TITLE: SEXUAL HEALTH NEEDS AND CONCERNS OF YOUNG MEN IN UGANDA

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

By

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Declaration:
Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.
The thesis Sexual Health needs and concerns of young men in Uganda is my own work.

Signature:……

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ABSTRACT

Sexual Health is defined as the integration if the somatic, emotional, intellectual and social aspects of sexual being (WHO, 1975). Sexuality is a human aspect that encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. The International Conference on Population and Development (ICPD) 1994, considered sexual health to be part of reproductive health, by incorporating it into the reproductive health definition. Until recently, it was considered and dealt with as an integral part of Reproductive Health in health programmes. However, sexual health is broader and more encompassing and should be considered as an underlying condition for reproductive health.
In Uganda, like most of the countries globally, the sexual health of men and especially young men has received, little or limited attention. Majority of the programs that are trying to target men are doing so mainly to use men as tools to get to the women especially in family planning related interventions. Globally, not much is known about male programs and interventions, how they function and what works best. The overall objective of this thesis is to identify the sexual health needs and concerns of young men in Uganda and effective approaches in meeting those needs, in order to develop recommendations for appropriate and effective interventions by those concerned.

Findings: For the Majority of young men sexual health concerns are not medical. They include issues like erectile dysfunctions, impotence, penis size, homosexuality, masturbation, sex performance anxiety, esteem issues, relationship problems, urethral discharges, painful urination, sexual abuse, bullying, body changes, and communication issues on sexuality and other issues surrounding manhood. Young men know little about their own sexuality and that of their partners. They hardly communicate about sex in their relationships, and are often influenced by various sexual myths and misconceptions. Various factors influencing their sexual health include social cultural aspects, religious affiliations, family setting, poverty, peer pressure and education level.
Therefore they need information and skills to make good informed decisions, to avoid peer pressure, take responsibility for their actions and be better communicators about their sexuality and health. Since the main problem seems to be lack of information, this paper will mainly adopts two IEC models. These are: the communication behaviour change model and the community mobilisation model. Several existing programmes were looked at and interventions like radio, IEC distribution where found to be efficient when targeting men.

In order to target young men it is recommended that various interventions should be used for instance mass media, community out reach programs, sex education interventions for not in and out of school young men, clubs, toll free help lines, advocacy interventions, IEC interventions and social marketing strategies. Most importantly there is need for more research to be conducted in this area especially in the African context.

Acronyms

ABC	Abstinence, Be faithful, use Condoms
AIDS	Acquired Immune-Deficiency Syndrome
ASRH	Adolescent Sexual and reproductive Health
CBO	Community Based Organization
FGD	Focused Group Discussion
FP	Family Planning
HIV	Human Immune-deficiency Virus
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
MDG	Millennium Development Goals
MGLSD	Ministry of Gender Labour and Social Development
MMR	Maternal Mortality Ratio
MOES	Ministry of Education and Sports
MoH	Ministry of Health
MSM	Men having Sex with Men
NCC	National Council for Children
NGOs	Non Governmental Organizations
PEAP	Poverty Eradication Action Plan
PIASCY	The Presidential Initiative on AIDS Strategy for Communication to Youth
PLWA	People Living With HIV/AIDS
RH	Reproductive Health
SHEP	School Health Education Project
SGBV	Sexual and Gender Based Violence
SRH	Sex and Reproductive Health
STIs	Sexually Transmitted Infections
STF	Straight Talk Foundation
TASO	The AIDS Support Organization
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UHSBS	Uganda HIV/AIDS Sero-Behavioral Survey
UNAIDS	The Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization
YMEP	Young Men As Equal Partners

Chapter I Introduction: Background information on Uganda

1.1 Demographic and social background

Uganda is a landlocked country located astride the equator in East Africa. It lies on about 241,039 square kilo meters and is administratively divided into eighty districts. Uganda has a decentralised system of governance with the local governments responsible for making decisions at the regional level. However the central government still remains in charge of national security, policy making, supervising and setting standards (UDHS, 2006). Between the 1970s and early 1980s, Uganda was hit by war and insurgency which greatly affected her economic and social infrastructure including education and health care. Currently the country is steadily recovering and between 2000 and 2006, her GDP growth varied between 4.7 and 6.6 percent per annum. Uganda has a total population of about 29million people. In the period between 1948 and 2002, Uganda's population increased five-fold mainly due to high fertility rates of about 6.7 births per woman and a decline in mortality. Between 1969 and 1980, her annual growth was 2.7%, which later increased to 3.2% between 1991 and 2002 census. .

1.1.2 Social Economic Situation

Employment

Uganda has a predominantly agricultural economy with about 80% of her population dependent on light agro-based industries and subsistence farming. Uganda gets most of her export revenue from coffee. 52% of males and 77% of females are engaged in agricultural activities (UDHS 2000-2001). Usually out of school youth work in low income jobs like barmaids, housemaids and food vendors.

1.1.3 *Literacy and Gender status*

According to the UDHS (2006), nearly 29% of young men and 23% of young females between 15-24years have attended secondary school education. Four out of ten women report that their husbands or partners make decision on their (the women's) health care. Data from the UDHS, 2006 shows that 60% of women and 53 percent of men have experienced violence while 40 percent of women and 11 percent of men experienced sexual violence. 60 percent of men in Uganda agree that wife beating is justified.

1.1.4 *Orphans and Vulnerable Children (OVC)*

Uganda has over 2million orphans. 15 percent of children under 18years has either lost one or both their parents. 8 percent of children under 18 years are considered vulnerable. Overall 21 percent of children under 18 years are either orphaned or vulnerable (UDHS, 2006).

1.1.5 *Poverty levels*

Cross sectional survey data shows that the incidence of income poverty (people being unable to meet their basic needs) has generally reduced

from 56% in 1992 to 44% in 1997, and down further to 35% by 2000. In urban areas the reduction was from 28% in 1992 to 16% in 1997. With the exception of Northern Uganda, in rural areas the reduction was from 59% to 48% between 1992 and 1997 (Okidi, 2002).

1.2 Health Sector

The health sector budget in Uganda has been devolved to local governments through a block grant (with exception of personnel salaries). Central transfers to local government are based on; **Recurrent budget**- (salaries, maintenance and district administrative costs) and **Development budget**- (partially includes capital expenditure and recurrent costs associated with vertical programmes) (Mossert, 2002) According to Hutchinson (1998), over 90% of the development budget is donor funded constituting over 50% of the total health budget. (Hutchinson, 1998) Ministry of Health's (MOH) duties have been restricted to formulating policies and guidelines, providing technical supervision, setting standards for Quality of Care (QOC), inspecting services and providing logistical support (Jeppsson, 2003). In 2001, user fees at first level government health facilities were abolished.

1.3 *National Health Policies*

Several polices have been developed to help improve life and health status of Ugandans. One such policy is the National Population Policy which has among its objectives, promoting positive health seeking behaviour and the reduction of the unmet need for family planning (only 37% of the demand for Family Planning services is being met UDHS,2006). The National Health Sector Strategic Plan 2005/06-2009/10 (HSSP II) was developed under the Poverty Eradication Action Plan (PEAP) and the Millennium Development Goals (MDG) The programme mainly targets the poor, children, women, elderly, displaced people among others and is dedicated to ensuring a sense of individual ownership of health services. The Sexual and Reproductive Health policy Guidelines were developed to address reproductive health issues following the 1994 International Conference on Population and Development (ICPD) Other health policies include; the Adolescent Sexual and Reproductive Health Policy, the HIV/AIDS Strategic Plan, the Gender Policy, among others.

1.4 Sexual and Reproductive Health Situation

HIV and AIDS

'ABC or ABc approach?!'

Uganda is considered by many internationally as a role model in the fight against AIDS. Uganda was successful in reducing HIV from a high of about 15% in 1991 (UNAIDS), to about 6.3% currently (MOH and ORC Macro, 2006). Uganda prides itself in using the Abstinence, Be Faithful and Condom Use (ABC) approach in reducing the HIV prevalence over the years. However lately there have been controversies in the ABC approach, tending towards favouring AB. Trying to establish the extent to which each

of the ABC factors has contributed to the reduction of HIV has become a highly political issue (Alan Guttmacher Institute, 2003). Of the ABC strategy, Abstinence is said to be the most controversial. Although it has always been part of the HIV prevention campaign, significant investments of money have been poured into it by the American government through PEPFAR. PEPFAR is also funding several anti-condom faith based organisations led by 1st lady Janet Museveni. (Zaccagnini, 2008). Noticeably, billboards have sprung up promoting abstinence and sometimes discouraging condom use. This contradiction between the AB and the C has caused conflicting messages and many believe it has may have contributed to the raising prevalence in HIV.

1.4.1 *Knowledge and awareness*

Knowledge of HIV/AIDS is high country-wide with 89% of women and 95% of men aware that reducing sexual partners to one uninfected partner greatly lowers the chances of getting HIV. 86% of women and 93% of men are aware of Abstinence as a preventive measure to HIV/AIDS. About 70% of women and 84% of men are knowledgeable about condoms as a preventive measure against HIV/AIDS. Among unmarried young people, 34% of young women and 44% of young men 15-24 years are abstaining (UDHS, 2006). Between the 2004-2005 UHSBS and the UDHS 2006 there was a noted increase in abstinence among men 15-19 from 58% to 65%. Men aged 20-24 who remained faithful to one partner also increased from 45% to around 53%. However within the same period the proportion of men 20-24 years who did not use a condom during their last sexual intercourse increased (UDHS, 2006).

1.5 *Maternal and Infant Mortality*

Maternal mortality Ratio (MMR) is measured to have reduced from 505 to 435 maternal deaths per 100,000 live births. (Refer to table 1.2) However, there is limited or no change due to sampling error. (UBOS and Macro International Inc., 2007) Infant mortality in Uganda has reduced from 89 deaths per 1,000 live births in the 2000-2001 UDHS to 75 deaths per 1,000 live births in the 2006 UDHS, however it is still rather high. One in every 13 children dies before reaching one year while one in every seven children dies before reaching five years. Mortality is higher in rural areas (88 deaths per 1,000 live births) as compared to urban areas (68 deaths per 1000 live births). Male children experience more mortality as compared to female children. Refer to Annex 1.

1.6 *Family Planning and contraceptive use*

There has been an increase in the unmet need for family planning. The 2000-2001 UDHS registered unmet need at 35% for total unmet need, 21% for spacing and 14 % for limiting number of children. According to the UDHS 2006, this unmet need is at 41% for total unmet need, 25% for spacing and 16% for limiting number of children. Total demand for family planning services has increased from 40% (UDHS, 2000-2001) to 64% (UDHS, 2006). It is worth noting that these indicators tend to look only at

the women. Men's contraceptive needs are not considered. Refer to table 1.1 for details.

Table 1.1 Contraceptive Use among Currently Married Women

	2000/2001 (%)	**2006/2007 (%)**
Injectables	6.4	10.2
Pill	3.2	2.9
Condom (male)	1.9	1.7
Not currently using	77.2	76.3

Source: UDHS 2006

1.7 *Age at first sex and marriage*

Median age at first sex for boys has continued to decline from 18.8 in 2000-2001, to 18.3 (Uganda HIV/AIDS Sero-Behavioral Survey (UHSBS), 2004-2005) to 18.1 years. (UDHS, 2006). For girls it has dropped from 18.8 in 2000/01 to 18.1years. Refer to Annex 1.

1.8 Sexual Violence

Forty Percent of women and 11% of men in Uganda have experienced sexual violence. Refer to Annex 1

Chapter 2
Problem Statement, Objectives and Methodology

In this chapter we look at the problem statement (why I have chosen to concentrate on young men's sexual health needs and concerns), the objectives of this thesis, methodology, search strategy, keywords and limitations of this research.

2.1 Why men?

Ugandan men have various health needs and concerns. Some of these concerns and needs are known and have even been documented in various studies and researches. Issues like HIV and AIDS, Voluntary counselling and testing (VCT), Sexually Transmitted Infections/Diseases (STIs/STDs), gender based violence, health seeking behaviour, family planning (FP), among others.

Unlike women, whose sexuality issues are usually, answered and lessons on womanhood given, (by the paternal aunt/ssenga, mothers, senior women teachers at school, etc) especially in the Buganda culture, boys are expected to simply grow into men. Culturally these men are expected to know everything about masculinity, growing up, body changes, sexual feelings etc. They have to fend for themselves and are viewed by many as merely economic providers. However many men fall short of this and end up becoming violent in a bid to hold onto their authority in the home (Baker,1997). Economic status, cultural beliefs and education levels are possible determinants that may influence this kind of behaviour. Moreover, research has also shown that men are eight times more likely (than anyone else) to transmit HIV to their wives or partners due to their adventurerous nature of having unprotected sex with various partners (Padian, 1997). Husbands are the greatest transmitter of STIs to their wives (Hunter, 1994). Sonfield (2004) reports that married men are less likely to report having multiple sexual partners than single men. Nevertheless, this puts them and their partners at a greater risk of acquiring STIs. In Uganda, women reported on average 2.2 lifetime sexual partners, while men reported 6.4 (UDHS, 2006). In many programs worldwide, men have been targeted but mostly as a tool or vehicle to reach their partners especially in aspects such as family planning (Hawkes, 2000). Therefore interventions targeting men for their own sake are needed.

Study objectives

2.2 Overall Objective

To identify the sexual health needs and concerns of young[1] men in Uganda and effective approaches in meeting those needs, in order to develop recommendations for appropriate and effective interventions by those concerned.

[1] Young men in this case refers to men 10-24 years of age and includes adolescents.

Specific objectives

1. To identify the sexual health needs of young men in Uganda
2. To identify the socio-cultural, economic and political factors that prevent young men from meeting their sexual health needs.
3. To analyse how IEC programs and health services meet these needs.
4. To identify the extent to which various interventions have met and addressed the unmet need for male sexual health issues.
5. Develop recommendations for effectively responding to the sexual health needs of young men in Uganda.

2.2.1 Research questions

- What are the sexual health needs and concerns of young men in Uganda?
- What are the socio-cultural, economic and political factors that hinder men from meeting their sexual health needs?
- Are health services meeting these needs? If so, how? If not, why?
- How are duty bearers meeting their obligations in protecting and supporting the sexual health needs of young men in Uganda?
- How are various interventions meeting and addressing the unmet sexual health needs of young men?
- What are the best approaches and interventions for reaching young men in Uganda?
- What lessons have been learned so far?
- What recommendations does this thesis suggest in better addressing the sexual health needs of young men in Uganda?

2.2.2 Methodology

This thesis will review both qualitative and quantitative data in order to address the study objectives. International, national and program reports and researches on sexual and reproductive health issues and sexual health issues will be reviewed from published and unpublished resources/books. This study will compare various male intervention programs worldwide, especially in developing countries similar to Uganda. However, best practices from other countries that may not necessarily be within the African context will also be considered where relevant. Information obtained from male intervention programs in this case will be compared with some of the international experiences where necessary, to give a more in-depth analysis.

Lessons learned shall be analysed where relevant in the Ugandan context. The author's own experience shall also be used to give a deeper insight into the issues at hand.

2.2.3 Search strategy

Search engines like Google scholar, Google, pub med, Medline and various websites such as WHO, UNFPA, John Hopkins, FOCUS, IPPF/RHO, Alan Gutmacher Institute, Family Health International (FHI) among others

will be used. Local organisation's websites will be visited for instance Straight Talk Foundation, Ministry of Health Uganda, Family Planning Association of Uganda, Naguru Teenage and Information Centre. Other scientific journals will also be used from the KIT library and other sources.

2.2.4 Key words

Male participation, reproductive health, male responsibility, Uganda, male sexuality, sexual health needs, erectile dysfunctions, infertility, impotence, STIs, male interventions, male sexual attitudes, culture, religion, sexual abuse, peer pressure, peer educators, mass media, Male sexual health, health services, Sub Saharan Africa, sexual behaviour.

2.2.5 Limitations

There is limited data regarding the sexual health needs and concerns of not only Ugandan men, but African men in general. Most of the available research is narrow and not exhaustive of sexual health issues like impotence, erectile dysfunctions, sexual abuse, masturbation, sexual anxiety, penis size issues, body changes like wet dreams and Men having sex with men. This is probably because these issues seem to be regarded taboo in many African societies.

Chapter 3
Literature review

This chapter looks at the international definitions of sexual health and sexuality, the sexual health needs and concerns of young men including the 'silent-taboo' sexuality issues of young men in Uganda.

3.1 Sexual Health and Sexuality[2]

According to World Health Organisation (WHO), Sexual Health is defined as the integration if the somatic, emotional, intellectual and social aspects of sexual being (WHO, 1975). However, this definition seems to have evolved over the years. A technical Consultation Team on sexual health that met in 2002 in Geneva defined sexual health as; a state of physical, emotional, mental and social well-being in relation to sexuality. They emphasized that it is not just the absence of disease. In order to foster good sexual health, there has to be a positive and respectful approach to sexuality and sexual relationships that are pleasurable, safe and free of coercion, discrimination and violence (WHO,2006). The WHO definition of sexuality is a human aspect that encompasses sex, gender identities and roles, sexual orientation, erotism, pleasure, intimacy and reproduction. It is expressed in fantasies, beliefs, attitudes, values, behaviour, and practices. The International Conference on Population and Development (ICPD) 1994, considered sexual health to be part of reproductive health, by incorporating it into the reproductive health definition. Until recently, it was considered and dealt with as an integral part of Reproductive Health in health programmes. However, sexual health is broader and more encompassing and should be considered as an underlying condition for reproductive health. With the emergence of the Human Immunodeficiency Virus (HIV), and an increase in STIs, public health concerns like sexual dysfunctions have had an increase in recognition including the need to focus more on sexuality and its importance to one's health and well being. Because of its mounting importance, WHO's Department of Reproductive Health Research has started to look into sexual health in it's own right. Its specific objectives are;

- To build the evidence base for high quality, non-discriminatory, acceptable and sustainable sexual health education and service programmes;
- To increase knowledge and understanding of the social and cultural factors related to harmful sexual practices in order to develop strategies to abolish these practices (WHO, 2004).

However in my opinion, the second objective seems to be looking more at traditional practices that may lead to harmful sexual practices. This may not partially apply for sexual health, but not all sexual health behaviour is due to harmful cultural practises. Issues like masturbation, sexual abuse, sexual anxiety are not necessarily cultural.

[2] Based on WHO draft definitions (WHO, 1975)

According to WHO, Sexual health encompasses issues like;

- STIs, including HIV, Reproductive Tract Infections (RTIs)
- Sexual well-being (satisfaction, pleasure and dysfunction)
- Violence related to gender and sexuality
- Aspects of mental health
- Unintended pregnancies and unsafe abortions
- Physical disabilities, chronic illnesses and their impact on sexual health
- Female genital mutilation/cutting

It is surprising that they included unintended pregnancies and unsafe abortions to that list, because in my opinion, these two are not necessarily sexual health issues but more of reproductive health concerns. It is important to make a distinct demarcation between sexual and reproductive health issues. Otherwise sometimes the two are used interchangeably. In addition to that, issues such as social wellbeing (communication skills on sexuality, peer to peer relations) do not seem to be addressed.

3.2 Sexual Health needs and concerns of young men

In Uganda, like most of the countries globally, the sexual health of young men and men in general has received little or limited attention. Majority of the programs that are trying to target men are doing so mainly to use men as tools to get to the women especially in family planning related interventions (Hawkes, 2000). It is true that women bear the greatest burden of reproductive mortality and morbidity including childbearing and childcare. However in sexual and reproductive health, both men and women are significant, therefore we can not continue to ignore the needs and concerns of young men. Globally, not much is known about male programs and interventions, how they function and what works best. In order to plan for appropriate health interventions, we first need to learn a lot about the way men in general (including young men) perceive their sexual health (Collumbien, 2000).

According to Sonfield (2002), in their younger ages, few men require medical services. Perhaps because most of their needs are centred around acquiring skills, knowledge and mindset (Sonfield, 2004). Instead they need information to make good informed decisions, to avoid peer pressure, take responsibility for their actions and be better communicators especially when it comes to their sexuality and health. As they grow older, issues of infertility, various cancers, vasectomy arise, and hence the need for medical services (Sonfield, 2002). Two other studies on men in Orissa, India and Bangladesh also indicate psychosexual disorders as the major concern among men. Other concerns mentioned were pre mature ejaculation and inability to maintain an erection (Collumbien, 2000). Several studies in the United States of America and Europe among

community and clinic based samples have shown similar results with 35-38% of men reporting pre mature ejaculation, (4-9%) erectile dysfunctions, (4-10%) inhibited orgasm as main concerns (Spector, 1990).

In my experience these concerns are quite similar to the ones Ugandan men (both in and out of school) experience. While working as the presenter and producer of The Straight Talk Radio Show, a weekly reproductive health talk show, I received more than 10,000 letters a month from young people all over Uganda. Over 70% of these letters were from boys. The main concerns raised were on; erectile dysfunctions, impotence, penis size, homosexuality, masturbation, sex performance anxiety, esteem issues, relationship problems, urethral discharges, painful urination, sexual abuse, bullying, body changes, and communication issues on sexuality and other issues surrounding manhood.

Some examples of questions asked by boys were;

- *'Is it true that having sex will heal my back pain?'* 16 year old boy, Busia
- *'My penis does not erect in the morning, am I normal? If I abstain from sex, is it true that my testicles will burst?'* 14 year old boy, Masaka
- *'My girlfriend told me that she thinks she is pregnant. Am scared that I am going to be imprisoned. What should I do?'* 17 year old boy, Mbarara
- *'I have rushes around my pubic area, could it be an STD?' 19 year old boy, Arua*
- *'I experience pain whenever I urinate, my friends tell me that it will stop if I have sex, but my penis is too small. What should I do?' 14 year old boy, Gulu*
- *'My girlfriend says that if I do not have unprotected sex with her, I do not love her. I am scared. What should I do?' 16 year old boy, Mbale*

In my observation, usually the majority of these boys had never discussed any of these issues with an adult before. Fearing getting into trouble for asking 'such' questions. The source of information for most of these boys was their peers. Hence myths and misconceptions surrounding sexuality were common. In order to deal with men, we need to find out exactly what their sexual health concerns and needs are, what the kind of services needed and by whom.

3.3 Shh…You dare NOT say!!!

Some of the 'silent' sexual health concerns experienced by young men in Uganda include the following;

3.3.1 *Intercourse and penis size issues*

In Uganda sexual intercourse among adolescents is fairly common. For instance, among younger adolescents 12-19years, males were twice as likely (15%) to have engaged in sexual activity than their females counterparts (8%) (National survey of adolescents, 2004). In my opinion, these statistics are questionable. Either boys are over stating their sexual experiences, or the girls are under stating their sexual encounters. This could be due to the fact that in Uganda, sexually experienced females are often regarded as loose and promiscuous. When asked who young men are having sex with, their partners are often much younger than them. Data from the UDHS (2006), contradicts the 2004 National Adolescent Survey by reporting the medium age at first sex for women being 16.6 years compared to 18.1 years for their male counterparts. Which is an indicator that young women may be more experienced at sex at a younger age. Talking about sexual intercourse in the context of HIV is somewhat acceptable, however talking about sexual matters on their own is rather challenging because many cultures view it as taboo and improper (Kwagala 2007).

Young men know little about not only their own sexuality but the sexuality of their partners as well, they hardly communicate about sex in their relationships, and are often influenced by various sexual myths and misconceptions (Ndong, 1998). In West Nile, young men reported beating or tying up their penises in order to control sexual feelings (STF annual report, 2007). According to a survey conducted for The AIDS Support Organisation (TASO), Uganda, young male clients reported having learnt about sex from their teachers, in biology lessons, from older women (especially house maids and elder sisters) during puberty (when sexual feelings arouse), from observing adults, peers, animals, magazines, films etc. 'Uncles' who are supposed to teach and mentor young men about sexuality issues are rare (Kwagala, 2007). Not surprisingly, a study conducted among adolescents (15-24 years) in Kakamega, Viniga and Bondo districts in Kenya by Family Health International (FHI) found that young men viewed sexual activity as a sign of manhood. Most young people said that it is not right for a man to stay one to two months without sex because intercourse is a way of preserving fertility and health. Many young men reported having sexual intercourse in order to gain community recognition and to test their virility (FHI, unpublished report). In Brazil, young men said that they are pressured by their fathers and friends to have sexual intercourse (Simonetti, 1996).

These findings are similar to the survey conducted for TASO where young men had this to say:

> *I was still ignorant until I finished my primary school and went to my sister's home. She had maids who had their funny conversations. However, I was not always taken up by their talk. One time when we sat together with my sisters and the maids, my sister started teasing me, "Eh my brother, are you impotent? With these girls here……" At the same time I had started reading those funny books. One day, one of the girls came to my bed. And what followed of course you know (Single man).*
>
> *We found one of my big brothers having sex with a woman (maid). We were 2 with my young brother. We told the woman that we were going to report them. She told us not to report her and in return she asked us to have sex with her. In the morning, I asked the other house girl and we started and after that I went on and on (male in discordant relationship).*

Source: Gathering evidence to promote sexual health in Kenya, Uganda, Brazil and India: Uganda country report. (Kwagala, 2007)

This pressure to indulge into sexual activity causes various risks and concerns. In various cultures (before the HIV era) boys were expected to gain sexual experience and it was acceptable for them to be sexually active before marriage while girls were supposed to remain virgins (NCC 1994, MGLSD 2007, Byamukama, 2007). Regarding penis-size issues, several young men seem to have questions and issues about the size of their penises and whether or not it can 'function well'. Sometimes boys with smaller penises get picked upon and made fun of. The following are examples of some of the letters I received regarding this issue;

> *'My friends always laugh and tease me that my penis is too small, and i will not be able to please a woman. How can I make it bigger?' Boy 15 years*
>
> *'My 'thing' is too small, even a condom cannot fit me. Am I normal?' Anonymous*
>
> *'I am afraid to shower with the rest of my friends because my 'member' is crooked and small. Please help me.' Boy 19 years.*
>
> *'My friends told me that I should use herbs to pull my penis every morning and evening in order to make it longer and bigger. But after using them for a week, I developed a rash around my organs. What should I do?' Boy 13 years*

3.3.2 *Men having sex with Men (MSM)*

In Uganda homosexuality is illegal and socially unacceptable. A recent survey by Kwagala,, (2007) reported that both TASO clients and counsellors viewed homosexuality as abnormal, immoral, criminal,

abominable, taboo and insane. And although it is happening in Uganda, there is hardly any documented evidence of its existence. Like in many African cultures, Uganda is in denial about the existence of homosexuals. Because of the stigma associated with MSMs, many of them live lives of secrecy, with the majority having both male and female partners. Increasing the risk of transmitting STIs to their female partners as well. (FHI, 2008) Despite social, legal and religious taboos, every society has men who have sex with other men (FHI, 2008). Uganda is no exception. In my experience MSM was very noticeable during my visits to various secondary schools especially single-sex schools. Several times, students would want counselling, or ask questions related to MSM. Although most of the time, no one dared ask out loud. Instead they would write the question on a piece of paper (anonymous) and send it to the front. Some examples of these questions were:

'When sleeping in the dormitory at night, my friend always comes to my bed and starts touching my penis and making me touch his. At first I was scared, but now I enjoy it. Is it normal?' Boy 16 years

'I am afraid to shower, because the older boys come into the shower and do things to me.' Boy 11 years

'There is this boy in my class who I love. He said he loves me too. Sometimes we kiss and have sex in the school toilet. But last week, I caught him and another boy having sex. What can I do?' Boy 19 years

'Is it normal to love a boy and a girl at the same time?' Boy 13 years

'Me and my friend sometimes have oral sex with each other. Can one acquire HIV through oral sex?' Anonymous

Although heterosexual intercourse is the main way in which HIV in Sub Saharan Africa is transmitted, there is growing evidence of the existence of MSM in all parts of Africa. The stigma and denial surrounding it has made MSM very vulnerable to STIs including HIV (Abdoulaye, 2005). A study conducted in Senegal confirmed that although MSM in Senegal is illegal and condemned by society, a high number of respondents reported having had insertive anal intercourse with a male partner in the month preceding the interview. However, one in four respondents also reported having had sex with their female partner in the same month. On further genital examination, 4.8% of the 463 participants had at least one STI. The most common symptoms of STI were genital discharge (24.6%), and pain during urination (20.5%). These symptoms are similar to the ones young males in single sex boys schools used to ask about. Uganda, like most of the Sub Saharan African countries has limited or no documented evidence on MSM. To date, there are no published studies on STI rates and risk behaviour among MSM in Sub Saharan Africa (Abdonlaye,, 2005)

3.3.3 *Sexual Abuse*

Usually when it comes to sexual abuse, young men are often viewed as abusers. However there is increasing evidence that shows that young men can be victims too. According to the UDHS (2006), 10% of men between the ages of 10-14years have experienced sexual violence. Twenty eight percent of men have experienced it between 15-19years (UDHS, 2006). Twenty percent of adolescent males aged 15-19years reported having been touched in an unwanted sexual way. Perpetrators of this sexual coercion were usually a schoolmate, friend, girlfriend or stranger, in that order (National Survey of Adolescents, 2004). This is also evidenced in various studies in Goa-India, Ibada-Nigeria, Leon-Nicaragua, Mexico city-Mexico, Phnom Penh-Cambodia and selected settings in Peru and South Africa were young men reported experiencing coercive penetrative sexual behaviours, unwanted touches and brushing of the private parts, being made to touch someone, verbal abuse, unwanted kisses and deception. Most perpetrators of the violence were men known to the victims i.e. older students, friends, or family members (Population Council, 2004).

Usually sexual abuse can happen to anyone. However populations like orphans, street children, prostitutes, young people are more often more vulnerable. While working with orphaned children in schools and communities, many of them reported that they were being sexually abused by a family member, neighbour, guardian etc. Most of the time, these young people were too embarrassed to open up, especially the boys. Some of the orphans had this to say;

> My father and mother died when i was 7 years old. I went to live with my uncle in the town. At first everything was fine, then he started coming to my bedroom, claiming he would make me a 'real man'. From then on, he started forcing himself on me. When I reported him to his wife, she was angry with me and threw me out of the house. I now live with my grandmother. Boy 14 years.
>
> When my parents died, my mother's friend promised to look after me and my sister. But now she says that unless I have sex with her, she will not pay my school fees. I am scared because they say her husband died of AIDS. But at the same time I want to continue with my studies. What should I do? Boy 16 years.

While not much has been documented on the sexual abuse of boys and men (as victims), this abuse has been known to occur in prisons, homes, workplaces, the army, police custody, schools and on the streets. Most sexual abuse programs and interventions in Uganda mostly target girls and women as victims. And yet as already seen, sexual abuse occurs in both girls and boys. Some organisations like 'Hope After Rape' were dedicated to helping victims of sexual abuse. However that organisation had to change its name to 'Hope Center' because of the stigma associated

with its former name. Sexual violence increases the risk of STI transmission including HIV through abrasions and cuts if the abuser is infected with the HIV virus.

Sexual abuse is often a difficult issue to deal with especially for the victims. For male victims it is even worse. It is known to cause psycho social consequences, poor mental health including suicidal intentions, anxiety on masculinity, emotional setbacks, and a 'culture of silence' were victims suffer in silence and usually never seek help due to self stigma and blame (Population Council, 2004).

3.3.4 *Impotence/Infertility*

Like in many African cultures, several Ugandan cultures, consider infertility a disgrace. In Nigeria, some men and women associated male infertility to having a small penis (Okonofua, 1997). Infertile men face a lot of stigma and ridicule from the community since in many cultures children are seen as a sign of wealth and prosperity (Barnett, 2008). Hence sayings like, '*Any man who has no children is a dead man*.' (Second Century Talmud Writings) In a research conducted in Zimbabwe, some men said that they had missed being employed or had been excluded from leadership roles in community because they had no children. Leading them into having sex with multiple partners with the hope of impregnating one-just to prove their fertility (Runganga, 2001). All these issues surrounding infertility lead men into perceiving themselves to be less masculine. A study of 36 couples in USA found that infertile men felt 'disabled'. Some even described themselves as losers (Nachtigall, 1992). In some countries like Egypt, when it is discovered that a man is infertile, he is usually never told, to save him the embarrassment.

Having seen all the stigma and fear associated with infertility from the aspect of various international communities, it is no wonder that men in Uganda also share these fears and like other men, would be reluctant to seek counselling and would rather keep their personal life private (Barnett, 2008). Infertility on many occasions is preventable, since many times it is associated with having a Sexual Transmitted Infection (STI).

3.3.5 *HIV/AIDS*

Three quarters of the forty-two million HIV infections worldwide are in found in Sub Saharan Africa. In some African countries like Zimbabwe prevalence is as high as one in three adults. Self perception of the risk of acquiring HIV can act as a motivation for adolescents to change their behaviours, especially those that put them at risk of acquiring HIV (Neema, 2006). In Uganda, 48% of males aged 15-19years, and 39% of 12-14year olds perceived themselves to be at great risk of acquiring HIV. While 23% of 12-14year olds and 15% of 15-19year old males perceived themselves not to be at any risk at all (UDHS, 2006). Perception of no risk may lead one to believing that HIV is not a threat to them, which in turn

may promote risky sexual behaviours like having un-protected sex with multiple sexual partners.

3.3.6 *STIs and discharges*

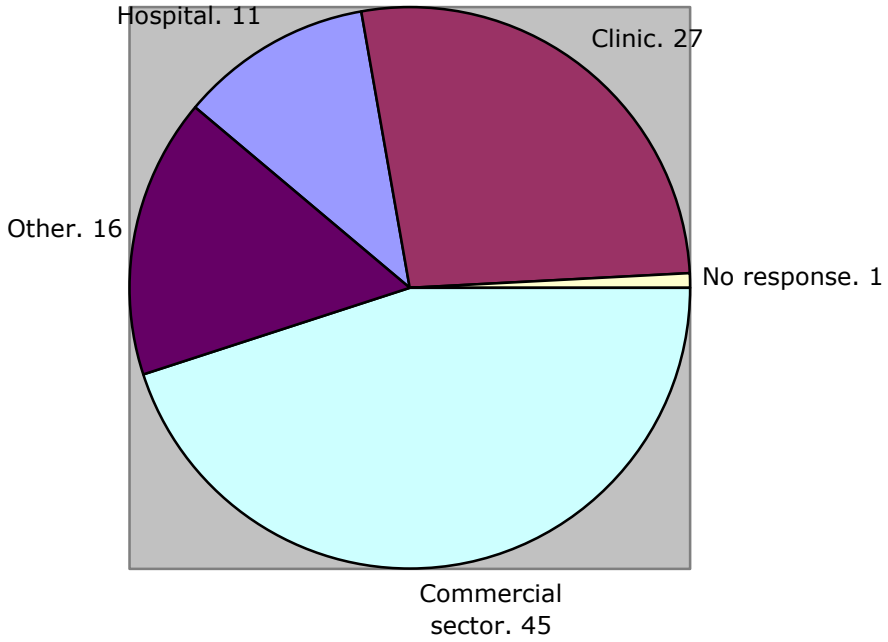
STI infection is usually associated with HIV. In Uganda, about 56% of adolescent males have heard of STIs other than HIV (National Adolescent Survey, 2004). According to the Uganda HIV/AIDS Sero- Behavioural Survey, 14% of sexually active boys between the ages of 15-19 and 19% of boys between 20-24years reported having an STI, discharge or genital sore/ulcer twelve months priory to the survey (UHSBS, 2004/2005). However, self reported STIs are higher among women than men (Kwagala, 2007). Low reporting may be attributed to lack of knowledge about STI signs and symptoms and stigma associated to STIs in general (UBOS & Macro International Inc, 2007). These findings are similar to the baseline survey results for 'Young Men as Equal Partners Project' (2007) were the main reason given for not seeking medical care was that the symptoms disappeared after awhile, and they (the young men) never knew it was an STI. The most known symptom by 42% of males was an ulcer or sore on the private parts. Other symptoms identified by a quarter of the males included genital discharge and itching in the private parts. 37% of men also mentioned pain while urinating (National Survey of Adolescents, 2004). Studies have shown that many men attempt self treatment of STIs and consult non-medical sources for treatment and advice mainly due to peer pressure, lack of self-confidence, and cultural norms (Dallabetta, et al, 1996 and Lande, 1993). Further still, the integration of STI/HIV into SRH services is challenged due to under staffing, limited knowledge and skills among health workers, inadequate infrastructure, restriction of drug prescription by certain health cadres, lack of interventions targeting vulnerable groups, stigma associated with STIs, lack of awareness on the clients part (MOH, 2006:63). However even if services are up scaled to attend to men's needs and concerns, there is no guarantee that men will actually access them (Sonfield, 2004). As Sonfield further notes, that even when services are available and affordable, men in many cultures resist using these medical services. And yet both men and women need STI prevention, screening and treatment services as a prerequisite in order for them to understand their sexuality and that of their partner so as to form healthy, respectful and coercive-free relationships (Sonfield, 2004).

3.3.7 *Condom knowledge and use*

Using condoms is important in preventing unwanted pregnancies and STIs including HIV. In Uganda, several surveys have shown that among young people, the condom is the most common contraceptive used with 44% of males reporting having used it. Although more than 50% of young sexually active male respondents reported that they had suggested the use of a condom at their last sexual activity (National Adolescent Survey, 2004) consistent condom use remains a challenge. With male adolescents being more likely to have used a condom with their partners or girlfriends

than with a casual acquaintance (National Survey of Adolescents, 2004). Reasons for using condoms vary, 39% of young men used the condom for pregnancy prevention only, another 39% used it to prevent STIs including HIV only while 22% used a condom for both reasons. Sources for getting condoms; 27% mentioned clinics, 11% from hospitals, 45% from the private sector, 16% from other sources (YMEP baseline survey, 2007).

Percentage distribution of source of condoms for sexually active men 15-24 years (YMEP baseline survey, 2007)



Source: YMEP Baseline Survey, 2007

In conclusion, there have been very few studies in Africa focusing on sexual health needs and concerns of men. In cases where some studies have been conducted, they are rather narrow and do not cover the issue entirely. However although this area has not been comprehensively researched, I have anecdotal evidence (from the letters received) that indicate many concerns. Since talking openly about many of these issues is taboo in many cultures, finding the proper acceptable way of answering them was a challenge. There is need for more research to be conducted on the sexual health concerns and needs of young men in Uganda.

Chapter 4
Factors influencing men's sexual health needs and concerns

The sexual health needs and concerns of young men have various factors that tend to influence them. In this chapter this thesis looks at some of those factors. The list of factors addressed here is not complete, however I feel that as per letters received from young men to the Straight Talk radio show, these were the main factors raised by the young men.

4.1 *Religion*

Religion is very important to young people with nearly all young people in Uganda identifying with a religion, and attending religious services at least once a week (National Survey of Adolescents, 2004). The Catholic, Pentecostal and Seventh Day Adventist churches were mentioned as a source for sexuality information and counsel (Kwagala, 2007). Nearly all young people in Uganda identify with a religion with 43& being Catholic, 33-34% Pentecostal and 12-13% Muslim. Among young male, 88% reported that 'religion is very important in their lives' (Neema, 2006). This has positive and negative implications on the sexual health of young men. For instance it may encourage them to remain virgins, or to continue to abstain from sex. On the other hand most religions are not tolerant of sexual health issues like masturbation, which many a times they consider as sin. These double messages (masturbation is normal and healthy, but on religious grounds it is a sin) tend to confuse young men. Also the religions mentioned above are somewhat rather extreme in some of their beliefs. For instance in the Catholic faith, sex is mainly viewed as a way for procreation. Some may interpret that to mean it should not be enjoyable or pleasurable.

4.1.2 *Family setting*

Family setting usually has implications on one's overall health including sexual issues. It is believed that children who have been raised by both parents are usually more likely to be better informed about sexual health issues including safe sex and abstinence. However in Uganda, less than half of the young people (40% of females and 44% of males) live with their biological parents (National Survey of Adolescents, 2004). This makes them vulnerable to peer pressure, lack of parental guidance. Making them an easy target for bad peer influence including myths and misconceptions.

4.1.3 *Cultural and traditional practices*

In Uganda, different cultures have different norms, beliefs and practices. Some of these are risky for instance in Western Uganda were there is a preference for very wet sex. Making it hard to use condoms, since on many occasions they slip off the penis. Also the men in this area use a sex style called *'kakyabali'* where they stimulate the woman's clitoris with the head of their penis. All the friction may end up rupturing the latex. Another cultural practice among the Baganda found in Central Uganda, is the elongating of the *labia minora* apparently to increase sexual pleasure

(Kwagala, 2007). Research needs to be conducted on the implication of this and many cultural practices.
Other risky cultural practices include polygamy which is acceptable in some societies. Although polygamy had declined from 32% in 2000/2001 to 28% in 2006 (UBOS & Macro International Inc., 2007, Ntozi, 2001) it is still quite high. Young men raised in these communities start to see these kind of behaviours as acceptable hence their involvement with multiple sexual partners. Having multiple sexual partners is reported high among men (29%) UBOS reports that 29% of men have multiple sexual partners (UBOS & Macro International Inc, 2007) Increasing their risk of acquiring and transmitting HIV.

Table 1.3 Percentage of young men who disagree with 'traditional gender norms' by age

	15-19 years	**20-24 years**
Sexual Relationships		
It is the man who decides what type of sex to have	26	22
Men are always ready to have sex	34	39
A man needs other women, even if things are fine with his wife/girlfriend	53	53
You don't talk about sex, you just do it	67	64
Women who carry condoms are easy	26	30
Homophobia and relationships with other men		
I would never have a gay friend	14	18
It disgusts me to see a man behaving like a woman	16	21

Source: YMEP Baseline Survey, 2007

Table 1.3 shows the perceptions of young men towards issues like sex, polygamy, condoms and homosexuality. It's a clear indicator that many young people still have misconceptions about these and other sexuality issues.

4.1.4 *Education*

Access to education has direct links to the sexual health of an individual. Education enables one to obtain knowledge and acquire decision making skills and increases chances of economic autonomy in future (Wind, 2002). However, although sex education is taught in the majority of schools in Uganda, most sexuality issues affecting young men are never discussed. And if they are, usually the teachers have limited or no facts about the issues. An example of letters received at the Straight Talk Radio show were;

'My teacher told me that the pain in my back is caused by accumulation of sperms.' Male 16 years

'Our teachers told us that homosexuality is a sin and it is practiced by people that are mentally retarded.' Male, 13 years

There have been various debates on sex education, with some arguing that teaching young people about sex will encourage them to indulge in sexual intercourse (Akinrinola, 2007). On the other hand, 'Knowledge is power. Information is liberating. Education is the premise of progress in every society, in every family' Kofi Annan, former UN Secretary General. In my opinion this depends of the quality of education and information provided.

4.1.5 *Peer pressure*

Friends are a key source of sexual health information to more than 50% of young men in Uganda (Akinrinola, 2007) Many times this causes peer pressure among young men. Since peer pressure creates male needs and concerns because it creates false or unrealistic images and expectations, create feelings of not being a 'real man'. Young people are vulnerable to pressure from their peers as they try to find their identity and to fit in. According to Asiimwe (2006), peer influence is significant in behaviour and is based on interests and beliefs cherished by young people. Information with the community is shared through a complex web of social networks. For instance community groups and clubs, social gatherings, church congregations etc (Asiimwe, 2006). Several organisations in Uganda have taken advantage of these community networks to change perceptions and practices to offer peer education. However majority of young men have never spoken to a peer educator. Young men in school were more likely to have spoken to a peer educator as compared to out of school young men (YMEP, 2007)
Some of the letters received through the radio programme that indicated strong peer influence were;

> 'My friends tell me that in order to be a real man, i need to have live sex with more than four girls every month.' Male 17 years
>
> 'After my cultural circumcision ceremony, my buddies took me to have sex with an old women in order to become a real man!' Male, Mbale district

4.1.6 *Poverty*

Poverty encompasses the inability to satisfy basic needs, leads to lack of control over resources, sanitation problems, a lack of political voice, health and education services. It also makes one vulnerable to violence and crime. In addition to that it can compromise one into risky forms of employment like transactional sex. (Butler, 2004) However higher income sometimes is associated with an increase in risky behaviours. For instance in Uganda, the number of sexual partners among men increases with wealth quintile (UDHS, 2006) Also worth noting is that among Ugandan

women, sex with multiple partners is more likely among women with secondary or higher education. However there is no clear linkage of education and multiple partners among men (UDHS, 2006)

4.1.7 Health services

The attitudes of health providers towards young men may affect them (young men0 from accessing services. Many health centres do not serve men (especially unmarried) because some condemn sexual activity outside marriage (CERPOD, 1996). Young men often feel embarrassed at health centers and fear that their issues will not be kept confidential. Experience in Uganda shows that young men do not mind receiving information from male or female providers as long as they are knowledgeable and respectful (Green, 1995).

In conclusion, many of the sexual health needs and concerns of young men seem to be influenced by cultural beliefs and attitudes, gender norms, religious values, level of education etc. In the next chapter we shall look at what has been tried and assess whether or not it has been successful.

Chapter 5
IEC Communication Interventions

As already seen from the previous chapters, the majority of sexual health needs and concerns of young men are not medical. They are more to do with attitudes, knowledge and information. Therefore in this chapter this thesis looks at some of the communication interventions that can be applied in order to change attitudes and perceptions of young men.

5.1 IEC Models

Although trying to identify and understand the sexual health needs and concerns of young men is complex, most of these needs are more to do with lack of information as compared to accessing of medical issues. In attempting to understand young men and identifying possible approaches in addressing their needs for the purpose of this study, I have chosen to look at them from mainly a communication and community aspect. Therefore I intend to adopt two IEC models.

- **Communication model**- based on the communication given and received in order to influence attitudes and behaviour
- **Community mobilisation model**- which promotes the collective health of the entire community

5.2 The communication model: Another important area to consider when dealing with men is the communication component. Information, Education and Communication (IEC) are important when designing the kind of messages intended to reach a particular audience. In this case, young men. This model which was developed by McGuire (1989) is meant to aid in the guidance and design of public education campaigns. (McGuire, 1989) In Uganda, this is very important because every household in the country owns at least one radio. Radio is one of the most penetrative medias for information. Currently in Uganda, there are more than 300 FM stations countrywide. Many of these stations are located and owned by the community. These FM stations are a good media of reaching out to the men with information of where they can get services and information concerning their health. According to McGuire, the five communication inputs to consider are;

- **Source –** who is giving the information (Person, organisation) Do people consider it a credible source of information? Relevance and clarity of the message.
- **Message -** content and form of the message. (What is said and how it is said) In Uganda this is particularly important because the source of a message should be sensitive not to insult people's cultures, religions, believes, norms, customs and other factors that people consider important.
- **Channel –** the medium through which the message is transmitted. For instance the radio station, timing of the program, day on which the program is aired. Other forms of media to use, like TV, newspapers. Language to be used.

- **Receiver –** the target audience. Issues like age, ethnic origin, current behaviour and attitudes.
- **Destination -** desired outcome of the communication including behaviour change.

This communication model is useful in designing educative communication campaigns and strategies. For instance, when designing programs targeting men, it is important that the source of the message be someone they respect and identify with. The messages should be put in a way that is acceptable to the men, use the language they understand, give examples that they can identify with. Use a media channel that is popular amongst them. Chose a time that is appropriate for them. We need to give health programs targeting men with a macho image, and move away from generalising information with the hope that men will somehow come on board too.
I have chosen these two models to use all three models because issues concerning the sexual health of young men are each one looks at behaviour change at different levels.

5.3 The community mobilisation model. This theory explains changes within communities and communal action for health. (Rothman, (1987) Men are not islands. They belong to a community, with norms, traditions, cultures and particular behaviour patterns. Singling them out of the community may not be the best idea. However working with them within the context in which they live may in the long run have more benefits and sustainability. Many times men are driven to act a certain way due to the external pressures they face; i.e the way society perceives and looks at them. Therefore, community mobilisation looks at the capacity of an individual to act collectively on issues affecting his health and the health of the community as a whole. According to Rothman (1987), we have to distinguish between three models of practice;

- **Locality development** - which emphasizes community participation and ownership of the program. It involves building community capacity to identify and solve health problems, consensus, cooperation and community mobilization is key.
- **Social planning** - which involves more of professionals to identify health problems in a community depending more on epidemiological evidence. These professionals consult with the community mainly to identify problems and find solutions. Usually the professionals are also the program implementers.
- **Social action –** this model mainly looks at building a community's capacity while being able to address the needs of the disadvantaged. The practitioner in this case takes on the role of an advocator and mediator on behalf of the disadvantaged.

These models are important when looking at the health needs and concerns of young men because they will help us to analyse the

challenges faced by male intervention programs. And how we can make men own these programs (Rothman, 1987).

Chapter 6
Approaches for reaching men

I have been trying to look at different interventions and programmes targeting young men in Uganda. But most of these services are integrated into other programmes like family planning services. This chapter looks at the traditional interventions and what has been done so far.

6.1 Health policies

Uganda has numerous health policies that are geared towards the improvement of adolescent sexual and reproductive health. Some of these include the following;

Table 1.3 Ugandan adolescent sexual and reproductive health related policies

Adolescent focused policies	Key pertinent issues	Remarks
National adolescent health policy (draft)	Specific themes considered include; reproductive health, substance abuse, mental health, accidents, disabilities, nutrition, oral health and socioeconomic consequences/occupational health To address adolescent needs and problems	This policy does not take into account adolescent sexual health including the sexual health needs and concerns of young people Still in draft form
National policy on young people and HIV/AIDS, 1998 (Uganda AIDS Commission)	Mainly addresses the transition of young people from childhood to adulthood in order to avoid adolescent sexual and reproductive health problems like early/teenage pregnancy and high HIV transmission between mother and child	Sexual health matters like erectile dysfunctions, masturbation etc are not addressed
National Youth Policy, 1999 (Ministry of Gender, Labor and Social Development)	To fulfil governments obligations as per the 1994 International Conference on Population and Development in Cairo and other International conventions	Approved but has not been thoroughly distributed and disseminated at national and district levels
Affirmative action policy for females at the university, 1990 (Ministry of Education and Sports)	Aimed at promoting equity by adding females 1.5 extra points on entry into the university	Implemented
Minimum age for sexual consent (Ministry of Gender, Labor and Social Development)	Minimum age of sexual consent set at 18 years. Sex below that considered sexual abuse and is punishable by law	Mainly protects girls.
Other policies with implications for adolescent SRH		
National population policy, 1995 (Ministry of Finance)	To address population growth including maternal	Does not incorporate issues of reproductive health and

	morbidity and mortality	sexual health. Needs to be revised
National Health Policy, 2000 (Ministry of Health)	Includes Adolescent Sexual and Reproductive health	Mainly focuses on female reproductive health issues Needs to be disseminated to all districts
Reproductive Health Policy (Draft)	Promotes availability and accessibility of services to adolescents	Focuses on services and yet most male sexuality health concerns are not medical
Sexual and Reproductive Health Minimum package for Uganda	Promotes availability and accessibility of services to adolescents	Focuses on services and yet most male sexuality health concerns are not medical
Universal Primary Education (UPE), 1997	Aimed at raising school enrolment especially for the girl child	Sex education lessons are not offered in all primary schools
National Gender policy, 1997	Aims at integrating gender into development efforts including ASRH	Has not been popularised at district level
National AIDS control policy proposals, 1996	Aims at providing a multi-sectoral response to HIV. Includes ASRH	Deals mainly with the HIV epidemic and related behaviour change issues mainly the ABC strategy.
Decentralization Policy, 1993	Aims at bringing services including ASRH closer to the people	Implemented but mostly deals with services

Source: Adolescent Sexual and Reproductive Health in Uganda; (Neema, 2006) Adjusted by author

These policies are the first step in the right direction and show the government's commitment towards the improvement of Adolescent Sexual and Reproductive Health. However, as seen in the table, these policies do not specifically address the sexual health concerns and needs of young men in particular. Many of them are general, while others tend to focus more on the girls. These are major gaps in the Sexual and Reproductive Health situation in the country because it's an indicator that young people especially men are simply expected to somehow know about their sexuality. According to Sonfield (2004), in meeting the Sexual and Reproductive Health needs of men, we need to focus more on educational, counselling and services that build skills and not merely on medical aspects (Sonfield, 2004) as most of the Ugandan policies tend to suggest.

6.1.2 Education in Schools

The Ugandan government has always recognised the importance of incorporating sex education into the school curriculums. In 1986, the *School Health Education Project (SHEP)* was setup as a peer education approach to the fight against HIV/AIDS. This project targeted secondary, tertiary and out-of-school youth and was implemented by the Ministry of Education and Sports (MOES) together with the MOH and various organisations and institutions (Asiimwe, 2006). In 1996, the Uganda Catholic Secretariat initiated the *Behaviour Change Program (BCP)* which was aimed at promoting spiritual values and redirecting moral conduct

among in-school-youth 13-25 years. The peer-based approach was adopted and *'apostles for change'* were recruited and trained (Asiimwe, 2006). However, this proved costly in the long run due to the school drop out rates and having to train new peer educators each time.

The Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) program is another sex education intervention that was introduced into schools. The PIASCY project was President Museveni's idea to incorporate sex education into school curriculums. In this program, teachers are trained on how to address issues concerning HIV/AIDS, sex and protection. Sex education teaching manuals were written and distributed to all primary and secondary schools (Buonocore, 2005). However, the sex education offered in schools does not incorporate all this. Many of the issues in sexuality like eroticism, pleasure, and sexual orientation are never addressed mainly because of religious affiliations, and also the fact that sexual issues are taboo in most cultures. Teachers do not find it easy to talk to students about these kind of issues. In addition to that, discussing these sexual matters between partners or even with service providers is also extremely difficult in many cultures (Butler, 2004). Further still, almost all these programs are conducted within schools, leaving out the out-of-school young men who in many cases are more vulnerable.

In 1998, a survey, 'Reproductive Health in school curriculum' was conducted by MoH in various primary, secondary and tertiary institutions among teachers, administrators, parents and youth. Some of the problems identified were;

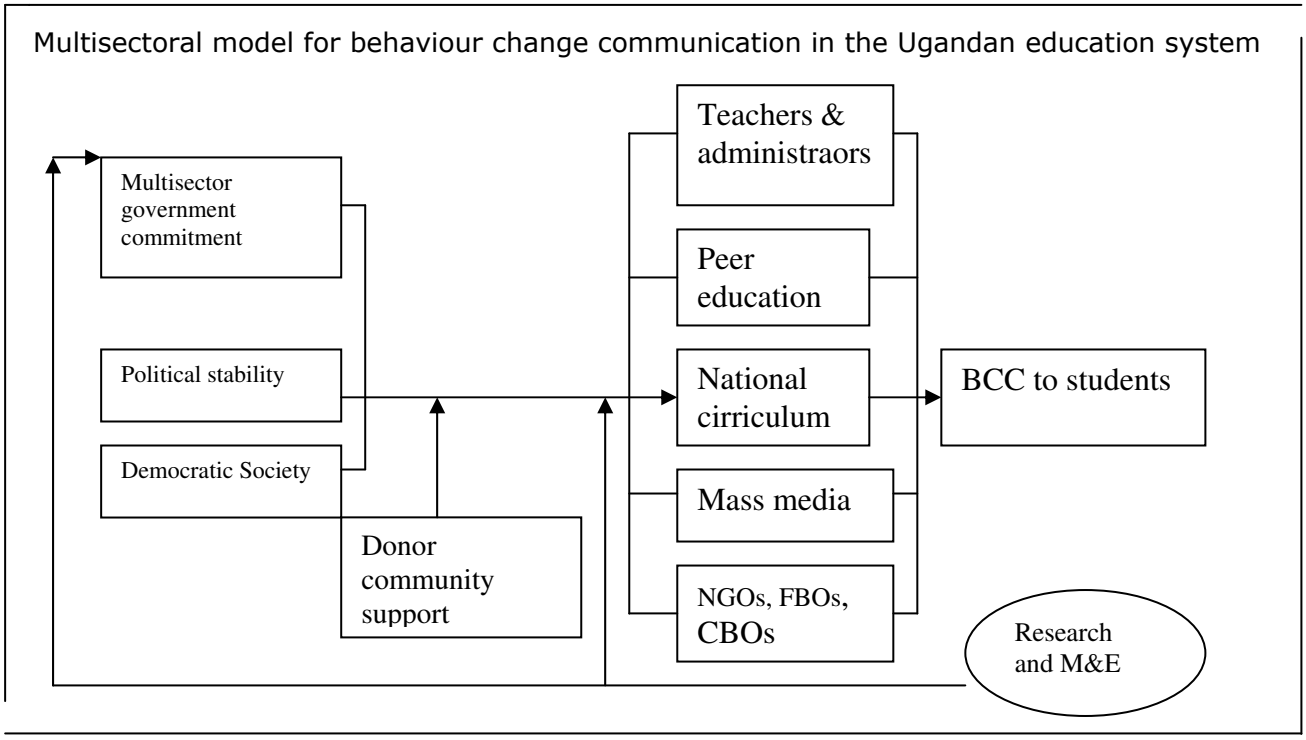
- Inadequate information on human sexuality
- Lack of parental guidance and counselling in Reproductive health
- Exposure of students to uncensored mass media and pornography (Reproductive Health in School Curriculum Survey, 1998)

In order to deal with these issues, a holistic approach was adapted in which teachers and peer educators were trained, Music, Dance and Drama was used to disseminate reproductive health messages. In order to incorporate these issues into the curriculums, administrators and districts were involved. The main topics addressed under the Reproductive Health in school curriculum included; Family life education, gender roles and development, socio-cultural beliefs and practices, early pregnancy, dropping out of school, premarital sex, STIs and HIV/AIDS.

The Guidance and Counselling component was also introduced in certain schools. In schools were it has been effective, indicators have shown a closer relationship between teachers and students, some schools have provided counselling rooms and allocated time for it, some parent-child relationships were bridged through counselling from trained teachers. In addition, trained teachers reported acquiring skills in counselling and communication. However, although knowledge levels were high, there was

no corresponding behaviour change (Morisky, 2006). In order to help young people to be able to translate knowledge into behaviour, the government in conjunction with UNICEF identified the need to teach life skills. Hence the introduction of the Life skills Initiative whose objectives were; to develop skills among youth in interpersonal relationships, self awareness and esteem, problem solving, decision making, effective communication, self awareness, resisting peer pressure, negotiating safe sex, critical thinking, chastity maintenance and formation of friendships (Morisky, 2006).

In addition to these efforts, the Ministry of education and Sports (MOES) together with the government, various NGOs teamed up to promote SRH information through extracurricular activities like sports and talks within the schools especially from People living with AIDS (PLWA). IEC materials like posters, leaflets, straight talk copies were distributed in the schools (Morisky, 2006).



Source: Overcoming AIDS, Lessons Learned from Uganda (Morisky, 2006)

The sex education taught in schools mainly deals with topics like; HIV/STI prevention, family planning, food and nutrition, sexual harassment and abuse, exercise, sex and recreation, family and relationships. (Morisky, 2006) However in trying to target young men, the full range of their concerns should be considered by researchers and programmers. (Hawkes, 2000) Issues like masturbation, homosexuality, sexual anxiety, sexual pleasure, penis size issues, erectile dysfunctions, infertility and other main sexuality health concerns of young men are not addressed. And yet, in order to enhance male and female sexual health, society

should provide access to comprehensive sexuality education and health care services that are affordable, sensitive and confidential. In addition to this, education and employment opportunities are equally important. (Haffner, 1995)

At the same time failure to discuss these issues leads to the abuse of ones sexual rights. According to WHO, these include the Right;

- To the highest attainable standard of sexual health and to access SRH care services
- To seek, receive and impact sexuality related information
- To sexuality education
- To respect bodily integration
- To choose a partner
- To decide to sexually active or not
- To consensual marriage
- To sexual relations
- To decide whether or not to have children and when
- To pursue a satisfying, safe and pleasurable sexual life

However it is not clear where issues like MSM, sexual abuse, erectile dysfunctions lay. In addition to this, UN member states have not yet approved these Rights. Perhaps due to its sensitive nature.

6.1.3 Advocacy

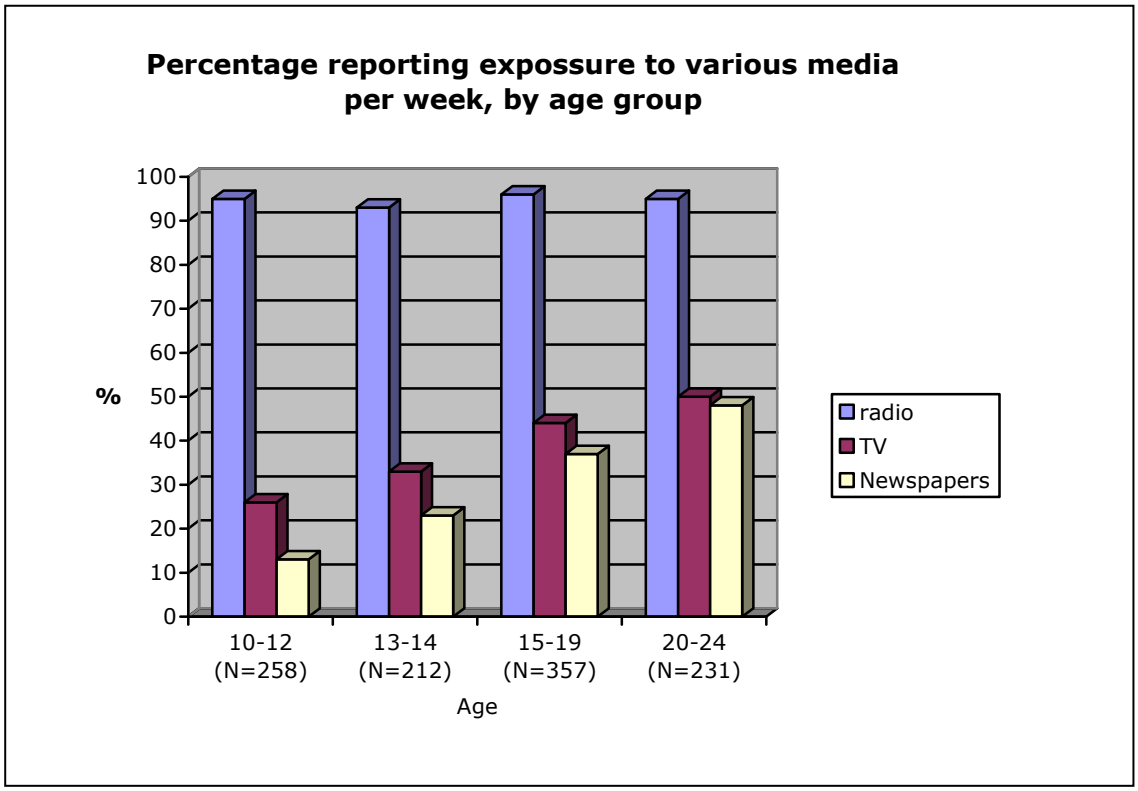
Raising awareness of the sexual health needs and concerns of men among key stakeholders like policymakers, donors, health providers, cultural heads and the general public is key. Donors and policymakers must be convinced that investing in men's sexual and reproductive health will eventually lead to social, economic development of the society as a whole (Sonfield, 2004). However, I could not find any data on what policy makers know about the sexual health needs and concerns of young men in Uganda

Already there are various programmes in Uganda that are targeting men's sexual and reproductive health needs and concerns i.e. Young Men as Equal Partners (YMEP). However like most interventions, these programmes mainly focus on the reproductive aspect, and mainly deal with men as partners and not necessarily as individuals in their own right.

6.1.4 Information, Education and Communication (IEC)

Media and preferred sources of information

Mass media is extremely important in conveying communication to not only adolescent males but also to the entire community. The YMEP baseline survey reports that radio is the most popular media with at least all respondents reporting listening to radio every week (YMEP baseline survey report, 2007).



Source: YMEP baseline survey report, 2007

This data is similar to that of the National Survey of Adolescents 2004 which further proves radio as the most accessed media, with 80% of adolescents reporting at least listening to radio once a week. More adolescent males access radio (21%) as compared to 11% of their female counter parts. Making radio a good source of information for young men. (National Survey of Adolescents, 2004). This is similar to various countries were young men mention radio as their preferred source of information. For instance in Bangladesh, 76% of young men said they preferred receiving sex education via the radio. This preference could be because of the anonymity that radio offers, making young men feel safe and un-judged.

The communication model by McGuire suggests five inputs which we could consider when communication young men's sexual health concerns and needs. (Please note that I am going to apply McGuire's key points to my personal training and experience in health broadcast journalism

Source: The source of information is almost like the soul of a message. The target audience needs to be able to identify with the source. Sources of information should be credible and trustable. For instance when dealing with young men, some have argued that it may be better to use a fellow young man to disseminate messages. However this is questionable because in my experience, when presenting the Straight Talk Radio Show, we assumed that the girls would identify better with me, and the boys

with my male co-presenter. Surprisingly, this was not the case. The boys wrote more letters to me, while the girls seemed to prefer my male co-presenter.

Message: The content of a message is important in the way it is communicated, for instance the tone of voice – is it judgemental, empathetic etc. For overly sensitive issues, it may be best for the presenter to act more like a link between the interviews.

Channel: In order to establish the most appropriate channel to use for the broadcasting of a radio show, it is best to conduct a baseline survey among the target audience to find out their preferred channel, appropriate time and day.

Receiver: The target audience's diversity at any one time should always be considered. Their age, ethnic origin, cultures, beliefs, customs and behaviours. So as not to insult anyone when conveying a message.

Destination: It is important when airing or dissemination a message, to know the desired outcome, and what kind of behaviour one is trying to promote in a particular target audience.

In my opinion, in addition to McGuire's key points, also important to note are other key issues like, Monitoring and Evaluation (M&E). Mainly to know whether the message has been received, correctly, and if the intended audience is applying in their day to day lives. For instance messages on sexuality communication can be broadcast, and during the M&E one can evaluate how many young men report communicating sexuality issues with their partners . Another important issue is pretesting and or post testing of various messages to check whether they are clear and acceptable. Combining messages with entertainment (Music, dedications, vox pops, sweepers, jingles, etc) is useful. Because it tends to take the tension away from certain messages and by lightening up heavy matters.

6.1.4.2 Sex education

Sex education is important and should be given in a sensitive, empathetic way that does not de-motivate male feelings and emotions. However it is pertinent that sex education should address issues that the men want to know, or that are most pressing to them at that particular time. Sexuality education for men should include decision making, life planning skills together with sexual health needs and concerns raised by the males. This knowledge and skills should be coupled with opportunities for social and economic advancement (Alexis E, 1998) In my experience, when having sex education lessons with young people, we would always do a needs assessment by enquiring what the young people already knew, and having them ask questions. Majority of the questions asked were on sexuality health concerns. Another study in Kenya found that pre-teens wanted to

know about wet dreams, while older males were mainly concerned about STIs and male/female relationships. (John Hopkins Center for Communication Programs, 1997) This is similar to another sexuality workshop conducted by The Indonesian Planned Parenthood Association's *Lentera* project, were male high schools students' concerns were mainly about masturbation, body image (penis size) sexual orientation, losing their virginity and STIs. (Kamil, unpublished paper) In Namibia, young men mainly wanted to know about how to sexually satisfy women. (Alexis, 1998

In attempting to address the sexual health needs of young men in Uganda, we need to learn from communication programs that have been successful in dealing with issues affecting young people. Straight Talk Foundation (STF) is a good example of a successful communication intervention. STF is a communication NGO that has been in existence in Uganda since 1993. It uses newsletters and radio as media to reach young people in and out of school. It also has media and face-to-face interventions for teachers and parents as gatekeepers of young people. STF has a print run of more than 8million copies annually. Some of the lessons learnt (On how to write effectively for young people) can be adopted when dealing with the sexual health concerns and needs of young men in Uganda. According to STF annual report 2007, some of the key aspects when writing for young people include;

i) Being sensitive not to sound like the message is blaming the intended audience. Belittling their feelings and not involving them may lead to the failure of that particular information.
ii) Realize that all readers are different and are at different points in their growth and sexuality. Therefore having sessions with different various messages is good, since more young people may identify with the various messages depending on their needs and concerns.
iii) Tread lightly, especially on supper sensitive issues. For instance using phases like, 'Readers this could also happen to you, or you should not be like so and so' instead key concepts should be repeated.
iv) Involving the readers is key at every stage, for instance getting them to write letters of advice to one another, to participate in quizzes, etc.

Source: Straight Talk Annual Report, 2007

Whereas I agree with those recommendations, it is not the only issues to consider when writing for young people-in this case men. In my opinion, other key issues include being able to communicate sensitive sexual health matters in an acceptable and non vulgar way. Pre-testing of messages with the target audience and their gatekeepers is essential. Also when it comes to publishing materials in local languages, one needs to be more cautious of what words or phrases are acceptable within a particular

cultural setting. Further still, young men should be given incentives to participate in communication interventions intended for them. In this case they can be encouraged with replies and gifts like t-shirts, stickers, posters, bicycles, and recognition (in the newsletter) for their participation.

6.1.4.3 Distribution of IEC materials - When writing for young men, channels of distribution are important. In this case distributing the copies to places where young men converge like schools, sports clubs, bars, and worship places is crucial.

6.1.5 Community participation and mobilisation

Since the Alma Ata Declaration in the 70s, community participation has been considered essential in health development. It is important when targeting young men to involve them in the program planning and intervention stages. Although many times, this implementation is influenced by national and local situations and therefore should be conducted within country specific context (Neema, 1999) In this case, adapting two of the three practices in Rothman's community mobilisation model is helpful.

- Locality development – related to sexual health needs and concerns of young men, it is important that they are involved in the planning and implementation of their programs giving them a sense of ownership. Programs targeting them should also aim at building their capacity to a level where they are able to identify and solve pertinent sexual health issues by building consensus within the community.

- Social action – enables the young men to identify relevant sexual health issues while taking into account disadvantaged groups like the physically handicapped, orphans, the out-of-school etc. This practice will enable young men to create audience specific messages targeting the various groups and their apparent needs.

In my opinion, the Social Planning practice is not very useful in this case since it mainly talks about professional intervention, including planning and implementing of interventions. Also since the bulk of young men's concerns and needs are not medical, there is limited need for professional intervention-which in this case would be in form of service providers.

6.1.6 *Social Marketing*

Social marketing is an important strategy when dealing with men. In Uganda various health campaigns have been conducted using fun and games as a marketing strategy. For instance campaigns have included bicycle races, soccer matches, music, (Johns Hopkins Center for Communication Programs, 1995), dance and drama, puppet shows, moving cinemas in order to attract men. Usually there are also competitions with prizes to be won. These serve as incentives to the men.

Social marketing has been especially successful in making condoms accessible and affordable. (Finger, 1998) Some drama shows have targeted men. However the impact on young men's attitudes especially concerning their sexuality still has to be established.

6.1.7 Peer Education and counselling

In Uganda, peer educators have been found to be a successful means of penetrating into the community with information and services. The majority of projects working with communities have trained peer providers who work within the community. Peer educators have also been documented as a good way of supporting men to prevent negative peer pressure, and arming them with skills to that help them resist myths. Peer educators have been known to be an effective way of handling sensitive sexual and reproductive health issues. (Morisky, 2006) In various schools and communities these peer educators are trained in counselling and communication skills and for various interventions, they are used to penetrate into the community with information and services. For instance condom and IEC material distribution. However most of the training is general, therefore dealing with young men's sexual health needs and concerns may be a challenge. Furthermore, peer educators need continuous supervision, support and training throughout the programmes to avoid burning or dropping out (Macharia, 2001).

6.1.8 Health Services

In Uganda SRH services are provided at private and government facilities. In hospitals, these services are integrated into the maternal and child health services. (Kwagala, et al, 2007). This may not be very effective and efficient in reaching young men with SRH information and services. Perhaps that is one of the reasons why young men do not access health services - because they perceive them to be for women and children, and also because in most health centres, the providers are female. In addition to that, there is not adequate information on what kind of services are offered at health centres and how men can benefit from these services. There are many issues that tend to affect services intended for men. Some of the documented challenges include; logistical issues like whether or not to provide services to men through separate facilities and by male providers, and how to make men comfortable in facilities that were primarily designed for women (Sonfield, 2004). Other issues of concern are what kind of counselling to offer men and ethical issues like ensuring the privacy and autonomy of women when providing their male partners with services. In addition to this, health providers lack training on how to deal with and handle men. Training is required not only on how to handle men, but also on how health providers can deal with their biases towards misconceptions about men and their sexuality (Sonfield, 2004).

Health workers in STI clinics for men observed that many of the clients sought care for non-physical complaints. This is a good indicator that STI clinics often do not offer solutions to the unmet need for male sexual health concerns (Collumbien, 2000). In attempting to understand the kind

of Reproductive Health[3] services needed by men, Engenderhealth developed a model for men's Reproductive Health Services. The model includes three different kinds of services needed for men. These are;

1. Screening – which includes taking sexual and reproductive history, cancer evaluation, mental health evaluation, substance abuse plus an age appropriate routine physical examination.
2. Proving information, education and counselling (education on sexuality and physiological developments, counselling on contraception, STI/HIV/AIDS, genital health and hygiene, interpersonal communication and sexual reproductive behaviour.
3. Clinical services for sexual dysfunctions, STI/HIV/AIDS, fertility evaluation and vasectomy.

However in low resource settings, this model has limitations. For instance apart from providing basic counselling, most of the other interventions require referral and treatment (Waelkens, 2003). Collumbien (2000) proposes educating men on specific sexual health topics as a better option. While Population Council (2001) suggests the need to address men's concerns about condom use and loosing ones erection while putting it on. Nevertheless, providers need to be trained on how to handle sexuality issues especially of young men. For instance in Ibandan Nigeria, providers were trained on changing their attitudes in order to comfortably handle sexuality issues (Adeokum, 2002) One way of making providers comfortable talking about sensitive issues is the use of flip-charts. Clients simply follow what is on the flip-chart making it more like routine. (Solo, 2000) Although in many African countries health providers have been trained to integrate HIV/STI interventions into programs like family planning, these courses have been too short for them to acquire skills on how to deal with sexuality matters. (ICRH/GU, 2000) However knowing how to organise sexual health services that will respond to the needs of men – including young men is still rather unclear (Waelken, 2003)

However its not all grim, In Israel, '*On clinics'* (a private sector network of clinics that offer quality sexual health care services to men of all ages) have proved rather successful, through their advertising interventions on TV and radio, focusing on sexual dysfunctions, and ensuring the quality and experience of health providers while ensuring confidentiality and discretion (Schenker, 2002)

6.1.9 Out reach services

In Uganda outreach services are popular among reproductive health interventions. Since men do not necessarily go to health centres for medical services, it is important to try and reach them with information and services where they are. For instance at the work place, at home, sports clubs, bars or drinking/socialising areas. The source of the information should be someone they identify with like a community leader

[3] Reproductive Health in this case also includes Sexual Health.

or a peer (Sonfield, 2004). In Uganda, according to the Busoga Diocese's Family Life Education Program, men in general have fewer domestic responsibilities, and therefore more leisure time to 'hangout'. Out reaches (If organised well) can each these men in places where they tend to 'chill-out' (AVSC International, 1997). Dealing with young men within the community instead of waiting for them at the health center, is effective because more young men are reached within the community. Also it reduces stigma associated with seeking medical services, since out reaches tend to target everyone regardless. However most of these services have been known to mainly deal with STI/HIVAIDS prevention and management of STIs (Waelken, 2003). Making them rather limited to deal with the sexual health concerns of young men.

Chapter 7

7.1 Discussion

- Mass media especially radio is a preferred source of information for young men. With majority of young men accessing the radio at least weekly.
- Sex education is important for both in and out of school young men
- Out reach services are important when targeting young men since majority of them do not go to health centers.
- Social marketing is a good way to involve men in programs and interventions and serves as an incentive for them.
- From the data presented, young men are indulging in sexual activity rather early. The male condom is the most popular contraceptive method.
- Globally, not much is known about male programs and interventions, how they function and what works best. At service level, SRH services are incorporated into maternal and child health services, which leaves out the men.
- Peer educators are a successful means of targeting young men with information and services (where necessary)
- Uganda has numerous health policies that are meant to deal with adolescent sexual and reproductive health issues, although emphasis is given to reproductive health issues.
- Involving young men in the planning and implementation of interventions intended for them is essential when designing programs intended for them.

7.2 Conclusions

- There is hardly any data on the sexual health needs and concerns of men in Africa. Available research is rather narrow and does not comprehensively exhaust the sexual health needs and concerns of men in Africa. Therefore there is need for more research to be conducted on this issue in order to be able to understand men better and plan effective interventions for them.
- Nearly all young people in Uganda identify with a religion. Among young male, 88% reported that 'religion is very important in their lives.
- Family setting usually has implications on one's overall health including sexual issues.
- Many cultures and traditions expose young men to risky sexual behaviour.
- Young men are prone to sexual myths and misconceptions especially due to peer influence.
- While some reproductive health concerns have been documented and addressed, many other issues especially sexual health issues

remain 'silent' and almost taboo to talk about. Majority of these sexual health issues are not medical.

- Politically, Uganda has several health policies that address the SRH of young people. Although there is no specific mention of young men as a target.
- Radio is the most preferred mass media for young men in Uganda.
- IEC interventions like posters and flip charts can be used to reach young men.
- Outreach services within the community have proven to be an efficient way to reach young men.
- Youth friendly health centres with interventions like sports and games, access to videos, internet services help in attracting young men to health centers.
- Peer educators help to provide information and services to young men within the community.

7.3 Recommendations

Researchers

- More research is needed in this area. The sexual health needs and concerns of young men are still a new area. Research will enable programmers to plan for what kind of interventions to use when addressing young men's sexuality.
- Research needs to be conducted on the perceptions of health providers towards the sexual health of young men.

Policy Makers

- Advocacy campaigns targeting health professionals, policy makers, donors, and other key stakeholders should be conducted in a bid fundraise funds and to convince them on the importance of investing in the sexual health research and interventions for young men in Uganda.
- Men have always been dealt with as partners or fathers, however deliberate interventions need to start addressing men as individuals in their own right.
- More resource mobilization is needed to fund research and interventions and programs targeting young men in Uganda.
- There is need to incorporate sexual health topics like infertility, masturbation, penis size issues, sexual dysfunctions and anxiety into the existing SRH sex education package offered in schools and within the community.
- There is need to train health providers on how to deal with and handle men in an appropriate manner. Also to change their attitudes towards men that seek sexual health services and information. Health providers should be comfortable to talk and counsel young men on their sexual health issues and concerns.

- With the condom being the most preferred method of contraception and STI control, its availability and supply need to be strengthened and shortages checked to ensure smooth supply.
- An international guidance document on sexual health should be developed to assist countries like Uganda to develop national strategies and policies on the sexual health of young men.
- Policies to protect young male victims of sexual abuse should be passed, to further protect the sexual rights of young men.

Interventions

- Regarding STI treatment and management, services should be accessible, affordable and friendly to young men. Although interventions targeting men interventions should never be at the expense of those for women.
- Out reach services within the community should be used to reach more young men with sexual health information and services (where necessary). Once organised well, more young men can be reached in places were they like to spend time. For instance at sports clubs, gyms, bars, places of worship, etc.
- Male age appropriate IEC materials like posters and factsheets should be distributed in all areas that young men find popular. To enable them to access information about their sexuality and sexual health issues.
- Young men should be provided with education, counselling and life skills training is key in positively changing their attitudes and behaviours. However another question arises here, who should give this information? And how should it be packaged? A consensus or understanding must be reached among health providers, policy makers, and other health advocates, on what information to provide and by whom. Taking into consideration specific needs of young men depending on their age, economic status, educational background etc.
- Male clubs should be formed within the communities as a way of ensuring sustainability and continuity of interventions and programs intended for young men. Clubs should be formed among the in-school and out-of-school young men. Activities could be organised according to the wishes of the club members. For instance they may decide to put some money together and start an income generating activity like fish farming, goat rearing etc. which in the long run provides economic empowerment.
- Clubs are also useful because they are an organised way of not only disseminating information but also provide a good atmosphere for peer-to-peer learning and interaction to occur.
- Mass media is reported to be one of the most preferred sources of information for young men. Therefore media like radio should be more utilised in disseminating sex education programs. Radio programs should be aired on more local or community FM stations in local languages so as to benefit the out-of-school young men. The

young men can actively participate in these programs through writing letters, responding to quizzes, giving advice to each other etc.

- There is need to train more peer educators within the community and teachers within schools in order to reach more young men with the correct information and services. In addition, this training on sexuality will help change their attitudes towards the sexual health concerns and needs of young men.
- Young men should be involved in the planning and implementing of their programs and interventions. This gives them a sense of ownership of the program, and ensures sustainability of the same.
- In order to attract young men to health centers, youth centers that provide recreational activities such as sports, computer access, video, internet, information and services should be set up.
- While women have 'Rights' with regards to making choices about reproductive health and accessing appropriate services, men are sait to have 'responsibilities'. Therefore there is need to reaffirm that sexual and reproductive health information and services are a Human Right and should be made available to all.
- Interventions to deal with young men (victims of sexual abuse) should be set up with counselling and medical services available.

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ANNEX 1

Select SRH Situation in Uganda (1995- 2006)

SRH variable	1995	2000/01	2006
Age at first sex - women men	16.1 17.6	16.7 18.8	16.6 18.1
Age at first marriage- median age (20-49 years -women) (25-54 years – men)	 17.5 23		 17.8 22.3
Polygyny: women men	30% 15%	32.2%	28% 17%
Had sex with more than one partner (within past 12 months) : women men			 2% women 29% men
Teenage pregnancy	43%	31%	25%
Total Fertility Rates	6.9	6.9	6.7
Contraceptive use: Any method Modern method	 15% 8%	 18.6% 14.0%	 24% 18%
Maternal Mortality Ratio	527	505	435
HIV prevalence			6.3
Infant Mortality		89	75
Ever tested for HIV: women men		8.4% 12.0%	29.4% 23.1%
Received results from HIV test in last 12 months: women men			 12.0% women 10.2% men
Sexual violence women men			40% 11%

Source: Kwagala (2007) Cited from UDHS 1995, 2001, 2006. (Adjusted by author)