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Sexual and Reproductive Health Education for Boys in Kapchorwa, Uganda

Meredith Colleary
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Sexual and Reproductive Health Education for Boys in Kapchorwa, Uganda

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Kapchorwa, Uganda

Spring 2015

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Abstract

This study examines the systems by which adolescent boys receive sexual and reproductive health (SRH) education in Kapchorwa, Uganda. Teenage pregnancy and early marriage are epidemics that hinder Uganda's development. As girls have consistently been the targets of interventions, this study considers how boys are included in these strategies. The objectives of the study are three-fold: to research the ways that boys receive SRH education, to identify the successes and shortcomings of these education systems, and to seek ways for these systems to be improved.

The study was carried out over a six-week period in the spring of 2015. The researcher held qualitative interviews with two teachers and two student focus groups at each of three secondary schools within Kapchorwa District. The researcher then taught a brief lecture on SRH at each school in which students were given the opportunity to ask anonymous questions about sex. Three focus groups were also held with adult community members. Additionally, interviews were conducted with the a representative from the Ministry of Education, the Kapchorwa District Education Officer and three NGOs that operate in the Kapchorwa area: Kapchorwa Child Development Center, the Women's Protection Center, and Reproductive Health Uganda.

SRH education was found to be inconsistent and spread thinly among many sources. The majority of education emphasized abstinence, and gave boys specific messages that may not be entirely effective in teaching them to respect females' sexual autonomy, nor in how to protect themselves from unplanned pregnancy. Recommendations are made on how these systems may be improved to better benefit boys, girls, and the community as a whole.

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1.0 Introduction

Teenage pregnancy and early marriages occur in high numbers in Uganda, eliminating girls' opportunities for further education and subjecting them to a difficult life. The Ugandan Demographic and Health survey found that 24% of girls get pregnant before age 19 (Nakujubi, 2013), and previous research points to the conclusion that the systems in place for teaching adolescents about sexual reproductive health, specifically about pregnancy and contraceptives, are inadequate. As adolescents hold on to misconceptions about contraception and culturally firm views of gender norms, marriage, and pregnancy, communities, particularly those in rural areas, pay the price. This study aims to understand the ways in which adolescents receive information about sexual and reproductive health, through qualitative interviews with students, teachers, NGOs, and adult community members in the Kapchorwa District. The focus of the study is on boys, who have been long overshadowed as research on interventions has historically been almost completely targeted at girls.

1.1 Background and Statement of the Problem

Early pregnancy and marriage is a major barrier to Uganda's development. When adolescent girls get pregnant, they most likely will drop out of school, ending their education. In 2002 for example, 13.3% of primary school female dropouts and 9% of secondary school female dropouts were the result of pregnancy or marriage (Kwesiga 2002, p. 192). However, it has been proven that investment in education translates directly into human capital. Girls with more education will be able to make higher incomes later on, better supporting their families and keeping them healthier. One study reports that Ugandan girls earn 20% more for every year of secondary education they complete (Peas, 2012). The effects of this will be cyclical, as their children will be less likely to be burdened with illness and malnutrition, and more likely to remain in school and thus make a higher income in adulthood. This has the potential to help lift the community as a whole out of poverty. Additionally,

educated women better understand the cost of raising children and the benefits of contraceptives, which can lead to smaller family sizes and therefore less financial burden on the family (Kwesiga, 2002, p. 34). Further, childbearing at a young age is physically dangerous; teenage mothers are twice as likely to die in childbirth than mothers in their twenties, and mothers under fifteen years are five times more likely to die (Biddlecom, Hessburg, Singh, Bankole, & Darabi, 2007, p. 15).

Women and girls are not the only ones to face the consequences of early pregnancy. By Ugandan law, defilement, characterized as “Any person who performs a sexual act with another person who is below the age of eighteen years,” is “on conviction liable to life imprisonment” (UPCC, 2007). Thus, men who have sex with young girls can potentially pay severe legal consequences. Additionally, should a teenage boy father a child, he or his family will (at the very least, in theory) be responsible for providing for it economically, which is obviously difficult to do at a young age. Therefore, it is critical that adolescent boys be aware of contraception, the mechanics of sex, and the potential dangers that sexual activity can have.

Boys play a major role in perpetuating these problems, and yet have largely been neglected in analysis of the topic. Existing literature posits that culturally, boys are expected to be sexually dominant and have uncontrollable sexuality, compared to girls who are expected to passively accept males’ advancements (Burns, 2002; Kwesiga, 2002). As a result of patriarchal society and power relations, women cannot negotiate sex or contraception use (Actionaid, 2006; Kabagengyi et. al, 2014). Although it is often times older men and not adolescent boys who impregnate the girls, the young boys of today will grow up to become these older men of tomorrow. Therefore, it is essential that interventions aimed at adolescent males be brought into the conversation.

1.2 Objectives

- I. To research how adolescent boys in Uganda receive information regarding sexual and reproductive health.

- II. To examine what the outcomes of these education systems are; how well or how poorly these systems of information distribution work.
- III. To find ways in which the various mechanisms of sexual health education for boys could be improved in order to lead to more favorable outcomes for themselves, girls, and communities as a whole.

1.3 Justification

While much research has been done on this topic through the lens of girls – what are they taught about how to protect themselves, what are the reasons for them becoming pregnant or married, and what are the consequences for them – less attention has been paid to the role that boys and men play. Yet, males are the ones who ultimately are impregnating the girls. Likewise, when adolescent boys become fathers, they also face consequences themselves – economic and emotional responsibility, legal repercussions, and potentially harmful social effects. Therefore, it is critical to examine the systems through which boys learn about sexual reproductive health.

Kapchorwa district is an excellent location for this study. Early pregnancy and marriage occur in higher numbers in rural areas (Biddlecom et. al, 2007; Kwesiga, 2002); with a population of around 110,000 and a fertility rate of 6.9, Kapchorwa embodies the small rural setting in which early pregnancy tends to manifest itself most visibly. In the district, remotely located in the Eastern mountains of Uganda, 99% of the population has no access to electricity, and the majority of its residents are subsistence farmers (Kapchorwa District Local Government, 2010). There are 22 secondary schools in Kapchorwa, eight of which are government funded, two of which are private, and twelve of which are community schools (*Kapchorwa District*). Though widely known for its prevalence of female genital mutilation, the same power structures that provide the environment for FGM enable teenage pregnancy and early marriage. According to one article, over 50% of girls below 18 in Kapchorwa drop out of school to get married (Senkaaba, 2008).

2.0 Literature Review

Sources of Sexual and Reproductive Health Information

Although little research has been done with a focus on boys, the topics of sexual and reproductive health (SRH) education has been thoroughly written about. In school, programs are in place to sensitize students on issues of sexuality. The government seems to recognize the need for greater SRH education, writing in the Ministry of Education's *Revised Sector Strategic Plan 2007-2015* (2008) that their goal of "ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills" has been "undermined by a combination of social ills that include civil strife, HIV/AIDS, early pregnancies...These not only threaten the life of young people, but also reduce opportunities for their development" (p. 11). However, the Ugandan school curriculum does not have a specific place for sexual health education to take place. Rather, in an effort to promote marketable skills such as literacy and numeracy, side topics such as sexual health are forced to fit into existing subjects such as science or religious education classes. The Ministry of Education emphasizes that the revised sector plan "puts the highest priority" on literacy and numeracy. The plan continues to outline that in order to work towards those areas in both primary and secondary schools, the revised curriculum will "Devote more instructional time [to those subjects]; and consolidate other vocational and other subjects into less time" (p. 22). Sexual reproductive health education qualifies as one of those "other subjects."

Government-promoted initiatives nonetheless do currently exist. For example, in 2002, President Museveni introduced the President's Initiative on AIDS Strategy for Communication to Youth (PIASCY), a largely moral-based approach that strongly advocates abstinence. This program mandates all primary schools to hold biweekly assemblies to disseminate one of 26 "messages," which all open with the message "choose to abstain." All secondary school information is to be disseminated in either Biology or Christian Religious Education classes (Cohen & Tate, 2005). Teachers nationwide were trained in the PIASCY curriculum, and although during trainings some teachers expressed interest in learning more about proper condom

use, they “were instructed to teach only abstinence to children” (Cohen & Tate, 2005, p. 34).

Information sources outside of the classroom have been found to be likewise inadequate. Previous research has found that parents do not talk to their children about issues surrounding sexuality, as that is considered culturally off-limits (Biddlecom et. al, 2007; Hulton et. al, 2000; Neema et. al, 2004). One study found that only 20% of 15-19 year old unmarried males in Uganda have ever talked to a parent about sex-related matters (Biddlecom et. al, 2007). As a result, previous studies have shown that most adolescents get the majority of their sexual and reproductive health education from their peers and the media (Biddlecom et. al, 2007).

Successes and Challenges

Despite the government’s initiatives in place, the effectiveness of these policies is unexceptional. As Neema et. al (2004) writes, “Though there are a number of policies in Uganda related to adolescent sexual and reproductive health, many of them have not been fully disseminated and utilized” (p. 29). Often times, instructors of sexual reproductive health are unqualified; teachers lack the training and expertise to teach the curriculum thoroughly and accurately. One study found that even if teachers do have the resources available to teach their students about contraception, culture becomes a barrier, as it would be “professional suicide to openly advocate condom use since some staff members would consider this as encouraging prostitution” (Burns, 2002, p.86).

Additionally, the programs that are implemented are often lacking in truthfulness. PIASCY, for example, in an effort to promote abstinence, often contains inaccurate or misleading information in its messages. A Human Rights Watch study in November of 2004 found that “teachers said that the messages about condoms they had been told to give in PIASCY trainings conflicted with that found in the science curriculum,” citing a secondary school PIASCY handbook which reads, “condoms have small pores that could still allow the virus [HIV] through (Cohen & Tate, 2005, p.34). Although condom demonstrations are occasionally done at school,

it is usually by outside groups separate from the school staff (Cohen & Tate, 2005, p. 35), meaning that it is inconsistent and is not guaranteed for all students.

Because of the gaps in education, major misconceptions exist about condoms and other contraception, including fear of harmful side effects to the body, unattractive changes to women's appearance, and decreased sexual pleasure (Actionaid, 2005; Hulton et. al, 2000; Kabagengyi et. al, 2014; Neema et. al, 2004). One study found that one in three adolescent males and one in two adolescent females in Uganda did not know that condoms should be used only once (UNFPA, 2013, p. 43). Besides misconceptions, many boys simply lack knowledge about contraception and the consequences of unwanted pregnancy (Biddlecom et. al, 2007; Hulton et. al, 2000).

In addition, men often block women's access to contraception and reproductive health services. Because men have more control over family resources than women, women often do not have the ability to pay for, or even travel to, family planning services on their own (Actionaid, 2005; Kabagengyi et. al, 2014). At the same time however, "young men tend to consider it the woman's responsibility to insist on condom use, because she is the one who can become pregnant" (Biddlecom et. al, 2007, p. 18; Hulton et. al, 2000). This creates a situation in which contraception is not being utilized, even if it is known about.

Recommendations for the Future

Efforts to address the problem have largely been focused on girls, encouraging them to better protect themselves and try to fight against the pressures that push them towards pregnancy. However, girls are not the only people involved in the epidemic. Until men and boys stop impregnating adolescent girls and standing in the way of their receiving reproductive health services, the problem will not go away. It has been hypothesized several times that increased sexual health education could help improve the epidemic of unwanted teenage pregnancy (Actionaid, 2005; Biddlecom et. al, 2007; Burns, 2002; Hulton et. al, 2000). Some literature suggests that in-school education needs to be increased, refined, and started earlier (Biddlecom et. al, 2007). Other suggests that efforts should be greater focused on

outside organizations, as this will remove religious pressures, as well as political motives that may be pushed by the government (Burns, 2002). An additional benefit of this approach is that out-of-school education has the potential to reach adolescents who are not in school, with “targeted community outreach” (Biddlecom et. al, 2007, p. 28).

3.0 Methodology

3.1 Data Collection Methods and Instruments

The study took a qualitative approach in order to bring to light the personal conceptions and cultural beliefs that direct boys’ ideas on sexual and reproductive health, using a combination of in-depth interviews and focus group discussions. The first two weeks of the study were spent in Kapchorwa District. Three secondary schools were visited, each with varying characteristics in order to obtain a diverse sample. The first school, Sebei College Tegeres, is a public, co-educational boarding school. The second, Kapchorwa Parents Secondary School, is a private, co-educational boarding school. The third, Kapchorwa Secondary School, is a public, co-educational day school.

At each school, two focus group sessions were held: one with six to eight female Senior One students, and another with six to eight male Senior One students. Senior One students were chosen because at that age, many are beginning to make their sexual debuts if they have not already done so. Therefore, their perceptions of sexuality and knowledge of reproductive health at this age is key to understanding the causes of their future, and in many cases, past, actions. Teachers at each school randomly selected the students for the focus groups. However, teachers were not present during focus groups at Sebei College Tegeres and Kapchorwa Parents Secondary School in order to elicit the most candid responses possible from the students. At Kapchorwa Secondary School, however, the Senior Woman teacher preferred to be present during the focus groups. While this may have restricted the

students' honesty, she proved to be a helpful asset in getting the students to open up and elaborate on their answers.

Focus groups were preferred because unlike large quantitative surveys, they reveal "detailed attitudinal and motivational information for specific target groups," and represent the range of knowledge among members of a target group (Hulton et. al, 2000, p. 36). These discussions allowed for a better understanding of adolescents' knowledge, misconceptions, and personal opinions on contraception use, by asking questions such as "where do you learn about sex outside of school?" and "what are some reasons why you would not want to use a condom?" Questions such as "what do you think when a classmate gets pregnant?" helped to gauge the students' perceptions of early pregnancy, marriage, and gender roles and responsibilities (see Appendix A for the focus group guide). Focus groups permit more nuanced and detailed responses that are key when explaining such complex social phenomena as sexuality and gender relations. Conducting these discussions at multiple schools helped to illuminate trends in order to improve the validity and generalizability of findings.

After the focus groups, the researcher conducted a brief lecture on sexual reproductive health to large classes of Senior One students. Each class lasted between one and one and a half hours. They began with an overview of the symptoms, prevention, and treatment of the most common sexually transmitted diseases in Uganda, and proceeded to inform students about methods of contraception. Afterwards, students were distributed slips of paper on which they were instructed to write down any anonymous questions they had about sex, pregnancy, contraception, or sexually transmitted diseases. The remainder of the class period, then, was spent going through and answering the questions one by one. While this class served to be a way of thanking each school for its cooperation, the students' anonymous questions also provided helpful data on their knowledge and misconceptions about sexual health.

Additionally, interviews were conducted at each school with both the Senior Man and Senior Woman Teacher. These teachers' position comes with the responsibility of being a resource for their students' gender-specific needs;

therefore, they were an obvious choice to ask about the students', staff's, and school's relationship to sexual and reproductive health education. Additionally, these interviews helped grasp how adults perceive early pregnancy, a valuable insight, as these perceptions influence the messages that students receive. Likewise, these interviews helped to gain insight on what sexual health education programs are offered in each school setting. In-depth interviews are a good method for this objective because they offer the chance to ask follow up questions and clarify if a question is misunderstood. Additionally, interviews provide a chance to hear the individual voices of respondents, whereas questionnaires cannot. Further, talking with people on the ground that are directly involved in the education of students, rather than researching the system from afar, gives a better picture of reality. See Appendix B for the teacher interview guide. Although the Senior Man and Senior Woman at Sebei College Tegeres were interviewed separately, time constraints required that a joint interview with both man and woman teachers took place at Kapchorwa Parents Secondary School and Kapchorwa Secondary School. All of these interviews took place in either an office or the school staff room, away from the distractions of students or other individuals.

In addition to speaking with students and teachers, three focus groups were held with members of the Kapchorwa community. The first of these was a group of eight adult women, held in a shop near the center of town. The second was a group of ten adult men and ten adult women together, held outside someone's home a few kilometers outside the main part of town. The final focus group was a group of five adult men, held in the sitting room of one of the participant's homes. Because not all of the participants spoke English, one of the participants in each group acted as a translator. Participants were found through contacts in the Kapchorwa community who were able to mobilize the individuals. Each focus group lasted about 45 minutes. The purpose of these discussions was to hear adults' opinions and thoughts on matters related to sexual and reproductive health, as adolescents receive messages from a variety of sources outside of school. Further, the majority of the focus group participants were parents themselves, and therefore had strong

opinions on their hopes and fears for their children, as well as experience relating to their children about sexual health (see Appendix C for list of questions).

An interview was conducted with the Kapchorwa District Education Officer (DEO), who held information regarding policies and trends in the district's school system. Additionally, interviews were conducted with mediators and an administrator from the regional Women's Protection Center, a shelter for gender-based violence. Another interview was held with a representative from the Kapchorwa Child Development Centre, an organization funded by Compassion International that serves the needs of orphans and vulnerable children in the area, providing basic needs, health services, and support in a variety of areas. Upon returning to Kampala, another interview was held with the Youth Officer of Reproductive Health Uganda, an organization that aims to disseminate information and services about reproductive health to individuals across the country. Speaking with these NGO's, which all deal with topics surrounding community education, defilement, and adolescent sexuality, helped round out the picture of where adolescents are receiving their sources of information on sexual health. Directly interviewing representatives at each organization helped to better gather what messages they direct towards adolescents, and how they reach those populations. One final interview was held with a representative from the Ministry of Education in order to hear a government perspective.

3.2 Data Analysis

After data collection, all interviews and focus groups were transcribed. They were then read and coded for themes surrounding the objectives of the study: in-school sources of information, out-of-school sources of information, successes of these systems, shortcomings of these systems, and recommendations for improvement.

Within these codes, additional categories were coded for. For example, within "shortcomings," findings were separated into categories of misconceptions, lack of basic knowledge, and barriers to better information dissemination. Students'

anonymous questions were also included in this process. Findings were then compared across sources and combined to create this report.

3.3 Limitations of the Study

Time proved to be a significant limitation to carrying out the study to its full potential. The study covered a period of six-weeks, but for some of those weeks, the Kapchorwa school district was on holiday, and therefore schools were not in session. This prohibited more than three schools from being included in the study. Similarly, while research was being conducted in Kapchorwa, some key informants such as the head of Reproductive Health Uganda's Kapchorwa branch were not in town, and therefore were unable to be reached.

Bureaucracy was another barrier. While there are several organizations involved in adolescent SRH education, gaining access to interview individuals within some of these organizations was difficult, given the short time frame. Likewise, potential interviewees were often difficult to contact, and therefore it was not possible to organize an interview before the research period ended. Language barrier and confusion over certain terminology proved to be another obstacle. This was overcome as best as possible by using translators and rephrasing questions when confusion presented itself.

As a result of these limitations, this study can of course be expanded in future research. More schools could be included, particularly those in more rural areas of Kapchorwa district. Similarly, there are very many NGOs involved in this area that could also be included in the study. In addition, this study examines particular sources of SRH education: schools, NGOs, and parents. In reality however, adolescents receive information about sex from a greater variety of sources. Further research on this topic should include an examination of those other sources, such as peer groups and media influence.

3.4 Ethical Considerations

Although this research was fairly low-risk to participants, careful measures were taken to ensure that ethical concerns were observed. Due to the strong social and cultural meaning that issues of sex, childbearing, and gender norms carry, it was critical to avoid compromising the reputations of participants. Therefore, individuals remain anonymous in this report unless they stated otherwise that their names might be used. All interviewees and adult focus group participants were briefed on the purpose of the study, and each signed a consent form (see Appendix D) that guaranteed anonymity prior to the start of the interview.

As minors were involved in the research, special concerns were taken into account. Names of focus group participants were not recorded in any way. Consent for using their responses in this report was given by each school's head teacher, who was briefed on the purpose of the study, and signed an informed consent form on the students' behalf. Students were made aware that their names and identifying information were not recorded.

Schools were thanked for their time by receiving a lecture on sexual and reproductive health, as discussed previously. This provided a valuable and much-needed service to the students; at each school, teachers had mentioned in their interviews that they appreciated outside sources bringing information on this subject to their students. Adult focus group participants were compensated for their time with light refreshments and bars of laundry soap.

Language barrier was a particular concern, as it was essential to select phrasing that did not come across as accusatory, judgmental, or offensive. Particular concern was taken to eliminate bias from interview questions; they were therefore phrased as objectively as possible. Further, while it would have been easy to carry out this research and analysis through a preexisting lens of Western thought, the reporting of these findings was aimed to eliminate any preconceived thoughts.

4.0 Discussion

4.1 Sources of Sexual Reproductive Health Education

In-Classroom Sexual Education

The findings of this study uphold the government's statements that school curriculum should be focused on literacy and numeracy "The Ministry has for a long time looked more at the key issues that will support them in reaching their...MDG [Millennium Development Goals] goals," explained a representative at the Ministry of Education, "They are all very clear. Quality, literacy, numeracy, et cetera." The teachers included in this study, as well as the Kapchorwa District Education Officer, agreed that there is no specific place for sexual reproductive health education in the curriculum. As a result, it is scattered among other classes offered at the school, and is scant. Often times, while teachers assured that SRH messages are being relayed to their students, they struggled to pinpoint where exactly these messages are coming from. "I think they normally teach that in terms of career guidance, which they normally do once a month," said a Senior Man Teacher, "And then they do special subjects like biology and other elective things." At another school, the Senior Woman Teacher explained, "We have reverend teachers. So sometimes, they address them on spiritual growth. And part of their communication will fall on sexuality and sexual health. Then we have the careers office. When we are talking to them on academic excellence, we also talk about sexuality. And then sometimes in a general assembly." A third school's Senior Woman Teacher explained, "There's a subject called Christian Religious Education, and in Senior 4, we have in our syllabus that topic. We teach them about...sex, reproduction...but that is only for those students who take that subject. It's not compulsory." According to the Ministry of Education representative, "life skills," is supposed to teach issues of sexuality. However, this is not a compulsory subject, and is "handled as an extracurricular activity."

Due to this scattered dissemination of messages, the specific topics relayed are not succinct or uniform across schools. When asked what topics related to

sexual and reproductive health were taught at the school, teachers' answers included "HIV/AIDS," ways of preventing pregnancy, ways of abstaining from sex, and PIASCY. One male teacher explained, "Sometimes it is just what we feel the students should know. ...We make them aware of what the reality of the world is today." When asked what individuals at the school teach these things to students, answers once again varied from school to school, ranging from biology teachers to religion teachers to career guidance counselors. "We don't have a specific teacher," said a different male teacher, "But it is the role of every teacher to talk to the students about that."

PIASCY programs existed in the three schools in this study. However, it was mostly an afterthought when teachers were explaining the programs their school had in place. All but one of the teachers did not even mention PIASCY until specifically asked about it. This may be because the government is no longer allocating funds to PIASCY programs, and therefore they are slowly falling out of practice. The Ministry of Education's perception on the implementation of PIASCY, however, countered this.

"The way it was implemented was that a lot of material was produced, and lots of strategies and activities were implemented within the schools...So when you go to schools, you'll find the talking compounds still very active. ...So even if the funding and the support to disseminate the information at the Ministry level is complete, the schools and districts are taking that on because there was a sustainable way of making sure that this continues on at all schools in the country." – Ministry of Education Representative

All of the schools, however, placed a very strong emphasis on abstinence education. Every teacher interviewed made it a point that abstinence was the main message relayed to students.

"We always tell them, please, for us here in Uganda, what you have to do is abstain from sex. Abstain until you get married. We tell them, sex is only in

marriage. Only allowed in marriage. Only. Abstain until then. That's what we tell them. Then some of them they tell you, 'but we lack self control!' No, if you lack self control, read a Christian magazine, be busy, play some football, netball, make yourself busy." – Senior Woman Teacher

Teachers did express that they also tell students about condom use, however it is to be used as a last resort. "We mainly emphasize abstinence," explained one female teacher, "and when it's inevitable, when they can't avoid, we advise on condom use." The Kapchorwa District Education Officer validated this sentiment:

"Basically, we emphasize abstinence. We tell the students and the pupils, 'you are not of age, you don't need to go into that...abstain!' That is our emphasis. Of course, we don't rule out these others. We also give them those other aspects. But we emphasize abstinence. Abstaining from sex, because of HIV/AIDS, because of pregnancy, yeah. We think that one is better for our students, if they can abstain. But of course, you also equip them with these other things, like condom use." – Kapchorwa District Education Officer

Teachers also ensured that they warn students of the dangers of sex. "We always warn them, and basically we advise them that early pregnancy will affect their education...the dangers may even be death," said one male teacher, "They can die, in the long run." Other dangers mentioned by teachers include dropping out of school, pregnancy, AIDS, STD's, the challenges of being a youth mother, and "producing bastards."

At two of the schools in this study, boys and girls are kept together in one classroom for some SRH lessons, and are separated by gender for others. Teachers at one school explained that students have shown strong discomfort when they are taught these things as one class.

"When you tell them when they are together...they are shy. For words like menstruation, they feel it should only be taught to girls, and yet it is

something they are all supposed to know.... Generally, it is information that benefits them both.” – Senior Man Teacher

“Sometimes when you are teaching a class and you mention things, you see them go like, ‘Oh! Ummm...madam....’ Some of them don’t want to hear about it. They don’t like it. While, when we separate them...then we talk to them and we tell them please, don’t shy away. Ask anything. Talk to us.” – Senior Woman Teacher

Of course, when separated, the subject matter taught then varies by gender, and boys and girls are not taught the same things. The information changes for “the dangers and some personal things,” explained one Senior Man Teacher, “There are some things that are private to the females, and others that are more private to the males.” The third school in this study, however, does not separate boys and girls when teaching SRH topics, although that may be simply a result of the short time allowed for these lessons.

NGO’s have a hand in classroom SRH education, as well. Reproductive Health Uganda, for example, targets adolescents by reaching out to their schools. Teams may go in and supply students with both SRH information and services.

“Our intervention...it’s comprehensive. It’s both information and services. We complement the two aspects. We train peer educators, even the teachers, then we do health talks, so at a time when you are providing services, at least the person comes from an informed perspective as far as accessing reproductive health services is concerned. Then we sometimes also have mural paintings in the schools that communicate messages.” – RHU Youth Officer

Once again however, time presents a challenge. Interventions such as those from RHU have to fit into the schedules of the schools, meaning that many students get left behind.

Out-of-Classroom Sexual Education

Sources of sexual reproductive health education outside of the classroom are likewise scattered. Every teacher and NGO worker interviewed in this study agreed that SRH education should begin with the parents. The parents' perceptions on why early pregnancy occurs and what its results are are critical, as this shapes the way that they talk to children about sexual reproductive health. Most parents in the three focus groups were in agreement that teenage pregnancy and early marriage is a problem in the community, and that it was dangerous for young girls. The dangers that parents mentioned were mainly dropping out of school, domestic violence, inability to care for the child, and violence from the father's mother.

“The level of income of these [married] children is very, very low. And they depend on their parents. That's when you find that the girl will be taken to stay with the mother in law, which is very, very dangerous, and hard. And if these children have never been to school...their thinking capacity is very, very low. Yes, this boy will be there, but he will still be wanting other girls, outside there. And that's when we shall get domestic violence in that house of children. There will be fighting, there will be quarrels everyday, and it has even lead to death. Of recent, we buried some young lady who was cut by her husband; they were together at that tender age of below 20.” – Female Community Focus Group Participant

“After pregnancy, a boy can deny a girl. He can just leave her there. That is how you get those unwanted children. Because they are unwanted, when they grow, there will be no proper care, and these children will lead to become street children. Especially in this area of ours. There are very many.” – Female Community Focus Group Participant

Men, however, seemed to be less concerned with the issue of early marriage than the women were. Of the 33 total community member focus group participants, only two gave an indication that early marriage or pregnancy could have benefits; both of these participants were male. “When they get pregnant when they are still

young, it will depend on the character of the girl,” said one of the men, “If the girl is a prostitute...it might be a turning point for her to calm down.”

Parents had widespread views as to why they believed early pregnancy happened. Several participants mentioned the influence of peer groups, as well as financial constraints that cause the girl to go off with an older man who offers her money. When asked about pregnancies involving adolescent boys, however, parents had a much more fatalistic attitude, indicating that it is the nature of boys that causes them to involve themselves. “It’s just their nature,” explained one woman. “Lack of self control. You may know [about the consequences], but still, you can’t control yourself,” one man rationalized, “and the adolescent boys in that stage – a boy just feels high.”

Parents were mixed in terms of whether or not they felt comfortable talking to their children about sexual health. Women claimed to be more comfortable talking to their daughters than their sons, for example one woman who said, “I will talk about it to a girl, but not a boy.” Similarly, some men expressed discomfort talking to their daughters, saying, “It is gender based. For me, I would be free to talk to my sons. But not my daughters.” While many of the other men claimed they would feel comfortable talking to their children about sex, however, women in the mixed-gender focus group jokingly suggested they were lying, interrupting the men to say, “They fear!”

Participants emphasized that they mostly tell their daughters only to abstain until marriage and about the dangers involved with sex, although one woman added that, “If you want a future for your daughter, you have to tell them [about contraception]...but we emphasize on abstaining, mostly.” When it comes to talking to sons about sexual health, the vast majority of parents, both male and female, said that they also focus solely on abstinence. A few of the participants, however, felt that abstinence-only education may be unrealistic, and that it was therefore important to tell boys to use condoms.

“Sometimes you can advise them [to abstain], but they can meet friends and they can go with girls. So at times you say, just go and use condoms.” – Female Community Focus Group Participant

“Honestly, abstinence might not – I’ll tell them to abstain, but I know...they will not listen because of peer groups. Because of peer influence, they cannot abstain. They will abstain in my presence, but in my absence they will go ahead. So I think protection methods is the best [thing to teach them].” – Male Community Focus Group Participant

Aside from these few parents who encouraged teaching condom use, however, parental guidance was limited to stressing abstinence, warning children of the dangers that early pregnancy may have on their futures, and warning them to stay away from negative peer influences. Students in all six focus groups corroborated this. Each group said that their parents talk to them about sex, but that they only emphasize abstinence; their parents do not tell them about contraception.

When parents were uncomfortable or wary of talking to their children about sex, many of them shared various strategies they had to indirectly relay the information. “I call the uncles,” one woman explained, “and I tell them all the secrets about these things and say, you talk to these children openly.” “Some use friends,” mentioned another, “like my friend I can tip her: ‘go and talk to my daughter, please. This is what she is doing.’” Despite the discomfort, however, parents largely expressed that they felt it was their responsibility to educate children about sexual and reproductive health. Interestingly, all female participants all said that it was primarily the parents’ job, more specifically the mother’s.

“It is the mother’s. Because the mother is closer than the father. Most of the time, the father gets up very early, and the mother is the one who remains with the children at home. So it is the mother who is supposed to talk to the child...And when the child gets spoiled, the father says, ‘no, that is the mother’s [fault]. Men are not responsible nowadays. They give women a lot of work.” – Female Community Focus Group Participant

On the other hand, none of the men expressed views that it was mainly the parents' responsibility. All male opinions offered on this subject suggested that the responsibility fell on a variety of people.

"All stakeholders here. Preachers should preach, teachers should teach, doctors should do it, drama groups should dramatize, parents should do it, everybody! It's a community responsibility. Even the media should help us."

- Male Community Focus Group Participant

Aside from parental guidance, a variety of local non-governmental organizations play a role in educating adolescents about SRH outside of the classroom. Reproductive Health Uganda, in addition to their in-school outreaches, organizes several programs that target young men, for example, the Rise-Up Project, which attempts to bring boys into the conversation surrounding teenage pregnancy and women's sexual rights. Part of this project is the "Young Men as Equal Partners" (YMEP) program, which attempts to work around the societal idea of men as decision makers by "making it a point that yes, we appreciate you [boys] are key stakeholders in health utilization and accessibility...but you are also clients and partners" (Interview with RHU Youth Officer). As part of this project, RHU holds male-only clinic days, wherein male peer educators discuss issues of sexual health with young men.

"Most of the problems young women and females get partly emanate from the ignorance of the males, because society grooms these men that they are already knowledgeable about reproductive health issues. ...When we are talking about teenage pregnancies, most of the time...it's the girl who most of the time suffers the consequences, and society decides that most of the interventions towards teenage pregnancies should target females! And it leaves out the men. So here in our program we are saying, 'men, boys, you are key stakeholders in teenage pregnancy.' So, can we target also the male?"

If he's not ready to go be a father, why would he wish the other little girl to be a mother?" – RHU Youth Officer

Other NGO's in the district address sexual health issues as well. The Kapchorwa Child Development Center (KCDC), sponsored by the Christian charity Compassion International, works with orphans and vulnerable children, intervening in four aspects of children's lives: spiritual, cognitive, social/emotional, and health. Early pregnancy and marriage touches the lives of the children they work with. "You find a child is no longer in the area, no longer attending our program," explained a KCDC Representative, "and when we follow up, we end up getting information that they have been married off. Then we've also got defilement cases."

As part of their goal of improving children's health, KCDC addresses sexual health in life skills training classes with an emphasis on abstinence.

"They are informed of child rights and the forms of abuses, and what they should do not to fall victims of pregnancy....Then we discourage them against family planning. You know, some of them are curious, they want to practice sex and all that. So we invite counselors who come and kind of straight talk with them and inform them of the dangers of early pregnancies...But we really don't encourage [condom use]. It's our wish that children do abstain, and that's what we encourage them on." – KCDC Representative

Similar to much of the in-school education, KCDC divides children by gender for these classes in order to give "appropriate information" to each sex.

"Usually the boy becomes the defiler in most cases, and then the girl is defiled. So, we have to give the right information to girls, like they should not fall victims of defilers. [Boys are told] besides avoiding being the abusers, the other issue is abstinence. We do encourage them to abstain." – KCDC Representative

The Kapchorwa Women’s Protection Center (WPC) is a regional gender-based violence shelter that mediates domestic violence cases. Male involvement is a key element of their efforts. Mediators at the center are all older men, trained in mediation and given the title “Male Champion.” In addition to mediating couples that experience violence, the WPC often goes into communities for “community sensitization. You write letters to the LC’s and local people there, and after, you assemble, and you meet them, talk to them about violence” (Interview with WPC Representative).

According to the representative and male champions interviewed, these community sensitizations are often well attended by a variety of people – male, female, young and old – adolescent males included. For the boys that are present, this serves as another source of information regarding sexual health. Of course, attending these sensitizations is not mandatory, nor do they take place everywhere across the region.

4.2 The Outcome of Systems of SRH Education

Successes of Education Systems

The education systems in place in Kapchorwa have some clear successes. Most students in the three schools included in this study are aware, to some extent, of contraception’s existence and purpose. When asked to list the ways of preventing pregnancy, students in all six focus groups mentioned condom use. Two out of the three male groups, and all three female groups mentioned the use of pills, injections, or family planning. Two of the three male groups, yet none of the female groups, listed abstaining from sex as a way to prevent pregnancy.

Likewise, male students seemed to be exceedingly aware of certain consequences of early pregnancy. When asked what some of the consequences of early pregnancy are, boys’ answers in all three groups included death or complications while delivering, the mother dropping out school, and the mother’s inability to pay for food and school fees for the child. When asked what the

consequences would be for the boy himself if he were to impregnate the girl, all three groups listed dropping out of school and being arrested. Additionally, one boy responded, “We will be beaten by the parents of the girl.” By far, the physical harm that may come to the female during pregnancy, and the legal consequences that may come to the male, were the most frequently listed dangers by all three male groups.

Similarly, students were able to list the benefits of having few children and avoiding unwanted pregnancy. All six student focus groups understood that children are expensive to raise, noting that providing many children with food, education, and “basic needs” will be difficult in the future. One male focus group also mentioned the expenses of providing medical care as a reason to avoid having too many children. Despite this, however, when asked how many children they wish to have one day, students in the male focus groups’ answers ranged from three to eight.

Challenges of Education Systems

Despite these successes, however, the systems by which students receive sexuality education have serious shortcomings. The in-school distribution of SRH information is inherently flawed. Schools lack the necessary basic resources to carry out proper sensitization. Because sexual reproductive health education is not explicitly in the curriculum, there is not enough time in the day to relate this information to students. “It’s not included in the curriculum, so it’s not included in the timetable,” explained the Senior Man Teacher at one school, “So we only create free time or some short time to pass on the information.” Teachers at both of the other schools corroborated this notion of time shortage. While the District Education Officer emphasized that “There is some element of” SRH education in the curriculum, he continued to express that even where it does exist, it is often overlooked.

“Of course, you know, our curriculum is examination oriented. The teachers don’t emphasize some of this. They go very much into the core subjects, leaving some of these things out. We have [SRH education in the curriculum]

actually, but the emphasis - when it comes to the practical aspect - the teachers will concentrate more on what they think will make the children pass.” – Kapchorwa District Education Officer

Further, because there is no specific place on the timetable for sexuality education, there is no guarantee that necessary information is reaching each individual student. For example, one female teacher expressed that, “In our curriculum...they have told us that we are supposed to [teach SRH]...but not on the timetable. But in assembly? We can mention a word or two to them.” Additionally, when the information is being disseminated in optional classes, such as Christian Religious Education, the students who choose not to take that class will not be exposed.

Four of the six teachers interviewed felt they, or other faculty members responsible for teaching SRH, were not completely qualified or comfortable talking to students about these topics. “We need more trainings, to update,” explained one Senior Woman Teacher, “Because on issues of sexuality...sometimes we teachers may not really handle it, so we need more trainings anyway.”

Additionally, students and teachers agreed that while some students may be open discussing matters of sexuality with their teachers, there are many who do not feel comfortable using their teachers as a resource. Teachers at each school said that the young students, such as Senior One and Senior Two students, might occasionally come with questions about sexuality; however, the majority of students, particularly the older adolescents, shy away from discussing these things with teachers.

Further, as discussed earlier, many schools rely on NGOs to fill in the gaps on educating adolescents where the school curriculum may fall short. However, each of the NGOs included in this study – RHU, WPC, and KCDC - complained of lacking sustainable funding. Therefore, there is concern that one day these programs will not be able to continue. “We’ve been working with them,” explained the District Education Officer about NGOs, “but of course their projects usually have a lifespan. When it ends, you again look around to see who comes to help you.” Furthermore, these organizations cannot possibly reach every adolescent:

“Some of these organizations, they come, and they target a few sub counties. Like we have one...that is only handling ten schools in two sub counties. The rest of the sub counties may not benefit from that. And there’s a tendency of the NGOs...to concentrate on the urban area, where it will access schools, but neglecting those where there is the most need. Those places on the periphery of the district, they are not getting some of these services.” – Kapchorwa District Education Officer

All sources in this study indicated that they felt it was the parents’ responsibility to do the majority of SRH education. However, this has its flaws as well. The lines of communication between adolescents and parents are not entirely open. Many parents, as discussed earlier, are uncomfortable talking to their children about sexuality. “Culturally,” quoted one male community member, “we don’t want to talk about issues of sex.” Even the representative at the Ministry of Education cited parental hesitation as a barrier to disseminating information to students in schools, stating that, “For us, the culture has been: we talk about abstinence and children shouldn’t know all this information; when you talk about it then they start practicing it.” Correspondingly, across all three adult focus groups, parents expressed concern that if they talked too much to their children about sex, their children would believe that the parents are encouraging it. Only one parent, across all three groups, was not concerned about this reverse effect. Said one mother, “If you talk to children all the time, telling them about sex, telling them to abstain, they will say, ‘...it seems Mommy knows these things more. Let us try these things and see how bad it is.’” A father in a different focus group shared a similar sentiment, that overexposure to sexual health information would cause it to be worthless:

“It becomes a song if you start repeating it, and it is useless. It becomes useless. They start mocking you...So, once in a blue moon, it can sink....But they don’t value a song. So always, repeatedly, might not be good.” – Male Community Focus Group Participant

In addition, many children don't feel comfortable talking to their parents, either because they feel awkward or are afraid of their parents' judgment. Said one male student in a focus group, "You fear to speak those words. Some of our parents are fierce."

Another theme that became evident in the three community focus groups was that parents had their own misconceptions and fears about sexual health and contraception. Women in both adult female groups lamented about family planning methods causing a long list of side effects, including excessive bleeding, decreased sexual desire, and increased appetite. One man was worried that family planning methods, such as the pill or injection plan, cause cancer. A few parents believed that contraceptive use causes birth defects in future children. Two more expressed concern that it can take "years" after stopping the use of contraceptives to be able to conceive again. Naturally, if parents have fears and misinformed ideas on contraception, they will not be able to pass on correct information to their children.

Furthermore, the conservative culture of the community creates reluctance about SRH education. Religion plays a role. The Reproductive Health Uganda representative interviewed stated that schools based on religion – a large portion of schools in the Kapchorwa district – "will give you a lot of hurdles when they hear 'reproductive health'...they'll give some hesitation." Similarly, when SRH education is taught in Christian Religious Education classes, the information relayed will be selective. Religion-sponsored NGO's such as the Kapchorwa Child Development Center, which is funded by a Christian charity, will likewise share selective information about SRH.

Ideas about gender are another barrier to educating young men about sex. In addition to the assumption that boys have naturally uncontrollable sexuality, the practice of male circumcision as a rite of passage, a common cultural occurrence in Kapchorwa, creates a heightened sense of masculinity in adolescents. "There are those who as soon as are circumcised say, 'I am now a man,'" explained one mother, "They fell as though they have that braveness."

Also, as a result of separating students by gender during SRH education, and the historical girl-centered focus of teenage pregnancy interventions, there is the

belief that education about sexual health and efforts at solving teenage pregnancy should be targeted mainly at girls. As a result, adolescent boys are not given the same critical information about preventing pregnancy that girls are. Reproductive Health Uganda recognizes this problem and tries to address it:

“There is that culture shock. Because...society grooms that issues related to reproductive health are a girl’s thing....but there is need for a lot of changes as far as knowledge and attitude and practices is concerned. So we try to break through those barriers of society.” – Reproductive Health Uganda Youth Officer

The Women’s Protection Center echoed a similar sentiment. When doing community outreaches, they encounter men who object to the work WPC is doing under the belief that they are fighting only for women, and that gender-based violence does not concern the men.

The Kapchorwa District Education officer sums up the general lack of clear, succinct information for boys:

“The biggest problem is access to information about reproductive health. Most of our students, I think, get information accidentally. There is no specific program that is giving the students information on reproductive health. It is actually very scant. The lack of information becomes a bad area. They are not aware. And even when that information is taken, parents tend to shy away. They don’t tell the children, they don’t tell them, ‘this, do like this’ ... and the boys only benefit because of the girls. Most of the NGOs that do come...are targeting the girl child.” – Kapchorwa District Education Officer

The Effects on Adolescent Boys

As a result of the insufficient sources of information, adolescents lack basic knowledge about sex and reproductive health. Of the 163 anonymous questions that Senior One students asked during the SRH classes taught at each school, 31 of the

responses were coded as expressing a basic lack of knowledge about the mechanics of sex and reproduction. Examples of such questions are: “What is pregnancy?” “If you are 12 years old, are you able to get pregnant?” “What is sex?” “Why do we play sex?” “What is family planning?” “What is the procedure of using a condom?” “How many condoms should one use when playing sex?” and “If we use a condom, how does it prevent pregnancy?” (See Appendix E for more selected student questions). Questions such as these represent a lack of basic knowledge, or incomplete knowledge about sexual health. It seems clear that adolescents have received some pieces of information from a variety of sources; however, the fundamental basis of that information – such as the biology of how pregnancy occurs, or the mechanics of how condoms prevent pregnancy and disease spread – has not been taught to students. It would appear that there is an assumption that adolescents already have a baseline understanding of sexual reproductive health, and that each source of information feels it just needs to fill in the gaps. In reality, however, no one source has taken on the responsibility of laying a basic groundwork of knowledge.

Additionally, students proved to hold serious misconceptions about sexual health and contraception. Examples of anonymous questions that show this are: “When you have kisses with a person...can you get AIDS or pregnant?” “Is it true that you can’t get pregnant if you have sex standing up?” “Some people say that when you use a condom it causes a disease called cancer, is it true?” “Is it true that nothing bad can happen if I am a virgin and have sex the first time?” “Is it true that when a girl, for example of 8 years, and boy of 16 years play sex it is more enjoyable to the boy than that of the same age?” Similarly, when male focus group students were asked to list ways of preventing pregnancy, responses included, “don’t share sharp objects,” and “use of cavera” as methods.

The selective information that is passed on to adolescent boys causes them to receive certain messages. The first of these messages is one of an unclear morality of sex. The overwhelming abstinence-only messages that adolescents receive doubtlessly lead them to feel uneasy or guilty about sex. Many of the questions that student asked showed confusion as to whether sex was a good thing or a bad thing, for example, “Is it good for a boy to do sex?” “Are young children allowed for sex?”

Other questions showed a sense of shame or fear of judgment for being sexually active, such as, “When you fear to go for condoms, what should you do?”

Additionally, as a result of cultural ideas of gender, trends of NGO interventions, and the separation of genders during sexuality education, boys learn that interventions and preventative measures need be targeted only at girls. This may lead to the belief that reproductive health is not a topic of boys’ concern, and that protecting women’s sexual health is not their responsibility.

A third message that boys receive is that control over contraception and reproductive choices primarily belongs to the man. All male student focus groups overwhelmingly believed it was the boy’s responsibility to bring condoms to a sexual encounter. When asked why, answers included, “because we are men,” and “because boys are the ones who suggest [sex] to the girls.” When these beliefs start at a young age, they carry on to adulthood. Women in the all-female community member focus group expressed frustration that men often do not want their wives to use family planning, and will restrict them from obtaining it. Said one woman, “few men accept, but the majority don’t, especially those ones in the rural setting.” This was validated by a man in one of the focus groups, who said, “We accept on our consent. We don’t want them going [for family planning services] without our consent.” When men feel that contraception choices are theirs alone, it can lead to domestic violence and anger within the household.

“The husbands in our culture, most husbands or most men don’t like family planning. So if you try telling them, ‘I want to go for family planning,’ you might end up being beaten. And that’s why most women go secretly.” –
Female community member focus group participant

Further, in over-encouraging adolescents to abstain from sex, educators often use what appear to be scare tactics. The male students interviewed, when asked about what the consequences of early pregnancy would be for them, immediately recited that they would be arrested and go to jail. That seemed to be their primary concern, far more urgent than the costs of raising children or

dropping out of school. This leads to the belief that those educating adolescents are so motivated to keep boys abstaining that they feel it is best to warn them of the “scariest” consequences. However, scare tactic such as these paint an incomplete and largely inaccurate picture of reality. It fails to emphasize that there are other, equally as severe consequences of early consequences for the boys themselves, such as the fact that they will need to be responsible for a child.

4.3 Recommendations for Improvements

Within these education systems, there is clearly room for improvement in which adolescent boys can better be taught to respect the sexual well being and autonomy of girls. Most of the individuals and organizations interviewed had some ideas on how this education should happen.

NGOs currently play a big role in picking up the slack where other sources of information fall short. “The primary role should be the parents, because that is the first contact of socialization in life,” argued the RHU Officer, “But what are we seeing? The parents are also socialized in an environment that does not discuss freely issues of sex. Now it puts the burden on the schools. The teachers are key stakeholders, but again, even the teachers need to be supported by organizations.” Yet these organizations struggle to have sustainable funding, and cannot possibly reach every adolescent. Therefore, it may be beneficial to shift the responsibility from outside organizations to the existing structures in adolescents’ lives.

If this were to be the case, then in-school education would need to be refined and increased in order to better reach as many adolescents as possible. Four out of the six student focus groups wished that they were taught more about SRH in school. Likewise, all six teachers interviewed agreed that their students would benefit from an increase of sexuality education. According to the Ministry of Education representative, a revised lower secondary curriculum, which will be implemented in 2017, will “integrate issues of sexuality and reproductive health.”

While there should be a place for SRH education within the government curriculum, it is critical that this place not be in religion-based classes, since these

will omit vital information about condom use and contraception. Boys and girls should not be separated for the majority of this education. It is necessary that boys are aware of females' needs and the consequences that may come to all parties involved. Although teachers said that keeping genders together causes the students to be shy, this shyness should not necessarily be accommodated. If adolescents are going to be sexually active with one another, they need to be comfortable talking about contraception, reproductive health, and potential dangers with people of the opposite sex. While some breakout sessions for questions may be helpful, the actual relaying of SRH education should be done to both genders at the same time.

Likewise, teachers need to not assume that students already have baseline knowledge about sex. The most basic mechanics of sex, the reproductive system, and contraception need to be explicitly and clearly outlined at an early age. Additionally, teachers need to have better training on how to teach sexual reproductive health. While some NGOs are attempting this, there is still the issue of not being able to reach everywhere. Thus, the government should implement a program for educating and training teachers about reproductive health. This should be separate from the teachers' manuals of PIASCY, as these are mostly focused on abstinence. Rather, these programs should be sponsored by a sector of government that is knowledgeable about sexual health and gender issues, such as the Ministry of Health or Ministry of Gender.

NGO efforts should be revised to target what classroom education cannot: out-of-school youth, and parents. Many felt that parents need to take a greater role in talking to their children about sexual health. As discussed earlier, however, parental education has its own flaws. In order for this to be a reliable source of information, parents need to feel comfortable talking about sex with their children. If NGOs are relieved of the responsibility of educating students in classrooms, they may have more resources to tackle the cultural barriers that cause parents discomfort. In doing so, these organizations will be able to sensitize parents on the importance of talking to their children about sex, as well as give parents correct information so that they are able to properly educate their children.

There also needs to be something done for adolescents who are not in school. In addition to reaching parents, this is where other NGO efforts should be focused. Through targeted community outreaches, NGOs have the potential to attract both adolescents who are out of school as well as those who are in school. It is important that in these efforts, young men continue to be actively targeted and brought into the conversation. The Reproductive Health Youth Officer explains the importance of this:

“By targeting boys specifically, it creates a win-win situation. Because I believe they are more empowered with correct and up-to-date information on sexual and reproductive health to the boys. It has a ripple effect, a multiply effect on the side of the girls. Then, realize that by us empowering the boys, these boys have sisters, have mothers, have relatives, sometimes they have daughters. So they use this knowledge as men to make it a point that they can help out. They don't stigmatize, they don't discriminate women given their physiological and natural occurrences as females.” – RHU Youth Officer

This was, however, the only individual involved in the study that suggested that boys be targeted in interventions. Given the messages that boys are currently receiving through their SRH education though, it is important that efforts continue to be directed at them. However, organizations must pay careful attention to the messages that adolescents will take away from these outreaches. These conversations must emphasize a respect for both sexes' sexual autonomy, and an importance for boys to be aware of reproductive health practices and consequences. As time progresses, further research should be done on the impact that such interventions have, and they should be refined accordingly.

5.0 Conclusion

Systems of sexual reproductive health education in Kapchorwa are sprawling and inconsistent. Adolescents receive gender-specific messages that

emphasize abstinence from almost all major stakeholders in their lives: parents, teachers, and communities. Comprehensive sexuality education that includes accurate information on how to use and obtain contraception, as well as its advantages and disadvantages, is rare.

Yet peer and media influence, as well as natural curiosity, causes adolescents to wonder about sex and often times engage in sexual behaviors. Additionally, personal factors such as shortage of food or school fees often drive young girls to fall into relationships with older men. Therefore, it is imperative that adolescents are not just taught about abstinence. Young people need to be aware of what to do should they choose to be sexually active. There must be more thorough education on condom use and other contraceptive strategies.

Furthermore, boys need to be targeted by teenage pregnancy interventions. For too long, the emphasis on interventions has fallen solely on the girl-child. Yet, girls cannot become pregnant if men do not coerce them to have sex, nor can they if boys respect their bodies and desires for contraception use. Adolescent boys need to be fully aware of the consequences that early pregnancy can have on the girl. However, they also need to be fully aware of the consequences that early pregnancy will have on them as boys. Continually providing selective, gender-specific information fails to create such a comprehensive understanding.

By including adolescent boys in efforts to reduce teenage pregnancy, positive outcomes will spread to entire communities. When girls are able to stay in school longer without having to raise children, they will be better educated and therefore able to create a better, healthier future for their families. Benefits will be far reaching, including positive impacts on the economy and healthcare systems. Therefore, for the welfare of Uganda's development, it is critical that greater attention be paid to the sexual and reproductive health education of young men.

Appendix A: Student Focus Group Questions

1. What do you learn about sexual reproductive health in school?
 - a. When did you first learn about how to prevent pregnancy?
 - b. Who teaches it to you – is it your teachers?
2. Do you wish they taught you more about sex in school?
 - a. Where do you learn about sex outside of school?
3. Do you feel comfortable talking to your teachers if you have questions about sexual health?
4. Do you feel comfortable talking to your parents if you have questions about sexual health?
5. What are some ways to prevent pregnancy that you have heard about?
6. Do you know where you can go to get condoms?
 - a. Would you feel comfortable going and getting condoms? Or would you feel embarrassed or nervous?
7. Do you think it is the boy's responsibility or the girl's responsibility to get condoms? Why?
8. What are some reasons why you think someone should use a condom?
9. What are some reasons why maybe you wouldn't use a condom?
10. Why do you think girls drop out of school?
 - a. What do you think of a girl when she drops out of school?
11. Have you seen many class mates gets pregnant?
 - a. What do you think when a classmate gets pregnant? Do you feel sad for her or happy for her?
12. What do you think are the downsides when girls get pregnant or married instead of staying in school?
13. When do you want to get married?
14. When do you want to have kids? How many?
15. **Boys:** What would you do if you had a girlfriend right now, and she gets pregnant?
 - a. Do you think it would be a big problem for you?
16. **Girls:** What motivates you to stay in school?

Appendix B: Senior Teachers Interview Guide

1. What sexual and reproductive health topics are taught in school?
 - a. What year do they start, how often are they taught, and by whom?
 - b. Is it part of the curriculum?
 - c. Does the school teach students where to get contraception?
2. Are boys and girls separated or taught these things together?
 - a. Are there certain things you tell only to the boys and certain things you tell only to the girls?
3. Do you think students are taught enough about sex in school?
4. Can students come talk to you if they have questions about sex?
 - a. Do many students actually do that?
 - b. What kinds of questions do they have?
5. Do you feel comfortable or like you have been given enough training to teach students about sexual reproductive health?
6. Where do you think your students learn the most about sexual and reproductive health?
7. Do you think the students could benefit from learning more about sexual and reproductive health in school?
8. In your opinion, whose job is it to educate adolescents about sexual health?
9. How often do you see girl students getting pregnant or married young?
10. What do you think when you see students get pregnant at a young age?
11. Why do you think girls get pregnant so young?
 - a. Do you think it's a problem?
 - b. Do you warn students of the consequences of this? What consequences do you warn them about?
12. At what age do you students begin dropping out with the most frequency?
13. What do you think is the best way to prevent girls from getting pregnant at a young age?

Appendix C: Community Member Focus Group Questions

1. How many children do you have?
2. What are your hopes for your sons?
3. What are your hopes for your daughters?
4. Do you think it is more important for your daughters to finish school or for them to get married and have children?
 - a. Do you think it is more important for your sons to finish school or for them to get married and have children?
5. Would you be disappointed if your daughters never got married? Why? How old should they be when they get married?
 - a. Would you be disappointed if your sons never got married? Why? How old should they be when they get married?
6. Would you be disappointed if your daughters didn't finish school? Why?
7. Would you be disappointed if your sons didn't finish school? Why?
8. Why do you want your children to get married?
9. How many children do you hope that your children have?
10. Do you feel comfortable talking to your children about sexual and reproductive health?
 - a. What do you tell your daughters about sex and pregnancy?
 - b. What do you tell your sons about sex and pregnancy?
 - c. Do you mostly encourage them to stay abstinent or do you also tell them about ways to prevent pregnancy and STDs?
 - d. Do you worry that if you tell them too much, they will think you are encouraging them to have sex?
11. In your opinion, whose job is it to educate children about sexual health?
12. Do you see young girls getting married as a good thing or a bad thing? Why?
13. Do you think children, especially boys, understand the consequences that teenage pregnancy has for them?
14. In the community, among adults, are family planning methods widely used? Are they encouraged or discouraged?

15. Do you find that men or women don't like to use condoms or family planning? Why?
 - a. Do you think the men respect the women's opinions about family planning?
16. What do you think are the biggest problems facing adolescents in your community?

Appendix D: Interview Consent Form

SIT Study Abroad
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CONSENT FORM

1. Brief description of the purpose of this study

The purpose of this study is to research the systems of sexual and reproductive health education that adolescent boys in Uganda receive.

2. Rights Notice

In an endeavor to uphold the ethical standards of all SIT ISP proposals, this study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop the interview. Please take some time to carefully read the statements provided below.

- a. **Privacy** - all information you present in this interview may be recorded and safeguarded. If you do not want the information recorded, you need to let the interviewer know.
- b. **Anonymity** - all names in this study will be kept anonymous unless the participant chooses otherwise.
- c. **Confidentiality** - all names will remain completely confidential and fully protected by the interviewer. By signing below, you give the interviewer full responsibility to uphold this contract and its contents. The interviewer will also sign a copy of this contract and give it to the participant.

Participant's name printed

Participant's signature and date

Interviewer's name printed

Interviewer's signature and date

Appendix E: More Selected Senior One Students' Anonymous Questions

- What is abortion?
- What is oral sex?
- As we girls when we are in menstruation periods are we allowed to have sex?
- If a man and a woman use condom will the woman get pregnant?
- I have played sex with a boy without condom long ago but I have not get AIDS. Why?
- What is the use of those fluids in the condom?
- What age does pregnancy start?
- Does female have condoms?
- What is meant by the term HIV/AIDS?
- How can we prevent STDs?
- What is a sign? What is a symptom? What are the signs and symptoms of HIV?
- Is it good for a boy to do sex?
- HOW CAN YOU CONTROL SEX DESIRE?
- Is it possible for me to go in for sexual intercourse at this stage of mine?
- My boyfriend asked me to have sex at this age, is it good for us to have sex?
- At what age should a girl have a boy friend?
- Is it good to practice sex with a sugar daddy by use of a condom?
- When you fear to go for condoms what should you do?
- What if the penis is small do you use a condom?
- Are pills also prevent sexually transmitted diseases?
- What about if your penis does not fit into the condom and you want to have sex what can you do?
- If a man and a woman use condom will the woman get pregnant?
- If the condom does not fit your penis what would you use, can you use cavera?
- Is it bad to use a cavera?
- If you use condoms does it cause any problems?
- Is it true that when a girl for example of 8 years and boy of 16 years play sex it is more enjoyable to the boy that that of the same age?
- Is it bad if I am mature and I don't have sex, like will my vagina dry up?

List of Acronyms

KCDC: Kapchorwa Child Development Center

NGO: Non-governmental Organization

PIASCY: President's Initiative on AIDS Strategy for Communication to Youth

RHU: Reproductive Health Uganda

SRH: Sexual Reproductive Health

WPC: Women's Protection Center

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