Female student aged 21).*

*Josephine: At times when you lack resources to procure your basic necessities like food, health materials like sanitary towels and contraceptives you think negatively, especially girls! Imagine running out of sanitary towels, let alone other things! You improvise with other health compromising products like cloths and toilet tissues! That's why sometimes we rely on boyfriends for such benefits, even older men. We don't want to have relationships with older men but because of limited resources we do! If you manage to find cheap sanitary towels they are burning and when it comes to avoiding pregnancy you can't afford emergency contraceptive pills or testing kits due to unaffordable costs and this is an issue you hardly disclose to a parent! (Female student aged 23).*

*Rachael: My concern is if condoms can be obtained freely at health centres, and sanitary towels cost almost the same price, why can't also female condoms and sanitary towels be given out for free of charge? You guys, we girls suffer more than boys in terms of accessing essential reproductive health commodities. (Female student aged 18).*

Unlike government hospitals, in private health centers including drug shops and clinics, reproductive health services are obtained at a high costs making it difficult for majority of young people to afford these services. This includes SRH commodities like sanitary towels, quality male and female condoms, emergency contraceptive pills and pregnancy test kits. Affordability of SRH services is a great challenge to young people's SRH lives. Parents and guardians do not necessarily understand this, and do not intervene financially. It was noticed that young people not only faced high costs on SRH commodities but also on SRH services such as testing and treating of STIs including HIV. From these young people's perspectives, they lacked funds to afford such vital services. The reproductive health workers at Reproductive Health Uganda

(RHU) and Naguru Teenage Information & Health Centre (NTIHC) reiterated this same concern.

#### *5.6.5. Perceived misconceptions and social sentiments*

The perceived misconceptions formed around the SRH services, especially on the effect of male circumcision and commodities like ECPs greatly affected young peoples' ability and interest in utilizing such services efficiently. When I asked these youths to elaborate on how they perceived these services, and probed on how their perceived misconceptions influenced their level of acceptance and utilization for the reproductive services they had challenges with, both male and female students stated as follows:

*Jane: I have grown up thinking that contraceptives cause infertility and barrenness to women! By the time you wish to have a child it's impossible because they destroy your fallopian tubes; that's what I hear from colleagues and other people at least! (Female student aged 23).*

*Teddy: I have a friend who died after a constant use of pills! I guess they prescribed to her wrong descriptions! She started slowly by slowly to complain about stomach ache then later on it was discovered that she had started developing fibroids in her womb! Her body started swelling, changing colour until eventually she died! I can't advise any girl to use family planning methods. (Male student aged 21).*

*Brain: I agree with these girls! Condoms reduce sexual pleasure and also increase chances of promiscuity among partners since honesty is not emphasised! How? Because if I know that I'm having one sexual partner why would I use condoms? (Male student aged 20).*

*Teddy: Although I don't agree with Brain that condoms increase promiscuity! I think that the female condoms were brought for sex workers not for couples and lovers! They are ugly and require long procedures of usage that's why I think also girls resist using them!*

*Marry: For me I think we are still young to start utilizing such SRH commodities and services! I have grown up knowing that family planning health care services are ideally designed for adults and married people! I think that's why we hardly find a positive attitude towards them! Even the HCPs I guess that's why they find it challenging to administer comprehensive information on them to us! (Female student aged 23).*

*Tom: Is it true that when you're circumcised you can't get infected with HIV or any other STI? Because I hear from most of my friends saying that as long as you are circumcised you can't contract HIV! (Male student aged 23).*

Evidenced from the above voices of male and female university students in a mixed sex FGI, it can be noticed that majority's perceptions towards particular health care services and commodities affects their ability to utilize particular services however much they have access. Whenever the health care services and goods are doubted of their likely effects, clients will hardly accept to utilize them. The social sentiments and misconceptions held by some youths directly influence their ability to continuously seek and utilize *available* commodities and services on market. This concern was highlighted in the AAAQ health provision framework as suggested by the world health organization's human rights perspective. However, majority of youths' perceptions and knowledge stemmed mainly from their friends and people they normally relate with. This implies that a lot of sensitization from informed HCPs is still needed continuously. If most males perceive male circumcision to be a preventive method for HIV/AIDs, this might be a huge risk that adds to girls' vulnerability relative to boys concerning the spread of the virus. Considerations for re-packaging the messages concerning this issue might be relevant especially if addressing young males and men to avoid misinterpretation. Much sensitization on female condoms and awareness might be relevant if such misconceptions are to be broken (e.g. these female condoms were originally designed for sex workers).

## **5.7 Concluding Discussion**

The findings presented in this chapter speak to the rights-based AAAQ framework to assess the provision of health care services in maternal health and general reproductive health services. This framework illustrates that health care products and

services must be available for utilization, accessible in terms of physical and non-physical structures, designed in an acceptable manner for the target group of clients, appropriate and of good quality.

The SRH needs of young people are unique and diverse despite sharing some characteristics. It has been noticed from the above interviews with male and female students that, despite the availability of some health care services, the level of acceptability for such services and commodities on the side of young people may be a challenge. This could partly be attributed to the quality in relation to service delivery and utilization, and also the pathways created to access different SRH services including privacy and confidentiality matters. In this study, unprofessionalism in service delivery by health workers in handling young people was still a big challenge.

Accessibility of RHS by some university students in Kampala was limited by a multitude of challenges ranging from professionalism of health workers to economic and societal challenges. These findings suggest a need for government and other stakeholders to ensure that policy provisions that improve access to SRH services by the youth are actualized. The findings reveal the need to equip health workers with knowledge and skills to enable them adequately address the needs of the youth at health care centres, and to devise alternative interventions to address the plight of males' youth with unique concerns.

In agreement with the 'AAAQ' framework, it was concluded that both male and female youths' expectations to SRH services included sexuality education, family planning methods including condom use, HIV testing, counselling and treatment among others. However, regardless of gender and sex (or other social inequalities and marginalisation like disability), they expected such SRH services to encompass all youths.

The study found that there were few designated health facilities within reachable distance for students. This was mainly a concern for students from Makerere University Business School; however, students from Makerere University indicated that they have an option of a university hospital that is located just next to the University's main gate. The only key challenge with Makerere University

Hospital in relation to youth friendly sexual and reproductive health services was that, this hospital also lacks adequate facilities and staff given the big number of people it serves on a daily basis. To compound on this health concern, the availability of youth-friendly reproductive health corners with adequate resources within workable distances around the university settings is still a challenge. Additionally the voices of many female students affirmed that they are unhappy with the quality of RH commodities supplied at the few available health centres.

In agreement with the 'AAAQ' framework, it can be concluded that both male and female youth expect accessibility to essential comprehensive sexual education on managing urinary tract infections, sexually transmitted infections including HIV, proper prevention of unwanted pregnancy, and incase it happens, they need knowledge on how to acquire treatment. Many young females have lost their lives after inducing abortions due to complications and lack of post abortion treatment and care. The concept of accessibility was not only limited to tangible services but also SRH information that was distributed through various means. Male and female university students attested to this fact that mass media has contributed significantly to information distribution.

There is also a challenge of stigmatization, shame and judgement on youths seeking SRHS including information. Those seeking information, more especially the girls, are stigmatised because they are viewed as sexually promiscuous, sluts, more so when they seek for services like condoms, while others are judged and stigmatised as having HIV and AIDS, even when this is not the case. Such challenges of stigmatisation, shame and judgement still limit majority of young people from accessing reproductive health services.

In terms of quality, it could be observed that some SRH services and commodities are unpleasant to the majority an issue contradicting with the human rights basis for professionalism as earlier discussed (see chapter 2). When health services and commodities are doubted as these young people were heard saying, this compromises not only on the service utilization but also their health.

This challenge might also be attributed to lack of adequate information that later on compromises their sexual and reproductive health attitudes for both male and female youth. On the other hand, although media images of sex and sexuality may be socially perceived to bare negative influence on youth sexual decision-making, there is considerable potential for the use of media in conveying messages about responsible sexual behavior.

From the above discussion, it follows that university students might be confronted with unique reproductive health challenges different from those of other youths. Whereas some factors stem from the impact of social agency, others accrue from structural arrangements within the health care system. It should be observed that much of the influences from the society that infringe on youths choices remain dynamic and versatile. The condom purchase related stigma that was cited as one of the impediments for safer sex relations and peer influence that acted as an informal mechanism in obtaining RH information, both carry along untold implications which have not yet been measured. On the other hand the institutional influences like unclear policies on abortion and the underreported significance of emergency contraceptive pills (ECPs) significantly affect young girls.

It was cited in the findings that parents are not willing to admit that youth are sexually independent. Some of these perceptions trace their roots to tradition, culture, and religious background this means that such challenges would need deliberate programmes to cutback these sentiments. It is important to mention that SRHS health workers are under obligation to try and create a friendlier environment where youth can feel welcome, in their distress. The cost of some essential SRH products should be revised and given priority focus. Therefore in terms of availability, accessibility and acceptability of SRH services for young people, different experiences were taken note of, all of which were in line with the rights-based AAAQ health provision framework on health care services in maternal health and general reproductive health services.



## **CHAPTER 6: HEALTH CARE PROVIDERS' AND PARENTS' PERCEPTIONS AND ATTITUDES**

### **6.0 Introduction**

This chapter sets out to explore the perceptions and attitudes of the exclusive male youth health care providers (HCPs) and male and female parents towards young peoples' SRH needs and sexuality concerns, particularly on increased risk-taking in sexual activities that endanger their lives, in terms of contracting HIV/AIDS and having to deal with unwanted pregnancies. I examined the parents' understanding of the SRH concept and explore their views in relation to the scourge of HIV/AIDS among male and female youths at universities, including unwanted pregnancies. I also examine the HCPs' perceptions towards parents over young peoples' SRH needs, on the basis of the programs designed by them. I explore the views and perspectives that HCPs and parents hold and that might be relevant for understanding the SRH dilemmas young people are faced with at the universities.

### **6.1 Health care providers' knowledge and understanding of YSRHS**

When I sought the health workers' opinion and views on how they perceived and understood young people's SRH needs and the services provided to university students male and female youth, one of the youth officers at Reproductive Health Uganda (RHU) had the following to say:

*Alex: First we need to recognize who young people are before proceeding to any description! Young people are diverse in nature; therefore their needs require a step-by-step analysis with due consideration being given to their age differentials, geographical locations and gender when defining their SRH needs! In my capacity, young people's SRH needs include life planning skills to enable them manage STIs, comprehensive sexuality education, and awareness about negative cultural taboos that rob them of their rights, parental guidance, and support when encountering hurdles with pregnancies.*

Another youth health worker, who was head of the youth training team at Naguru Teenage Information and Health Centre (NTIHC), had the following to say when I asked him how he envisioned and understood young peoples' SRH needs and the services given to male and female youth at the clinic:

*Denis: Young people irrespective of their sex differences need access to full SRH rights, equity and equality in empowerment for both male and female, nutritional needs, confidentiality and privacy while communicating services to them. Particularly male and female youth need more stand-alone health centres separate from adult facilities with skilled peer health workers to attract and enhance communication with young people. But remember boys and girls are different hence their needs should be addressed differently.*

Owing to the above submissions by HCPs, this knowledge and understanding appears to be comprehensive and encompasses the other interviewed health workers' opinions. The SRHS comprises a range of sexual and reproductive health gender packages of services, commodities, including sexuality information. Thus ranges from the socio-economic to health related concerns.

#### *6.1.1. Unprofessionalism of health care workers and media*

Drawing on in-depth interviews with health care providers working at the two youth reproductive health centres in my study, it was noticed that one of the leading factors for unwanted pregnancies and high HIV rate among male and female university students can also be traced to unprofessionalism by health care providers in terms of service delivery. Over this concern, two of the HCPs' working with Reproductive Health Uganda (RHU) and Naguru Teenage Information and Health centre (NTIHC) stated:

*James: I have gradually observed some HCPs at some health facilities denying a particular service to young people based on personal judgement! Most of them have mixed feelings between their religiosity, culture and professionalism! By the time a young person reaches a health centre he/she has broken several barriers! Note for example that amongst university girls some are sex workers while others are born with the HIV virus! Therefore denying such services to young people affects their sexual health and might affect their relationships as well! Therefore the tendency to*

*withhold relevant sexuality information and denial of commodities like condoms and pills owes better explanations for the persistent high rates of HIV contraction and unwanted pregnancies in addition to other health challenges they face! Some HCPs subject them to strong examinations, which might scare them from telling their problems; they rather die in silence! (Gender and youth coordinator, at RHU)*

*Denis: Whereas young people's negative health outcomes are partly attributed to a host of other factors, we shouldn't miss the fact that today the media has also made a big damage as far circulating sexualized images and nude pictures in their tabloids! The concern is no longer on relevant issues in the country but rather the platform is more on sexualized pictures and stories! Try to look around on front pages of certain newspapers displayed by street vendors you will judge your self! Majority of these young people only use the Internet for viewing pornographic material and WhatsApp on smart phones for receiving sexual clips! (Head youth counsellors, at NTIHC)*

Other youth HCPs agreed that most of the health workers who deliver SRH services to young people do not appreciate young people as mature clients, which impacts on young people's lives. This challenge was re-echoed in most interviews as a limiting factor for young people to utilize and access health SRH services. In the previous chapter 5, young people claimed that on several occasions HCPs deliberately deny administering particular commodities with a judgmental attitude that either they are still young or they will increase their chances of becoming sexually active (see chapter five). With a reference to the AAAQ framework for health provision, services might be *available* but hardly *accessible* by male and female youths. This coincides with what the youth said in the previous chapter. Noticing from such statements from HCPs, majority of young people hardly take the courage to approach health clinics even if they are established for fear of strong examinations. *Accessibility* to services then becomes cumbersome which contradicts with the stipulated world health organization's human rights health provision framework 'AAAQ' for health professionalism. Secondly a point raised on the negative contribution of the media in publishing and giving platform to nudity and pornography other than discouraging such materials, has emerged as an influential factor on young peoples' attitudes and perceptions towards their sexuality life. Sexualized images and materials are allowed

in some newspapers worst of all given the front page as attracting headings and displayed on streets of Kampala to be accessed by anyone in spite of age and gender.

#### *6.1.2. Availability of drugs and treatment for STI's and HIV*

Another factor pointed out by most of the health care providers on the current trend of high rates of HIV/AIDS contraction amongst young people especially university male and females, was the availability of drugs and medicines for deadly STIs as this issue was elaborated by some HCPs as follows:

*Alex: You notice that people are more relaxed than before on contracting HIV/AIDS in our society! Today people living with HIV look healthier due to the effect of antiviral drugs! With such unnoticed effects of drugs, majority might be convinced that HIV is curable! This has led to the fear for the virus to go lower than before due to the availability of drugs like ARV's and PEP! In the same way you notice that the number of youths born with HIV has grown up and merged in the society without a trace, and besides, the affected bear fewer symptoms! This has given assurance to many that HIV is no longer the scary disease that it used to be in the early 1990's!*

*John: Donor interests in relation to funding and policies have punched lope hole in our strategies towards administering SRH services for young people! For instance, in the 1990's when our government used to focus more on preventive measures for HIV strategies such as 'Abstinence. Being faithful and Condom use' (ABC) without donor dictation, the prevalence went down! Today the emphasis in the donor funding is much concentrated on treatment like giving drugs like ARV's, PEP without preventive messages that involve routine bodily health testing for infection!*

Evidenced from the above statements drawn from HCPs' perceptions and attitudes, it can be noticed that the scourge of HIV/AIDS remains a major challenge among university students both male and females for some major reasons. One is that majority of the affected victims of HIV/AIDS bare fewer symptoms, which may have created false confidence among many that HIV is a curable disease than it used to be in the late 1990's where it was more scary. This factor was attributed to increased availability of ARVs, PEP drugs and their strong effects such as healthier bodies. Additionally, there less strategies drawn for preventive massages and mechanisms as opposed to treatment and provision of drugs due to donor interests in directing and

controlling the aid funding. With such factors, Youths might be at a high risk of contracting and spreading the virus. Unlike the worst days of 1990's when HIV/AIDS victims were noticed in public due to less access and availability of drugs, and many symptoms on their bodies, youths including other people were scared to indulge in sexual risk taking activities, which dropped percentages of contraction amongst people to 20% (Uganda Aids Commission, 2012). The government directly intervened with the 'ABC' strategy, more of preventive strategies than treatment campaigns.

### *6.1.3. Unemployment and limited opportunities for young people*

The rate of unemployment among young people contributes greatly to risky-taking sexual behaviours, and affects SRH service utilization among young people at universities today. Over this challenge, one of the health care providers at Naguru Teenage Information and Health Centres stated:

*John: Most of the young people are unemployed that makes them idle and redundant; thus they become recipients for the good and bad! Whenever young people are idle it increases their chances of bad thoughts, and they have more time for sex! It is not surprising to see them grappling with such challenges! In search for jobs and other opportunities, many desperate girls are sexually exploited! If it so happens that this girl has experienced sexual abuse in exchange for any generosity, she won't tell anyone in fear of being condemned or shamed; not until you notice physical changes such as pregnancy or serious symptoms of an infection! Due to limited opportunities, youths especially males have devoted their efforts in other monetary ventures such as sports betting and gambling which do not add value to their health lives! Today it is a challenge to empower a young person with knowledge who is already desperate! Even if sensitization workshops concerning reproductive health and sexuality are organised at universities, the turn-up will always be low in case the reimbursements are not included! On the other hand, the priority on media has been lost! Media companies have fewer interests in YSRH services and information awareness because such programs are not well funded and yield less profit to the companies! This means that few adverts will be run on media such as TVs, radios, billboards and posters! The only media channel where such valuable health concerns are communicated exhaustively is the Uganda broadcasting centre (UBC), a channel rarely watched by*

*young people especially university students! Therefore sensitization and awareness becomes a challenge in addressing health concerns! (Head youth counselling).*

The fact that majority of these university youths are unemployed and have limited alternatives for life skills, majority may end up venturing their resourceful time in unproductive ventures such as gambling, betting while others increasingly find enough time for indulging in sexual practices. This challenge greatly affects the female youths since they might be the most vulnerable gender to sexual abuse even if they are searching for employment. It is noticed that even if opportunities for availing information concerning SRH, turn ups are low due to changing interests of young people in the socio-setting. The HCPs noticed further that it is very hard to empower a desperate youth with resourceful knowledge without survival handouts.

#### *6.1.4. Overburden health care system and inconsistent supply of SRH commodities*

Furthermore, the challenge of unwanted pregnancies was greatly attributed to a huge health delivery burden that has systematically outstripped the capacity of agencies and health centres dealing with the SRH services for young people. This was re-echoed by the health training personnel working with NTIHC and RHU as illustrated below:

*James: Access to condoms has been a challenge in the country! I remember a scenario in 2012 between a period of September to December when condoms were missing in all public health facilities a situation that set many young people's lives at risks of contracting HIV and unwanted pregnancy! However, this was as a result of poor quality condoms from certain firms in China that forced the government to pound them after realizing their effects in Ghana! (Gender & Youth coordinator, at RHU)*

*Alex: Circulation of knowledge and information is limited to only those in schools but is limited further by the accessibility in terms of costs! Besides that, the language of communication used on charts, media billboards, brochures, prescriptions and posters is in English yet we are living in a multi cultural society! In the end this creates misconceptions and misinterpretations on the interventions and knowledge flow of information! (Youth Officer, at RHU)*

*John: More than half of the population in this country is youth and with such huge numbers, you cannot expect the approaches to youth challenges in SRH to be streamlined! Youth corners need enough funding because they are under-resourced and limited resources are directed according to donor interests! (Head youth counsellors, at NTIHC)*

In the same vein, institutions concerned with youth SRH needs and services were held responsible by university students for giving controlled information to on contraceptive pills and side-effects as evidenced by majority (see chapter five). According to the HCPs interviewed, this controlling of information reinforces the already held misconceptions and misinterpretations associated with contraceptives in the country, which in return, limits young females' capacity to utilize these essential SRH commodities. Furthermore, it is noticed that the condition of health facilities in Kampala handling YFSRH services might be lacking adequate resources to enable efficient service delivery for young people. This may be accompanied by the constant shortage of health materials and commodities like condoms as the HCPs attributed to this challenge on the procurement of poor health quality care products citing the 17<sup>th</sup> September 2012 scenario where a medical doctor sued the UNFPA and the Uganda government for importing defective products of condoms that set peoples' sexual health lives at margins of contracting the STIs/HIV. This challenge was highlighted in the new vision newspaper that surfaced on the 6<sup>th</sup> May.2013.

When I asked health care workers to comment on how the policies and legal frameworks have affected the service delivery and implementation on the ground, some of the interviewed HCPs elaborated as follows:

*Alex: Uncoordinated legal policies at the national and local level have paved way for young peoples' SRH challenges! Perpetrators especially older men (having sex with young university girls) are exonerated through bribery and instead sentenced free! In cases of sexual abuse, culprits negotiate with the daughters' parents to close the files! You also notice that Uganda has a lot of good policies on paper but implementation is always a challenge! Older men/women sleeping with young people is not strange anymore! Laws are not stringent enough and this affects young people in the end, especially females! HCPs are also operating with little knowledge on existing policies guiding their actions for instance abortion laws! (Youth officer at RHU)*

*Alex (again): Additionally, there are no autonomous and independent institutions that are specifically concerned with youths SRH concerns! Only a small department is embedded in the ministry of Gender, Labour and social development which is small and not enough to accommodate all the branches of YSRHS and needs! Again if you are to check for representatives over there, majority are older people in that department who might barely know about what young people go through!*

Drawing from the above contributions by HCPs, Uganda may be having excellent ASRH policies concerning young people but proper implementation might still be lacking. Majority of the perpetrators caught violating young peoples' sexual rights and health might not be apprehended accordingly due to corruption, which continuously affects young people especially female girls since they are the most recipients of the negative outcomes of sexual violence. Since the UDHS (2013) highlighted the fact that youths comprise half the number of the population existing in the country today, there might be a need to establish a full ministry/department to fully concentrate on young people's affairs rather than a small department as observed by the HCP above.

#### *6.1.5. Parental and societal attitudes from HCP's point of view*

Over the sexual and reproductive health concerns of young people, I asked the four HCP in my study to give me their perspectives on whether the society has been receptive towards the SRH programs designed for young people and what they think of parental relationship with their children in preparation and guidance during sexuality and reproductive health times.

*Dennis: Today young people have limited alternatives for better lives! Perhaps this is attributed to parental neglect and upbringing...if you recognise it, a majority of these youths at universities are raised from different schools and families, which hardly introduce them to multiple alternatives for life such as sports, games, competitions among others. A child raised in such arrangement has different options for life when faced with challenges! For the children you see that get pregnant and indulge in risky sexual behaviours, they have limited alternatives for their lives.*



*James: The society hasn't come to accept the realities we are living in! It is a shock to hear an adult asking why and how a young girl can ask for a condom! A case in point was when some young girls who are born with HIV happened to negotiate for safe sex with young men, and instead were ignored with much confidence that where can young girls acquire the virus! It was not until contracting the killer disease that these young men narrated their stories!*

*John: Prior to administering youths SRH services, society especially parents, haven't been cooperative with the HCPs in sharing the responsibility of welcoming SRH programs! How? A majority thinks that such SRH services are none other than encouraging sexual behaviours among their children who thus are getting spoilt! Parents think that SRH services are centred on condoms distribution; family planning and showing young people how to enjoy sex, which is a wrong perception! With such held misconceptions from the society, don't expect a lot of support for youth SRH programs.*

*Alex: A majority [of parents] do not want to talk about sex but are interested in knowing whether their child has a boyfriend/girlfriend! Sex discussion is a no go area. Parents don't appreciate young people being sexually active and independent! Perhaps due to cultural sensitivity, a majority shun away from sharing sex education and information with their sons/daughters!*

Majority of HCP's perceive young people's SRH needs to be limited by parental and societal attitudes that hamper meaningful discussions on sexuality concerns, with parents as well as with health care providers who deliver sexuality education programs. Some parents are partly held accountable by HCP for controlled sexuality information and less negligence for proper youth's preparation during reproductive health times. But however, over this concern, the parents were interviewed and asked to give their perspectives towards the SRH concerns of young people in the following themes below:

## **6.2 Parents' attitudes and perceptions of YSRHS and needs**

In relation to male and female youth SRH needs and services for young people, I examined the parents' attitudes and perceptions to ascertain whether they had an

explicit knowledge on this notion. When I explored how these parents envisioned young people's SRH needs and services, a majority had limited knowledge on this notion as observed from the statements made below:

*Margret: I think young peoples' SRH needs are those services centred on sexual advice, abstinence from sex relations and pregnancy! May be other matters pertaining to sexuality! Besides that, I don't think that young people need a lot of information on such adult concerns! I mean they are still too young to be introduced to sexuality packages of information, products and lessons (Married mother with 3 daughters and 1 son).*

*Kiberu: I guess it's a whole package of reproductive health services strait from what these youths eat in terms of food, sexuality Knowledge on (e.g. contraction of STIs, condom use, family planning, effects of drug substance name it), so to me this SRH you're talking about is a range of array! (Married father with 3 sons)*

*Mary: According to my understanding, I believe SRH services for young people must involve controlled packages of sexuality information though it's vital now days! Especially girls should be involved and introduced to contraceptives in these services as soon as 15 years, and abstinence from sexual relations before marriage! (Married mother aged 54 with 3 sons).*

This idea was shared by most of the parents interviewed that indicated that, parents spend less time with their children to try and understand their sexual lives. However with those parents, who seemed to understand this notion of SRH needs and services for young people, were informed by either their education levels or with experience drawn from friends else where. However, parents from middle class families might have more knowledge and understanding over their children's SRH needs and services than those from lower classes simply because, they have an advantage of medical insurance; they are learned and can afford taking their children to better schools which are also fully resourced with communication facilities like computers, internet and better teachers. This was also noted from one graduate parent who stated during an interview as she stated:

*Mary: In this era of modernity, it is imperative that we parents should help our growing children to access information on reproductive health and sexuality! Besides, even if we prohibit them, the environment favours them to access the same information via Internet, peers and school... I was able to have only three children whom I can afford to look after well, due to my level of education and financial capacity; so I think we should help our children understand their sexuality and reproductive health for their own good safety...! (Graduate Married mother aged 54 with 3 sons).*

Therefore the level of understanding of SRH services for youth varies among the parents according to social status.

#### *6.2.1. Socialization process, cultural taboos and norms*

When I asked parents to comment on the current SRH services and concerns of young people on HIV/AIDS and other related health issues, and why they think young females at the universities continue getting pregnancy when still in school despite their level of knowledge and exposure to relevant materials, varying views emerged:

*Kiberu: In the older generation, social roles and expectations were well defined! Individuals appointed by the community members taught young people a set of clear and well-defined roles that governed their sexual behaviour! However with the current urbanization the role that was played by the entire community is now left for the schools that are slowly phasing such arrangements from their structure! Because of work, both parents have to live the children in the hands of housemaids and only remain with tasks of tuition and food at home! If you're lucky you will only find out when your son is in trouble for drug abuse or impregnating some ones' daughter! If you have girls you will find yourself as a parent shouldering financial burdens of her pregnancies or abortion when it's too late! (Married father with 3 sons)*

*Margret: Young people are more stubborn now days! A few hardly take advice from parents, which have caused a vacuum in the [generational] knowledge flow! You can't imagine how those girls behave when they grow breasts on their chests! Hmm, they become second wives in their parents' homes taking no advice not until that day when she lands into trouble with a pregnancy or an HIV infection! Even if you try to comment on her dressing before leaving the house she will instead ignore you until*

*she comes back in the night! Our social settings including families don't allow girls to get pregnant while still in school or under parents' control at home! I think its lack of discipline and disrespectfulness that has landed them into trouble! (Married mother with 3 daughters and 1 son)*

Evidenced from the parents' contributions above, some of them hold the view that young people have deviated from their expected social responsibilities among which, they are expected to accept parental authority, listen to the advice from their elders and stay away from sex until marriage. However, because of pressure for work, parents themselves thought that their responsibilities in child up-bringing is neglected and rather their role is assumed by care takers like domestic housemaids especially female maids at home. This creates different pathways concerning young people's discipline, knowledge and sexual behaviours. Contrary to the perceptions of many parents and community leaders, Patron and colleagues (2009) revealed that young people who engage in unsafe sexual practices suffer serious consequences in societies that deny this reality thus failing to prepare them adequately. It is noticed that culture is at interplay and an influential element in young peoples' SRH concerns. The representational voices obtained from the above discussions indicate that parents and other family affiliates such as uncles, aunts, elder sisters and grandparents are influential sources of knowledge, beliefs, values and attitudes young people during the transition from childhood to adulthood. However, majority claim that since this youth generation has paid little attention to these role models' advice, many have become spoilt. In relation to this notion, Barnett (1997) states that parents consider themselves as role models in shaping young people's perceptions on gender roles and influence the choices that young people make about their own sexual behavior. Parents and other family members often have the power to guide children's development towards healthy sexuality as a normal, natural and progressive experience within their lives.

#### *6.2.2. Parents' limited knowledge on the existing sexuality education programs*

Over this concern, most of the parents are uninformed about the existing sexuality education programs for young people within their communities of residence, in health care centres and schools. The limited knowledge on existing youth SRH programs has

caused resistance and an unwelcoming reception to such programs by most parents, as indicated below:

*Faith: Am not sure whether today there is such much programs catering for young peoples' reproductive health in terms of awareness! The only thing I can here of is adverts on media and particularly on married couples family planning concerns, and condoms! If there were such arrangements for particularly youths, at least we could see the impact in society may be less pregnancy levels, or discipline among youths! (Single mother of 4 girls and two boys)*

*Marry: I wish there were educative programs in the curriculum education system that can address young peoples' SRH concerns! Because when we send our children to school, we expect them to learn a lot of things including knowledge on their SRH that parents can't provide to their sons/daughter! I remember those days at school when HCPs used to visit our hostels, classes with different sexuality information packages for boys and girls...yes girls especially were checked for pregnancy and STIs, including given counselling! (Married mother aged 54 with 3 sons).*

Most of the parents seemed to share the same view that sexuality education programs have departed from the norms of society and from the education curriculum where young people are supposed to be engaged for knowledge. Most referred the situation to their old school days when they used to have such arrangements that worked for them. Today sexuality education might not be a priority in most schools and perhaps phasing out from the education structures of schools and universities. However according to the Uganda National Exams body, some subjects were introduced in high schools to cater for this challenge like biology and Christian education though not comprehensively addressing the challenges. Further still this challenge of addressing SRH concerns in schools is handled by a number of reproductive health agencies in the country (see chapter 1).

Most of the SRH programs and SRH services designed for young people were not appreciated by the parents as I explored their attitudes and perceptions captured in the examples below:

*Margret: I don't support the SRH educative campaigns idea for young people! They have done more harm than good! They are full of sexuality information that I believe is increasing the curiosity and sexual urges amongst young people through try and error! If you give out condoms to even an innocent child he/she is tempted to find use of it with any one including prostitutes! (Married mother with 3 daughters and 1 son)*

*Josephine: The availability of family planning methods (contraceptives) has increased young peoples' sexual practices with much confidence to terminate unwanted pregnancies today! I wonder! Girls now days are less concerned with STIs including HIV than with pregnancy! Unlike before where young people had no alternatives apart from abstaining until marriage, today young girls, especially those at University, are exposed to contraceptives, like pills and injections, which provide them with confidence to engage in frequent sex with any one regardless of protection [against STI/HIV]! (Married mother age 52 with 2 daughters).*

*Kiberu: I wouldn't encourage young people, especially young females to start contraceptive use at an early stage! Contraceptives bare long-term side effects on individuals' bodily health! Every one needs to bare kids so when these girls start consuming these products, chances are high that they might get infertile if not face death! You can notice that this could be the reason why women are becoming more barren today! I would never have allowed my daughters to utilize those services in case I had them thank God that I have boys (Married father age 57 with 3 sons).*

Although parents varied in the attitudes and perceptions towards youths SRH programs, majority have not appreciated the positive impact of such services in the society. However the variations in the perceptions might be attributed to the socio-economic status of some parents, as those from the middle class families seem to recognise the relevance and need for such SRH programs than those from lower income families. With such few negative statements made by some parents that the SRH programs have increased the sexual activities and spoilt youths. Other parents are still holding misconceptions that certain SRH services have side effects thus discouraging their children from utilizing them. The held misconceptions by most parents might be attributed to their less involvement and awareness. May be some parents might be less involved in such young peoples' arrangements and may lack

proper information regarding youth existing SRH programs in schools and in the communities.

### **6.3 Concluding Discussion**

The perceptions and attitudes of some parents on young people's sexuality programs and services as not being within the cultural norms for socialization hamper the designed programs for youth-friendly SRH. Since the parent generation of the current Ugandan society expects young people to continue valuing chastity, and sex among young people becomes clandestine because of it, then male and female youth may be left at the margins of negative health outcomes. For example, in one of the socio-cultural studies conducted by Shoveller and colleagues (2004) on sexuality among youth in Canada, youth had learned at an early age to remain silent, keep secrets, or never directly describe their own sexual experiences to their parents or other adults, even when they felt they needed help or advice. According to the HCPs, since parents commonly show less interest in and have negative attitude towards sexuality education programs designed for youths based on perceptions that they are encouraging sexual practices and promiscuous and immoral behaviours, they have hardly seen any positive achievements. In fact, studies conducted in Africa revealed that many adults are still holding negative misconceptions on young peoples' sexuality education (e.g. Rivers & Aggleton, 1999; Pattman & Chege, 2003; Parikh, 2005; Renold, 2005).

Drawing on Scheper-Hughes and Locks' (1987) three bodies' approach to analyse and discuss youth encounter with sexual and reproductive health services, their concept of body politic explains how the state and other agencies surveil and control individual's bodies in societies, which in this case Uganda has had a YSRH policy on adolescent since 2011. Despite uncoordinated policies at national and local level as observed by the HCPs referred to above, a majority of youth might be having poor access also after the introduction of the Ugandan AYFSRH policy (2011) upon which they are required to administer reproductive health services for young people. As Scheper-Hughes and Lock (1987) noticed in their third level of analysis of body politic, the act of unprofessionalism practiced by some HCPs to deny particular services to young people might be perceived as an act of controlling their bodies in

reproductive matters. Similarly, as noticed in chapter one, while laws concerning youth's protection against different forms of sexual violence are secured in the constitution, perpetrators have continued to violate these young peoples' sexual rights and freedom by conniving with victims' families to drop charges and cases for (e.g. rape, sexual coercion, assault and violence among others). The society can therefore be accused for its neglected responsibilities for accepting cases of older men having sex with young university girls that have resulted into negative health outcomes for them.

Health care providers' attitudes and perceptions of parents towards sexual and reproductive health services of children are influenced by social-economic status of the parents. The variations in the perceptions might be attributed to the socio-economic status of some parents, as those from the middle class families seem to recognise the relevance and need for such SRH programs than those from lower income families. Some parents have the capacity to make the same affordable to their children in cases where there is need to pay money. This reiterates the objectives of the AAAQ framework that recognises that for reproductive health services to be functional, those who need them, such as the university students, must access them.

The fact that a majority of these university youths are unemployed and have limited alternatives for income sources, majority rely on parental support in terms of money and material needs. This greatly affects the female youths since they might be the most vulnerable gender to sexual abuse even if they are searching for employment or need money for reproductive commodities and services. It is noticed that even if opportunities for information concerning SRH are available, turn up are low due to shame among young people. It even becomes very hard to empower a desperate youths with resource knowledge without financial support. Notably, some negative perceptions among some parents towards the sexual reproductive health programs claiming that they have rather increased sexual activities among the youth remain a challenge on YSRHS and needs among the youths. Parents may have neglected their responsibility towards young peoples' health concerns due to several factors, such as employment demands and lack of time. Therefore, a comprehensive intervention on social-economic transformation and sensitisation is what could help to mitigate these challenges.



## **CHAPTER 7: NEGOTIATING SEXUAL RELATIONS AND POWER DISPARITIES**

### **7.0 Introduction**

This chapter attempts to present data generated from young male and female university students, male health workers including male and female parents on issues related with inequalities and power relations involved in negotiating safe sex and accessing and utilizing SRH services. As highlighted in the previous chapters (5 and 6), power dynamics pose a significant challenge throughout young people's SRH decisions on sexuality life and behaviours affecting their lives. In this chapter I therefore explore and discuss the power dynamics at play between male and female students' when entering sexual relationships, and when attempting to access and utilize SRH services. The areas of concern are gender relations that include the issue of age in female students' relationships with older men, in generational relations between child-parents, and between youth and health care providers; all relations involving the issue of authority in SRH matters.

### **7.1 Gender and age / power negotiation in sexual relations**

#### *7.1.1. Male domination in decision-making*

Connell (2009) has emphasised that women especially young adults aged 15-24 are less likely to negotiate safer sex relations and take upright decisions against their partners in relationships due to strong patriarchal structures of gender relations which exist in the ideal societies, as observed by Male dominance over females in matters pertaining to decision making to upright choices on sexuality practices and behaviours. According to Connell, this challenge is as a result of power dominance to establish their masculinity over girls/women. This power disparity is commonly manifested through young males / men's domination in terms of controlling resources, sexuality influence in choices of family planning methods and condom use. Over this particular concern, one of the youth training managers at Naguru Teenage Information and Health Centre noted:

*John: Since the nature of our society in Uganda is highly patriarchal the SRH services normally target women rather than men! This privileging of women over men in a patriarchal setting where society depends on men for decision making, this*

*information concerning SRH needs and services acquired by women, ends up being prejudiced by men!*

This is a case of men including young males, having the jurisdiction over the information that young females obtain from health centres. This opinion did not defer much from other health workers' opinions who felt the same way. Another health worker at Reproductive health Uganda said:

*Alex: The power hierarchies and influence while negotiating safer sex with a condom, not only lies in the hands of young men but also older men whom in most cases are married seeking for pleasure from young university girls whom they perceive as sex objects, easy going and more attractive than their married women at home! Young females normally have less power negotiation skills in fear of being called names (e.g. 'backward girl', 'unromantic' among others) in case they insist on using protection!*

In reference to the above views generated from HCPs, it has been noticed that gender imbalances / disparities may have impacted on young university students disproportionately. Drawing on statistics from the Uganda Aids Commission (2012), this age cohort of 18-24 represents the highest percentage of new HIV infections in Uganda for which gender disparities and male power influence play a tremendous role in this dilemma. Youths themselves might be faced with a challenge of discursive power amongst themselves to practice what other peers are doing in their sexual relations and also power exerted unto them by older men pressurizing them for unprotected sex in exchange for attached benefits. Young university students both male and female may indulge in risky sexual activities because of the generational trend to be like others.

In relation to power influence over upright decisions on sexuality, views obtained from focus group interviews with female students (see chapter 5) established further that the purchase of male (or female) condoms in the open market is next to impossible as vendors and service providers prejudice adds to these girls shyness. According to the female students, if a young lady presented a male condom to her male sexual partner during a sexual act, she would find it hard to explain and risk being labelled '*malaya*', which means 'slut' in the local language. The inexplicable

short supply of female condoms and their underutilization could also be attributed to the socially constructed idea that presupposes men to wield the power to initiate sexual relations other than women. When I asked one female students in a same-sex FGI, some gave the following explanations:

*Prudence: I think female condoms are rare in health centres and drug shops due to gender disparities! Always it is assumed in Africa that sex is supposed to be initiated by males unlike in other contexts were it doesn't matter for a female to initiate a sexual intercourse! Again I think that as long as you have accepted a sexual relationship with a man in our cultural setting, he is entitled to the sexual freedom to enjoy your body at any time, whether you like it or not, as long as he wants sex he can do it the way he wants! (Female student aged 23).*

This shows how difficult it is for females to be in control in sexual relationships, despite being targeted in SRH programs. Another female youth from the same focus group interview added:

*Mariam: In whatever relationship, men are so controlling almost in all spheres of life! That is why I hate relationships because men infringe on your freedom to an extent of controlling your ideas and opinions! You can't deny your boyfriend sex even if you want unless you are sick in bed! Me, one time I suggested to my ex-boyfriend to use contraceptives he almost run crazy with me and yet he didn't want to use condoms for his own personal reasons! So you find yourself in a compromising situation whether you know the right thing to do or not! (Female student aged 22).*

Despite these female students being fully aware of their rights and how to protect themselves, they still have a problem with challenging the socially condoned male domination in sexual relations in practice. Lack of self-confidence and low self-esteem might also add to their inability to override their male partner's decisions in sexuality matters. Even though they are conscious about the outcomes of unsafe sexual practices their decisions are suppressed:

*Julia: My boyfriend doesn't allow me to use contraceptives, including condoms, even if I insist! Men, especially boyfriends, find it strange for a girl to keep a condom! Even your fellow girlfriends when they notice that you have a condom in your bag,*

*many start pointing a finger at you! My friends' boyfriend started a serious fight one day for finding a condom in her bag! This is nothing else than controlling your freedom to protect and enjoy sex responsibly! When you refuse to be submissive the way this guy wants to make love to you, he dumps you and finds other girls and many are out there! Our culture tells them that a man is always right and is the head of the relationship including ideas! (Female student aged 23).*

Drawing on the above submissions from female participants, majority of these girls might be challenged to express their upright sexuality decisions and negotiate safer sex relations in relationships due to male partner influence and power imbalances. Furthermore, young females are challenged to have protections like condoms or contraceptives even if they want to in fear of their partner's reactions or being perceived as promiscuous girls. In regards to this dilemma, Connell (2009) noticed that because of strong patriarchal structures of gender relations existing in societies, men tend to dominate women in all spheres of influence including the decisions taken in reproductive health. This power disequilibrium is mainly manifested through different forms (e.g. sexual domination / influence in choices of family planning and condom). This control comes as a result of low self-esteem and determination

On the other hand the male youths' presented their own views and opinions over the issues concerning male domination in decision-making in sexuality between them and females in the following way:

*Moses: It's useless to accept decisions from a girl! When you accept the life style that women are suggesting and taking decisions in the home or in your life including decisions on sexuality, you are not man enough; you become less masculine before your colleagues! I grew up knowing that a man is supposed to be head other than a tail; a notion that has existed for some time and has helped our grandfathers to maintain their [sexual] relationships with their wives!(Male student aged 23).*

Other males in the focus group interviews had closely similar opinions towards managing decisions in relationships. In a similar way, another participant stated:

*George: Controlling decisions in a relationship determine the nature of man you are! If you allow a girlfriend to decide for you then you are not a man! In fact to make a*

*girl pregnant is one way of proving that you are a grown up man among other boys. (Male student aged 24).*

In most of patriarchal societies including Uganda, a majority of the females are still under influence from men over the utilization of the SRH services. Despite access to education and increasing availability of SRH services, this situation has not changed significantly from former generations. The challenge for the girls, referred to above, is that the men do not want to change since this would challenge social sentiments as well as their own feeling of masculinity. Generally most SRH programs for youth target women who become beneficiaries of this knowledge. It is however not clear how effective this type of information is, especially when most women still live under patriarchal settings.

The consequences associated with leaving men/males out of participation might be more than little appreciation of women/female SRH rights in all spheres of sexuality life. With this concern, one of the youth health workers during an interview highlighted:

*James: male and female youth are perceived differently by the society in terms of their gender roles and sex, which affects also on service delivery! Much information, education and awareness is extended more to the girls than boys even in program development and execution! This kind of arrangement delinks males from involvement and participation. A man will never appreciate any positive arrangement/program were his having little knowledge or information that's why we have this challenge of sexual violence, coercion, abuse, rape and perceiving female youths as sex objects.*

Whereas the gender and youth health expert highlighted that paying little attention to males involvement in the existing reproductive health programs may delink them to active participation and involvement, another health worker from Naguru Teenage Information and Health Centre said:

*Denis: we need to appreciate males as change agents, active participants, users of reproductive health services and products, and partners to support the females to access and utilize SRH services other than seeing them as passive messaging but*

*messaging that involves them so that they have a part to play and live responsibly in their sexual relations.*

Drawing on the above submissions from some of the youth health workers in their respective designations and organizations, it is noticed that men/males may often be limited chances to participate/involve in youths SRH programs to learn and appreciate their roles and responsibilities. In line with studies by Greene and colleagues (2000) concerning involvement of men in reproductive health, revealed that there has been a formal recognition that more equitable relations between male and female and reproductive rights are important ends in themselves as well as the central means of reducing fertility and achieving population stabilization. Power disparities also play out in girls' sexual relationships with much older men, and in sexual relations that involve transactions or benefits, economic or otherwise.

#### *7.1.2. Cross-generational and transactional sex*

The term cross-generational sex is used to describe older men who use their privileged position to have sexual relationships with much younger females beyond the age interval of 10 years. Furthermore, young girls who have sex with older men often do it to acquire economic benefits. The UDHS (2011) noted that transactional sex involves the exchange of sex for money; favours or gifts and can take place between young girls and older men or among youth themselves.

When I probed as to why females have unprotected sex with much older men and same age mates (males) in spite of having knowledge on the likely consequences, majority attested to the fact that nowadays, it has become a common practice to exchange sex with economic or other material benefits. On this growing practice of intergenerational and transactional sex, some female participants said:

*Mariam: Today campus life is expensive and challenging in a way that you are attracted to the nice things other girls from rich families own! In situations where your friends are having boyfriends giving them perfumes, taking them for shopping and holding smart phones, you're tempted to find alternative ways to have such privileges. No parent can give you all this apart from tuition unless you're from a nice*

*family! So you find yourself accepting offers from even guys you would never date in your life! (Female student aged 20).*

*Norah: A man can approach you for sex while you are seated somewhere at an outing or a function with tempting offers! You first think through it well knowing that it's bad to sleep out on the basis of sexual returns...but because you have needs and problems such as tuition payments you accept! Most guys with such financial offers only exchange benefits with unprotected sex whether you like it or not! Some times it can be a job offer you are targeting and that is the only way to get a job. (Female student aged 23).*

On the other hand, when I tabled this issue towards the male youth during the focus group interviews, a majority agreed that such practices like transactional sex exist due to the financial and material benefits attached in return. The male students blamed females for desiring money and things fast. One male youth explained:

*Tony: Today most girls are obsessed with money and fancy things like expensive smart phones, constant shopping and being driven around in fancy cars! Young men, myself included, can't afford such privileges; only older and working men can!...You know very well that a majority of the older men are married thus looking for sexual satisfaction [especially unprotected sex] from these girls! But remember that this girl considers you as an official boyfriend of her age as well! It's so paining that this becomes a sexual chain for contracting HIV/AIDS! (Male student aged 21).*

Hence, one with economic power can influence the one without to exchange sex for money, favours or gifts. It is not unusual that many of the young people in Uganda face the challenges of limited resources as a result of increasing unemployment rate. For example, Kiwuuwa and Baguma (2014) refer to a consultant with the National HIV/AIDS strategic plan who attributed the high HIV/AIDS prevalence rate among young females (which is double that of males) to increasing unemployment among youth where rich men can take advantage of female students who lack resources. The power disparity in this case plays a critical role in determining if young females opt for safe sex. In societies and situations where transactional sex takes place, it has been noted that young females bear the consequences of these sexual relations due to less

negotiation power and skills to negotiate safer sex with their male partners (e.g. Gregson et al., 2002; Long field et al., 2002). Due to economic attachments and benefits involved in transactional sex, girls can hardly influence males to use condoms due to the power disparities between them. Furthermore, another challenging issue of cross-generational and transactional sex is strongly linked to unwanted pregnancies that might end in unsafe abortions as discussed in the next section.

### *7.1.3. Nexus of transactional sex and unwanted pregnancies and unsafe abortions*

In a similar argument, the practice of transactional sex in the findings of this study was found to be an influential factor leading to unwanted pregnancies and unsafe abortions among university girls. Noteworthy unsafe abortion is defined by WHO (1992) as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. As mentioned in chapter one, the Ugandan constitution does not prohibit abortion, but it is only permitted on the grounds of preserving the life and health of the pregnant woman.<sup>2</sup>

Both male and female youth who participated in the focus group interviews mentioned that whenever a man offers gifts and other benefits in line with the female expectations, chances are high that he demands unprotected sex in return. Some of the participants in this mixed sex FGI explained accordingly:

*Sarah: It is hard to resist such a temptation! In most cases you're left with no choice even if you might not intend to! On a serious note there is no way you can deny a man unprotected sex if he meets your financial bills and payments! I can't say that I do it but other girls do! (Female student aged 23).*

*Jackie: I agree with Sarah! The reason as to why men meet all these expenses for a girl's interest is sexual satisfaction! And they make sure that even if you insist on condom use at least they find a way of breaking it so that they fulfil their targets!*

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<sup>2</sup>Article 22 (2) in the Penal Code section of the Ugandan Constitution (2005), it is stated: "No person has the right to terminate the life of an unborn child except as may be authorized by law." From this article it can be observed that there is no absolute prohibition on the termination of pregnancy in Uganda, but the indications for abortion is limited.



*Sometimes these guys persuade you that even if you get pregnant it is easier to take pills [EPC?!]! (Female student aged 24).*

*John: Here is the challenge, whenever a girl takes away your money, the only thing you think about is revenge and that revenge is making her pregnant! At least you're reassured of benefiting in return from your money /expenses on her by making her pregnant for purposes of a child! (Male student aged 23).*

*Evelyn: To me some times such relationships with expectations of gaining something at least are better than staying in a love relationship when you benefit nothing! And sometimes even you see some girls being supported by their parents especially those from poor families as a means of sustaining the house! (Female student aged 23).*

Evidenced from the above submissions made by male and female university students that whenever a man offers gifts and other benefits in line with the female expectations, chances are high that he might demand for unprotected sex. Young people particularly university girls may engage in transactional sex with older men to support their basic essentials (e.g., clothing, food, tuition fees) or obtain desirable materials (e.g., cars, smart phones, shopping fashionable clothing and jewelry, and afford expensive meals at restaurants) or as a way of joining the social status. Females have less powers to negotiate for safer sex as such practices of unprotected sex always come with consequences of unwanted pregnancy that might lead to unsafe abortion for which many young females especially these students are ill-prepared.

On the other hand, the patterns of gender inequality habitually limit young females' economic option that makes transactional sex one of the few economic options available to them. In reference to the study conducted by Bantebya and colleagues (2014), young girls themselves may initiate such relationships or might be pressured into doing so by parents who want them to bring resources to the household. These authors highlight the vulnerability of young females entering such types of relationships while others point towards female youth's agency in perceiving this as a means to achieve financial and developmental objectives for their lives.

## **7.2 Concluding Discussion**

Data generated from both male and female university youth students, including youth HCPs and parents, have defined four major relational combinations through which power is exerted and experienced whilst negotiating SRH needs and access to services. These relational combinations include, (1) the relationship between HCPs and youth, (2) the generational hierarchy relationships between youth and parents where socio-cultural and economic influences on male and female youth's SRH needs for services are exerted, (3) male influence over sexuality decision-making in general also in same-age sexual relationships, and (4) the increasing practice of cross-generational and transactional sex. Hence, access and utilization of SRH services by young people can be contemplated through power hierarchies at play between gender, age and social status.

Some of the male HCPs, including male and female parents have conflicting notions of young people's SRH needs and their utilization of services as discussed above. A majority, are still holding to the strong perception that providing such services like sexuality information and reproductive health products like contraceptives, pills and condoms will instead encourage sexual activities too early. Whether at higher levels of education or not, youth are expected to follow what is defined as acceptable social norms in their community authorized by elders and parents. Parents' claim for authority in these matters is further exacerbated by a lack of communication with the young people in question.

Drawing on Scheper-Hughes and Lock's (1984) body politics in the analysis, parents' disciplining attitude, which is meant to control young peoples' sexuality, also put these young people at risk of contracting STIs, including HIV/AIDS, or girls having to deal with unwanted pregnancies alone or seeking unsafe abortions. In fact, mixed feelings on youth sexuality might also impact HCPs' perceptions and attitudes resulting in rudeness or denying them SRH services. Hence, both health care providers' and parents' claims to authority in sexual matters, and exertion of control, affect the way young people seek to cater for their SRH needs and access services.

It should be observed that in a male dominated society like Uganda, men craft most decisions including custody and the number of children in a family. Ceremonies and rituals like bride price in patrilineal groups, which live on in Uganda, inadvertently continue to place women in a subordinate position relative to men, and where a wife/woman's womb can be purchased.

The findings in this study showed that young females did not own their rights to retain the information obtained from SRH centres and sexuality education because the practicality of such information was subject to their boyfriend's scrutiny. For instance the voluntary purchase of a condom by a woman was not straightforward, since if she did buy it, it would invite conjecture with her boyfriend, and therefore she would avoid any attempt to do so (see also UDHS, 2011). It is these attitudes that frustrate the effectiveness of some SRHS programs for youth in the community. This continuous arrangement of holding men at a high pedestal is mainly expressed and supported by the culture and religious influence as earlier discussed. In his work, Connell (2009) revealed that in strongly patriarchal order societies, women might be denied personal freedom, which in this case limits young females entitlement to making their own decisions in sexual relations. Furthermore, both male and female youth might find themselves denied access to SRH services from HCPs or parents.

From a gender perspective, the power differentials between male and female youths and between them and older usually wealthier men might be a particular risk factor for contracting STIs/HIV/AIDS including unwanted pregnancies among girls. In most cases, these cross-generational relationships are transactional depending on the circumstances upon which they are formed. Age and gender discrepancy in sexual relationships position especially young females at heightened risk of sexual coercion, violence and exploitation because older men often have more power, use persuasion language, are economically stable in addition to more often being infected with HIV virus than younger men. Due to their economic status, power differentials in gender relations in addition to age differences, a majority of these men hardly use protection in transactional relationships with young girls. For instance, the older men's attitude towards young female university students are that they are HIV free, desire for sexual satisfaction and exploitation, and a win-win situation of benefiting from their privileges offered in exchange for sex.

Several studies have revealed that such relationships are common throughout sub-Saharan Africa including Uganda for which most are associated with unsafe sexual activities, low condom use practices that are linked to increased risk for contracting HIV and unwanted pregnancies (Bantebya et al., 2014). One study in Zimbabwe provided clear evidence that age-disparate sexual networking explains gender differences in HIV infection rates among youth in that country. The importance of men's/male involvement in the sexual and reproductive health youth programs, while imperative, the need to address power disparities in gender relations is also of importance. Studies have shown that paying little attention to males' roles and contribution towards the fight against HIV/AIDS and family planning including unwanted pregnancies remains vital for making men more responsible sex partners.

As noted in Chapter one, noteworthy in this regard is men's continued dominance over young females' capacity to access and utilize available SRH services and the need to address this issue. Secondly, the impact of economic status for young females in regards to asserting their choices and rights to resist coercive advances from more privileged men remains a challenge.

## CONCLUSION

Uganda has a policy guideline for adolescents and youth friendly SRH services and rights drafted by the Ministry of Health Uganda, (2011). This policy was designed to enable health care providers deliver health services and care to young people efficiently irrespective of gender, sex, ethnicity or any other affiliation. However, upon reflection in program design and service provision, these policies breed a good ground for a supportive and conducive environment for addressing youths sexual and reproductive health needs and services. The adolescent and youth policy guideline of (2011) on youth SRHS highlights pathways for administering SRH services to young people including their rights to full access and utilization of RH services. Among other policies include National policy Guidelines and Service Standards for SRHR by the Ministry of health (2006), National Health Policy, National adolescent Health policy and the SRH minimum package for Uganda.

However, not much qualitative research studies have been conducted about university youth student's experiences and expectations towards their need for SRH services in Uganda. My study therefore contributes to the existing discussions on the sexual and reproductive health concerns of male and female youth aged 18-24 years, the group feared to be the most at risk population for contracting STIs, including HIV/AIDS, and having to deal with challenges of unwanted pregnancies that can end in unsafe abortions. Power disparities experienced by young people from HCPs, parents and in sexual relationships informed sexual decision-making and the utilization of SRH services. High costs attached to reproductive health services such as treatment for STIs, including HIV/AIDS is a concern that is reiterated across Sub-Saharan Africa, female university students in my study stressed a concern on subsidizing costs on sanitary towels as well to avoid being absent from the university during their period. Most of the young females in Uganda cannot afford these gendered reproductive health commodities due to limited resources. This challenge has also left many young females involving themselves in risk-taking sexual behavior like transactional sex to be able to acquire these commodities.

Emerging as a critical issue in this study is the use of the emergency contraceptive pills (ECPs) in preventing unwanted pregnancies among university girls. A majority of the female university students that participated in the group discussions said they resort to ECPs due to less interest and desire for either using or negotiating condom use with their sexual partners and to some as a quick precautionary measure (see chapter 6 & 7). There has been an overemphasis on the use of condoms and a general use of the term contraceptives without clearly distinguishing the specific socio-cultural context within which contraceptives are applied. As much as the ECPs remain significant for preventing unwanted pregnancies among young women, they do not prevent them from contracting HIV/AIDS. Consequently, this leaves the efforts of the SRH systems not well defined and too weak in trying to address SRH challenges for youth. It was clearly acknowledged in the existing literature (see chapter 3) that sexual activities among young people are often clandestine and unplanned, which attracts a lot of unforeseen consequences (Bankole & Malarcher, 2010). Given such facts then, it defeats logic, to try and de-emphasize emergency prophylactic approaches and instead augment lesser concerns in mitigating the effects of risky sexual behavior. In fact, sexual activity is difficult to ascertain, however the literature reviewed critically identifies gaps in rapid response by SRH stakeholders to the ever growing 'risky sexual behavior' among youth.

Another issue is the shame related to unwanted pregnancies, and the social stigma attached to it, which has been widely addressed in the literature, but where not much is said about the contraceptive concerns of the youth themselves when engaging in unprotected sex. Unintended pregnancy is a validation of unprotected sex that also confirms that the stakes of acquiring HIV/AIDS are high. Similarly, the shame and social stigma unleashed especially on young females by parents and communities following an unwanted pregnancy, continues to be a huge challenge for the girls. The nexus between silencing of free discussions on sexual matters with parents and the sexual development of young people, presents a serious dilemma to the prevention of unwanted pregnancy. On the one hand, parents want their children to stay away from risky sexual behavior, yet they want to remain tight-lipped on matters to do with sexual activity; pointing to double standards at play when it comes to youth's sexual

and reproductive health. Important as it is, parent-child communication has also received little attention from the plethora of SRH literature on youth SRH programs.

Male and female youth frequently mentioned youth health corners, as important places where they can go, meet and dialogue on a number of issues pertaining to their reproductive health concerns. They also noted that youth health corners should also be well facilitated with adequate reproductive health supplies, designed in a more conducive physical environment enabling free interaction with qualified youth-friendly health personnel.

This research advances the view that the conjecture of young people's access and availability to SRH services and attitudes towards this access to SRH services by HCP and other stakeholders, presents a complex arena. The landscape of SRH service delivery by both government and private SRH agencies is constantly confronted by a multiplicity of socio-cultural, political and economic factors. These factors are manifested in numerous forms, which include; power dynamics, complicity of parents and latent societal norms and selective interpretations of SRH services. The impact of these dynamics has not only acted as a barrier to accessing SRHS but has also set the pace for change at the grassroots level. Equally important, on the one hand the target group, which is male and female youth, aged 18-24, hold expectations for their SRH needs and HCPs and other agencies possess diverging views of youth SRH needs. This gap presents a phenomenon where programmes to ensure access to SRH services may be relegated to mere chance. It is at this juncture therefore that more deliberate effort needs to be invested in finding ways to bridge the gaps among various interest groups, in order to guarantee a balanced delivery chain of SRH services. There is little evidence that sensitization efforts have increased service utilization or have improved the quality of reproductive health outcomes among the youth. There is a need for intensifying stakeholders' dialogue on issues relating to meeting youth SRH needs and expectations age- and gender-wise.

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## Appendices: 1. Interview guide for male and female parents

### IN DEPTH INTERVIEW GUIDE

#### **Introduction**

Dear informant (s), you have been selected to participate in this research effort aimed at finding out the male and female university youth students' experiences, expectations and attitudes towards the sexual and reproductive health services provided in Uganda. Your honest opinions are highly valued for the success of this research and will be treated with absolute confidentiality. The information gathered shall be exclusively for academic purposes of this research.

#### **Informant's details**

Interview date & place: .....

Informant's designation: .....

Recording code / theme : .....

Duration of Interview : .....

- 1) How do you understand the sexual and reproductive health needs of young people? If yes what are these needs?
- 2) How often do you hold talks with your children on matters concerning, unintended pregnancies, unsafe abortions, HIV/AIDS prevention etc.
- 3) At what age would you freely allow your son / daughter to utilize RH products like pills, condoms etc.? Give reasons for your answer.
- 4) Do you have any challenges while sharing sexuality information/awareness or advise with young people? And what do you normally talk about?
- 5) In your opinion, how do you think the youth prefer to get this information concerning their SRH needs/ services? **Probe fully**
- 6) How would you react incase your daughter disclosed to you that she is pregnant or has contracted an STI, or has plans to abort a foetus?
- 7) Do you think young people today are adequately equipped with knowledge and information concerning their SRH needs? Please explain your reasons.
- 8) In your opinion what could be the underlying factors for university students getting unwanted pregnancies / unsafe abortions and acquiring HIV today?

## Appendix 2: Youth Health Care Providers at RHU and NTIHC

### IN DEPTH INTERVIEW GUIDE

#### Introduction

Dear participant, you have been selected to participate in this research effort aimed at finding out the male and female youth experiences, expectations and attitudes towards sexual and reproductive health services Kampala, Uganda. Your honest opinions are highly valued for the success of this research and will be treated with absolute confidentiality. The information gathered shall be exclusively for purposes of this research.

#### Informant's details

Participant Code : .....

Organization Name : .....

Designation : .....

Recording code / theme : .....

Interview place : .....

#### Interview guide for youth counselors & officers

- 1) How do you understand the youth SRH concept in relation to their needs?
- 2) From your experience and interaction with youth, how would you comment on their perception in regards to the YFSRH programs designed for them?
- 3) What type of youth SRH programs does this organization render to the youth? Probe & seek for comments in respect to youth preferences.
- 4) How do you deliver these SRH programs to the university youth? Probe more
- 5) In your expert opinion, do you feel that the SRHS have reduced the incidences of unintended pregnancies, unsafe abortions, unprotected sex and other challenges published and unpublished?
- 6) According to Ministry of Health, UNFPA, Ministry of gender & UBOS reports of 2011-2013 indicators statistics indicate percentage increase in youth unwanted pregnancies at 54% and a 6.7% increase in HIV amongst the youth, from your expert opinion what could be the problem?

- 7) Comment on the community's response towards the sexual and reproductive health services of young people.
- 8) What roles do parents and educators play in advancing the agenda of SRHS?
- 9) In your expert opinion do you feel that the policy makers have designed relevant policies and programs to adequately meet the SRH needs of our Ugandan youth?

**THANK YOU FOR YOUR TIME & CONSIDERATION**

## IN DEPTH INTERVIEW GUIDE

### **Introduction**

Dear informant, you have been selected to participate in this research effort aimed at finding out the male and female youth experiences, expectations and attitudes towards sexual and reproductive health services provided in Uganda. Your honest opinions are highly valued for the success of this research and will be treated with absolute confidentiality. The information gathered shall be exclusively for purposes of this research.

### **Informant's details**

Participant Code :.....  
Organization Name :.....  
Designation :.....  
Recording code / theme :.....  
Interview place :.....

### **Interview guide for a Gender & Youth coordinator**

- 1) How do you understand / consider to be the sexual and reproductive health needs of young people?
- 2) How are SRH programs for young people tailored and implemented in the communities? And who are your target population? Probe.
- 3) How do you ensure that those youth with disabilities are suitably accounted for as equal beneficiaries of the SRHS?
- 4) According to Ministry of Health, UNFPA, Ministry of gender & UBOS reports of 2011-2013 indicators show that there are percentage increase in early youth pregnancies at 54% and a 6.7% increase in HIV amongst the youth, form your expert opinion what could be the problem?
- 5) Do you feel that there still gaps to be addressed in this area of gender, youth and their RH needs as much as several strategies have been designed?
- 6) In your designation, can you highlight on the existing gendered barriers to accessing and utilization of the SRHS of young people in the communities?
- 7) Elaborate on the currently designed programs on SRHS on young people by RHU?

**THANK THE PARTICIPANT AND CLOSE INTERVIEW**

## Appendix 3: University youth students

### 🗨️ FOCUS GROUP INTERVIEW GUIDE

#### Introduction

You have been selected to participate in this research endeavor aimed at exploring the male and female youth experiences, expectations and attitudes towards the sexual and reproductive health services provided in Uganda. Your honest opinions are highly valued for the success of this research and will be treated with absolute confidentiality and anonymity will be preserved. The information gathered shall be exclusively for academic purposes.

#### An interview guide for male youth aged 18-24 years

- 1) In your view, how do you understand YFSRHS? **Probe fully.**
- 2) Can you identify the most needful SRH packages in your life and how best you would like to access such services in your life? **Probe more.**
- 3) Are there any challenges faced while seeking these SRHS as young people? If yes, in what ways and how do you try to overcome them **PROBE FULLY.**
- 4) Generally how do you obtain information and knowledge concerning health issues, awareness, sensitization and SRH services in the public domain and space today? Depending on the source, how has this information shaped your attitudes and perceptions? **PROBE**
- 5) For instance you are faced with a serious health concern, where do you access advise / services or assistance? And how would you comment on that.
- 6) As young people, what are your attitudes and perceptions towards SRHS? Any positives/ negatives about these services or do you suggest anything.
- 7) Do you think female university youth are facing sexual violence and coercion while negotiating proper sexual relations? What do you think might be causing this challenge? Give reasons for your answer.
- 8) How would you comment on the prevalent rate HIV epidemic amongst your friends and particularly age group? What causes this spread according to you?
- 9) Let's assume university students are well versed about health concerns because of education, including sexuality information, then why do female students then acquire unwanted pregnancies?

## 🗨️ FOCUS GROUP INTERVIEW GUIDE

### **Introduction**

You have been selected to participate in this research endeavor aimed at exploring the male and female youth experiences, expectations and attitudes towards the sexual and reproductive health services provided in Uganda. Your honest opinions are highly valued for the success of this research and will be treated with absolute confidentiality and anonymity. The information gathered shall be exclusively for purposes of this research.

### **An interview guide for female university youth students**

- 1) In your opinion how do you understand the concept of YFSRHS?
- 2) Are these services provided in your community? If yes, where do you obtain them and how do you access them?
- 3) Generally how do you obtain information and knowledge concerning health issues, awareness, sensitization and SRH services in the public domain and space today? Depending on the source, how has this information shaped your attitudes and perceptions? **Probe**
- 4) Have you encountered any challenges to utilizing and accessing SRHS in your lives? Can you identify some? **Probe**
- 5) Can you share any experience where you or friends have benefited in the utilization of the SRHS? (Optional)
- 6) What type of reproductive health needs do you want to see addressed, as young people? **Probe.**
- 7) As young people, what is your attitude towards the SRHS designed for consumption?
- 8) Why do you think university girls get unwanted pregnancies yet they seem to be more knowledgeable about the consequences and for what reasons would force some to commit unsafe abortion? **Probe.**
- 9) Do you think male youth/men override your decisions in negotiating safer sexual relationships? In what ways? **Probe.**
- 10) How would you comment on the practice of intergenerational sex today amongst female students and older men?



## Appendix 4: Introduction Letter From UOB



UNIVERSITY OF BERGEN  
*Faculty of Psychology*

Bergen, 15 May 2014

To whom it may concern,

I hereby confirm that Emmanuel Kamyá is a student at the MPhil Programme Gender and Development at the University of Bergen, Norway. The MPhil Programme is a two-years' course, during which the students attend compulsory classes (1. year) and perform their own independent research in the form of a Master Thesis (2.year). All students collect their own data material through fieldwork in the summer semester between the first and the second year

Emmanuel Kamyá will perform his field studies in Uganda on the topic, Female and male youth's expectations, experiences and attitudes towards sexual and reproductive health services in Kampala. As his supervisor, I would greatly appreciate any support or help that you and/or your organization may provide him.

Sincerely Yours,

Dr. Thera Mjaaland  
Supervisor/Associate Professor

---

Street address:  
Christiesgate 13

Postal address:  
N-5020 Bergen, Norway

Telephone:  
47-55 58 27 10

Telefax:  
47 55 58 98 71

## Appendix 5: Letter of acceptance from the IRO, Makerere University



FROM THE OFFICE OF THE VICE-CHANCELLOR  
(INTERNATIONAL AFFAIRS OFFICE)

Monday, 23<sup>rd</sup> June 2014

### TO WHOM IT MAY CONCERN

#### **INTRODUCTORY LETTER FOR MR EMMANUEL KAMYA – UNIVERSITY OF BERGEN, NORWAY**

The bearer of this letter is Mr Emmanuel Kanya, an MPhil Student at the University of Bergen, Norway one of the long standing collaborating institutions with Makerere University since late 1990s. Under this collaboration, continuous student exchanges are taking place.

His programme of study is "**Masters in Gender and Development**". He is carrying out data collection from various public universities and likely to engage into Focus Group Discussions (FDGs) and one-to-one interviews with students at different levels of study.

Mr Kanya's topic is "*Female And Male Youth Expectations, Experiences and Attitudes Towards Sexual And Reproductive Health Services in Kampala*"

Any support and time offered to him will greatly be appreciated.

Kind Regards



Martha L. Muwanguzi Ngobi  
Head, International Office



In future correspondence please quote the reference number above

## Appendix 6: Acceptance and Introduction letter from RHU



### Reproductive Health Uganda

RN/RN/RHU/INT/2014

July 11, 2014

Mr. Emmanuel Kamyu  
University of Bergen  
N-5020, Bergen  
NORWAY

Dear Emmanuel,

**RE: RESEARCH STUDY**

Your request to undertake a research study on the **topic, Female and male youth's expectations, experiences and attitudes towards Sexual and Reproductive services in Kampala**, with Reproductive Health of Uganda (RHU) is granted. During your stay, you will be required to operate in accordance with the rules and regulations of RHU. RHU will not be responsible for any expenses you may incur during your internship, such as lunch, transport, etc

You will be based at RHU-Head Office, and will be directly supervised and answerable to Mr. James Tumusiime, the Gender and Youth Coordinator. Often our staff travel to the field and this could be a learning opportunity for you. For such learning purposes, RHU will accommodate you on its scheduled travel where appropriate, but will not be responsible for any eventuality that occurs to you while travelling or in the field. You will also need to provide for your own up keep. RHU will however ensure that the respondents are at your disposal.

The acceptance for this offer requires you to write a report and submit it to the Director of Programmes through the Gender and Youth Coordinator, at the end of your stay

In case the above conditions are acceptable, please formally reply.

Sincerely,

Dr. Peter Ibembe  
**Director of Programmes**

**Cc:** Governance and Human Resource Coordinator  
Gender and Youth Coordinator  
Records and Information Management  
Youth Office  
Service Provider In-Charge-Katego

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Plot No. 2 Katego Road Off Kira Rd.  
P.O. Box 10746, Kampala, UGANDA  
Tel: +256 414 540 658 Fax: +256 414 540 657  
Email: rhu@rhu.or.ug

A Member Association of  
 **IPPF** International  
Planned Parenthood  
Federation  
African Regional Office