Enhancing Age-appropriate Adolescents Sexual Reproductive Health Services for Young People below 25 Years (EASY-U25) - BASELINE

FINAL REPORT

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It is our sincere hope that the process and findings of this survey give UYDEL and its partners the requisite information and insights for planning better interventions for Youth and Adolescent Reproductive Health.

Cover Photo: Focus Group Discussion with Female Adolescents and Youth in Katwe

List of Acronyms

- AIDS: Acquired Immunodeficiency Syndrome
- ART: Anti-Retroviral Therapy
- ARV: Anti-Retroviral
- ASRH: Adolescent Sexual and Reproductive Health
- CBD: Community-Based Distribution
- COC: Combined Oral Contraceptive Pill
- CRC: United Nations Convention on the Rights of the Child
- EASY U25: Enhancing Age Appropriate Reproductive health services and occupational prospects for young people below 25 (EASY 25)
- EC: Emergency Contraception
- ECP: Emergency Contraceptive Pill
- FP: Family Planning
- GBV: Gender-Based Violence
- HCs: Health Centre(s)
- HCT: HIV Counseling and Testing
- HIV: Human Immunodeficiency Virus
- IAFM: Inter-Agency Field Manual on Reproductive Health in Humanitarian
- ILO: International Labour Organization
- LWF: Lutheran World Federation
- MARA: Most-At-Risk-Adolescents (refers to HIV/AIDS)
- MSM: Men who have Sex with Men
- NGO: Non-Governmental Organization
- NTIHC: Naguru Teenage Information and Health Center
- OCP: Oral Contraceptive Pill
- PEP: Post-Exposure Prophylaxis for HIV
- PLHIV: Persons Living with HIV
- PMTCT: Prevention of Mother-to-Child Transmission of HIV
- POP: Progestin-Only Pill
- RH: Reproductive Health
- SDG(s): Sustainable Development Goal(s)
- SEA: Sexual Exploitation and Abuse
- SMC: Safe Male Circumcision
- SRH: Sexual and Reproductive Health
- STI: Sexually-Transmitted Infection
- UDHS Uganda Demographic and Health Survey
- UNFPA: United Nations Population Fund
- UNHCR: United Nations High Commissioner for Refugees
- UNICEF: United Nations Children's Fund
- VCT: Voluntary HIV Testing and counselling
- WHO: World Health Organization
- YFS Youth Friendly Service

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Executive Summary

With funding from Bread for the World, UYDEL in partnership with LWF is implementing the Enhancing Age Appropriate Reproductive health services and occupational prospects for young people below 25 years (EASY U25) project, targeting 3000 youth in three divisions of; Makindye, Nakawa and Rubaga in Kampala. Trend International Uganda Limited was therefore contracted to conduct a baseline study among the vulnerable youths and adolescents in the three divisions with the objectives of assessing the; context, magnitude, knowledge, attitudes and practices, and challenges young people face in regard to access and utilization of appropriate SRH services as well as explore alternative livelihood options for the young people living in the slums of Kampala. The assignment was undertaken between December 2019 and January2020, and in this report we present the findings from the survey.

A cross-sectional survey design was adopted, employing both qualitative and quantitative approaches. Out of the three divisions, nine parishes were selected and 32 villages which formed the clusters for the study sample. A total of 789 respondents participated in the Household surveys, out of whom, 56% were female and 44% were male. An additional 303 youth participated in the FGDs at community level and over 10 key informants were purposively selected to corroborate the raw data from the adolescent and youth respondents. Standard survey tools were designed and shared with the client for approval and pretested in the field with a few adolescents and young people, as part of the quality control procedures.

The majority of the participants were in the age group 15 – 20 years with 94% of the respondents indicating they that they had ever attended formal school, although 65% of them were no longer in school.

The survey revealed that most of the young people were sexually active and already struggling with the consequences of unplanned pregnancies and STIs, including HIV/AIDS. 64% of the respondents in the face to face interviews indicated they had a boy or girlfriend although only 18% of the respondents from the same group indicated that they had ever gotten married.

It was reported that the traditional systems of disseminating sexuality education have been weakened over time, so peer groups, schools, churches, the media, traditional health practitioners, and NGOs have now emerged as the most prominent sources for this information, but the level of effectiveness is also wanting. A lot of the deliberate information dissemination is done at the school although this was reportedly elementary and shallow.

The survey revealed that there is evident need for SHR information and services among young people and for specific age groups. The visits to health facilities for treatment and uptake of other SRH services was reportedly increasing, with preference for services specifically tailored or outreaches targeting them, although there is still a poor attitude towards family planning and use of the contraceptives for the unmarried but sexually active young people. Social and cultural norms have largely prohibited parents and children from directly discussing sex, while conservative views still persist within the religious leaders and elders and these tend to be

counter to the efforts at increasing access of SRH information and services. There are reported challenges about the appropriateness of the services given to the young people.

A relatively large number of young people are considered to be at risk given the challenges to information dissemination and service delivery, but this is also associated with the huge unemployment and mass poverty within their communities. The youth in the slums are largely marginalized with limited opportunities for decent work, and no access to financial services. They have limited skills and the means to upgrade or train are also limited.

The survey concluded that the health sector environment in Uganda still poses some structural and policy challenges for the delivery of SRH services for adolescents and youth, this given the early initiation into sexual activity and non-use of contraception have increased the risk leading to unwanted pregnancies and STD infections, which go beyond the repercussions on young individuals and their families but also impose a heavy cost on society. Young people need to receive adequate and timely information on SRH to help change their attitudes and practices. Increased investment in the sector is therefore much needed. Investments in the area of youth economic empowerment is also necessary to enable the young people to acquire marketable skills and to start up and operate their own productive ventures.

1.0 INTRODUCTION

1.1 Background and Context

Nearly one-quarter of Uganda's population is between the ages of 10 and 19 (categorised as adolescents and youth). Adolescence is a challenging phase of life, within which the individual attains physical, sexual and social maturity. The youth and adolescents especially in the slum areas of Kampala in Uganda are often at risk or already struggling with the consequences of unplanned pregnancies and unsafe illegal abortions as well as Sexually Transmitted Infections (STIs), including HIV/AIDS. Unemployment is quite wide spread and the chances for decent work opportunities are also limited.

A number of publications indicate that a great deal is known about Adolescents' Sexual and Reproductive Health (SRH) knowledge and behaviour in the country, but much remains unclear. Although it is well known that Uganda has done much to stem the rising HIV/AIDS pandemic within its borders, Ugandan adolescents and youth remain vulnerable, in large part because knowledge alone does not prompt them to take action to protect themselves. As a first step towards improving the options available to adolescents to protect their sexual and reproductive health, we need to understand what lies behind this gap. We also need to know more about whether and where adolescents go for health-related information and care, and how to make it easier for them to obtain the services they need. The strategies for meeting these challenges are of concern to government at all levels; national, district and local in addition to program managers, parents and young people themselves, as part of the end goal of securing and ensuring a healthy future for Uganda's youth.

1.2 Rationale and Content of the Report

With funding from Bread for the World, an International donor, Uganda Youth Development Link (UYDEL) in partnership with Lutheran World Federation is implementing the project "Enhancing Age-appropriate Adolescents Sexual Reproductive Health Services for Young People below 25 Years (EASY-U25). Therefore, as part of the process of planning for the project implementation, UYDEL contracted Trend International Uganda Limited to provide consultancy services to conduct a baseline study among the vulnerable youths and adolescents in three divisions of Kampala City, under the above-mentioned project.

The EASY- U25 Project

EASY-U25 as a project is addressing; Poverty, Commercial Sexual Exploitation, Teenage Pregnancy and Motherhood, STIs including HIV and Aids, and Gender Stereotypes among 3,000 adolescents both boys and girls aged 12-25 years of differing ethnic background but living in the slums of Kampala. The intention is to reach these young people with Age Appropriate Reproductive Health information, including HIV/AIDS and STIs prevention and Psychosocial support services.

The overall goal/objective of the project is reduced vulnerability to economic deprivation and enhanced access to SRH services among adolescents and youth, within Kawempe, Makindye and Rubaga divisions in Kampala, by 2021.

The expected outcome from the project is the reduced vulnerability to economic deprivation and enhanced access to SRH services among adolescents and youth (aged 12-25), within the three divisions. This will entail enhancing the ability and competence of the young people to make informed choices about their sexual and reproductive health through the utilization of the peer to peer networks, as well as mitigate the underlying socio-cultural, gender and other factors that drive the HIV epidemic among this section of the population.

The Project is also targeting to support 500 young people (both boys and girls aged 18-25 years) to access vocational training and start-up capital. It is planned that the young people will participate in the selection of their preferred vocational skills and business enterprises. Additionally, the project intends to work closely with 100 peer club members (40 Males & 50 Females) to be trained in psychosocial support and life skills in order for them to provide peer to peer support to fellow adolescents. Other indirect targets for the project shall include: medical workers from private and public health facilities - offering SRHS; spiritual counsellors; male partners of girls in commercial sex, among others.

1.3 Young People and Sexual Reproductive Health Rights

The World Health Organisation (WHO) defines adolescence as the period between 10 – 19 years of age. It is a continuum of physical, cognitive, behavioural and psycho-social change that is characterized by increasing levels of self-individual autonomy, a growing sense of identity and self-esteem and progressive independence from adults. Adolescents are learning to think abstractly, which allows them to plan their futures.

Experimentation and risk taking are normal during adolescence and are part of the process of developing decision-making skills; adolescents are both positively and negatively influenced by their peers, whom they respect and admire. Adults play an important role in this regard as well and can help adolescents weigh the consequences of their behaviours (particularly risky behaviours) and help them to identify options. The influence of at least one positive and a nurturing family are protective factors during this period of development and can help adolescents cope with stress and develop resilience. Below is the categorization accorded to adolescents and young people:

Term	**Age range**	**Source**
Children	0 – 8 years	Convention on the rights of the child
Adolescents	10 – 19 years	UNFPA, WHO, UNICEF
Very Young adolescents	10 – 14 years	UNFPA, UNICEF
Youth	15 – 24 years	UNFPA, WHO, UNICEF
Young people	10 – 24 years	UNFPA, WHO, UNICEF

Adolescent and youth-friendly reproductive health services are those reproductive services that are accessible to, acceptable by and appropriate for adolescents and youth. They are in the right place, at the right price (free where necessary), and delivered in the right style to be acceptable to young people. The fundamental right of individuals (including young people) to decide, freely and for themselves, whether, when, and how many children to have is central to the vision and goals of the International Family Planning agenda under, FP 2020 which brings together 69 counties[1]. Yet today, many of the more than one billion young people (ages 10-24) living in those 69 FP 2020 focus countries do not have access to high-quality SRH care programs that meet their needs and empower them to determine matters related to their sexuality.

Studies show that young people are not affected equally by reproductive health problems. Orphans, young girls in rural areas, young people who are physically or mentally impaired, abused or have been abused as children and those migrating to urban areas or being trafficked are more likely to have problems. Unfortunately, many young people are prevented from accessing and using modern forms of contraception due to discrimination, stigma, and a lack of information.

However, Government of Uganda is a signatory to the Global Sustainable Development Goals (SDGs), and the Ministerial Commitment on Sexuality Education, Sexual Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa (ESA commitments). Under the SDG 3, 4 and 5, Maputo Plan of Action 2016 plus ESA commitments, State Parties are required to provide SRHR knowledge and services to all people especially youth. We have seen these domesticated through the Uganda Vision 2040, the Gender in Education Policy and Strategic Plan 2017, National Strategy for Girls' Education in Uganda (2014-2019), and the National Sexuality Education Framework 2018-2022 and Draft School Health Policy.

In 2017 the Government of Uganda revised its original commitment of 2012 to reduce the unmet need among adolescents from 30.4% in 2016 to 25% in 2021. This it hopes to do by improving the number of health structures in hard-to-reach places, strive to expand its reach and provision of services and method mix. However, according to the UNFPA/MoH report, 2012, there are still major challenges for adolescents and young people in the area of SHR. These include: low use of modern contraceptive methods by sexually active adolescents and youth; large number of early marriages; high rates of unintended pregnancies among school girls, and high exposure to GBV and the high levels of economic vulnerabilities among especially urban slum youth. The main underlying causes are lack of sexuality education, cultural norms that discourage talking about sexuality, lack of access to SRH services, gender inequality and insufficient attention to GBV.

1.4 The Uganda Health System – the Case for Adolescent SRH

The Government of Ugandan has adopted policies that create an environment supportive of ASHR. These include the: National Adolescent Policy 2004, with the goal to mainstream

[1] FP202 is a global partnership working to reach 120 million more women and girls with access to voluntary family planning information, services and supplies by 2020.

adolescent health concerns in the national development process as a way to improve the quality of life and standard of living of young people; 2011 Uganda National HIV/AIDS Control Policy, which addresses ASRH as well as access to voluntary testing and counseling (VCT). Additionally, the National Health Policy 2017, seeks to reach everyone in a comprehensive integrated way to move towards wellness, through achieving universal health coverage and delivering quality health care services to all, at affordable cost. The policy commits the government to fulfill youth development goals as spelled out at the 1994 International Conference on Population and Development in Cairo, where the sexual and reproductive health needs of youth are addressed. These policies are a critical step in the provision of SRH services for the young people, but their appropriate implementation is equally important and much remains to be done in this respect.

A variety of programs for sexual and reproductive health information and services for young people are also available, including; media campaigns, peer education and outreach programs, youth development programs and community health facilities. Programs also exist within the school system and in other, informal settings. There are International and National organizations, such as UNICEF, UNFPA, the Programme for Enhancing Adolescent Reproductive Lives and the Family Life Education Programme that have developed interventions aimed at behavior change and service delivery for adolescents. However the extent of their services and the effectiveness of the mechanisms they employ are a subject of debate.

1.5 Objectives of the Assignment.

The overall objective of the assignment was to assess the context, magnitude, knowledge, attitudes and practices and challenges that vulnerable adolescents and young people face in regard to access and utilization of appropriate SRH information and services.

The baseline was therefore expected to;

a) provide benchmark information for measuring the EASY U-25 achievements and outcomes over the project life span
b) verify the project result framework's adequacy with realities observed on the ground and provide inputs that will assist in updating the actions taken by target adolescents
c) identify new approaches to tackle ASHR among slum youth and adolescents.

1.6 Rationale for the Assignment

Half of Ugandan women and nearly four in ten men aged 15–19 years, have ever had sex. Among 18–19-year-olds, this proportion is much higher for both sexes, reported to be 77% and 59%, respectively.[2] Although the same report depicts adolescents as reportedly waiting longer before having sex, a number of sexually experienced adolescents and youth still report having had two or more partners within a year, while sexual coercion still occurs among them.

[2] Research in Brief. 2005 Series No. 2. Next. Protecting the Next Generation.

This is bearing in mind that nearly one-quarter of Uganda's population is between the ages of 10–19 years, yet many of these young people are at risk or are already struggling with the consequences of an unplanned pregnancy or a sexually transmitted infection (STI), including HIV/AIDS. To minimize these risks and secure a healthy future for adolescents, it is necessary that policymakers, journalists, service providers and advocates have solid evidence regarding the sexual and reproductive health needs of Ugandan youth.

1.7 Scope of work

Guided by the terms of reference and in consultation with UYDEL and Lutheran World Federation (LWF), the consultant was expected to;

- to design standardized tools and finalize methodology for the collection of quantitative and qualitative data for the Baseline Survey, taking into account the objectives mentioned above.
- collect and analyze available secondary data related to project objectives
- conduct primary data collection in three divisions of Makindye, Nakawa and Rubaga in Kampala Capital City, nine parishes and twenty-five villages within those locations
- analyze and interpret data to develop a comprehensive baseline report
- develop monitoring tools to adequately measure results and objectives
- Share key findings and insights with relevant staff and stakeholders through consultations

2.0. APPROACH AND METHODOLOGY

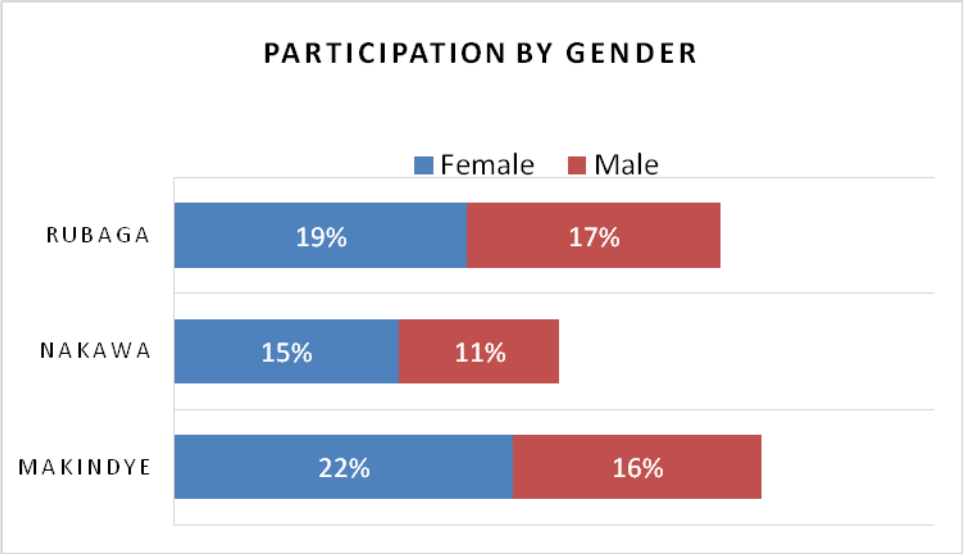
2.1 Overall Approach

Given that there is no reliable data on the number of youths in the city and the study areas in particular, and the range and nature of RHS options available to them, for the quantitative component, the approach used a simplified cluster sampling method based on the WHO sampling strategy.

A cross-sectional survey design was adopted, employing both qualitative and quantitative approaches and targeting male and female adolescents aged 12–25 years, and particularly living in the study area of; Nakawa, Makindye and Rubaga Divisions. Household interviews using a standard household questionnaire were conducted and the survey team conducted individual interviews with selected key informants on addition to Focus Group Discussions with relevant interest groups. Specifically, a comprehensive review of relevant secondary data sources and documents was conducted to generate important information in line with the study objectives.

2.2 House-Hold Interviews

The baseline survey was conducted through face-to-face household interviews with randomly selected respondents from each of the 3 divisions as dictated by the ToRs and as planned for the EASY-U25 project implementation. A total of 789 respondents participated in the survey, out of whom 56% (445) were female and 44% (344) were male, as represented in the graph below:



The study was conducted in three divisions of Kampala, Nakawa, Makindye and Rubaga. Three parishes were selected out of each division making a total of nine parishes. Three to four villages in those parishes were targeted. The villages were selected basing on the most populated areas

according the updated 2016 UBOS population census statistics, and in areas with especially youth in risky sexual behaviors.

Table 1: Participation in Households by Division and Parish

Division	Parish	Number of Participants	Percentage of Total respondents
Nakawa	Banda	100	13 %
	Mbuya	71	9 %
	Mutungo	29	4 %
Makindye	Katwe	100	13 %
	Kibuye	100	13 %
	Makindye	105	13 %
Rubaga	Mutundwe	99	13 %
	Kasubi	85	11 %
	Nakulabye	100	13 %
Total		**789**	**100 %**

The interviews were guided by a standard questionnaire that was designed, reviewed and pre-tested in one village from each division, for purposes of quality assurance. The instrument was administered by a team of 6 enumerators (two for each Division) and 3 field supervisors with the lead consultants over-seeing the whole exercise in consultation with the client. Prior to the data collection exercise, the entire team of 6 enumerators, 3 supervisors, 1 data entry clerk and the team leaders went through a training customized to the nature of the survey and they were equipped with the skill to conduct individual interviews. The data collection exercise for the face-to face interviews was conducted over six days starting on starting 18th December through the festive season and ending on the 31st of December 2019.

2.3 Sampling methodology

The sampling approach employed in this study has previously been used in studies to estimate coverage levels in the Expanded Program on Immunization (EPI), using a simplified cluster sampling method, based on the random selection of 600 respondents in 30 clusters (20 respondents selected for each cluster). So using a table of random numbers, up to 10 clusters were selected from each of the three divisions to comprise the three study sites.

Three parishes were sampled out of each of the three divisions and 3 - 4 villages were targeted per parish. The village will form the cluster, so up to 27 villages shall be targeted out of the 9 parishes within the 3 divisions with each contributing 3-4 clusters of 20 people each, every division had an extra cluster from which youth were selected for FGDs. Parishes with bigger population numbers provided 4 instead of 3 villages. The minimum number of respondents was therefore 180 per site (division). This technique helped to provide an equal probability to all resident youths and adolescents to be included in the sample.

The household was the point of focus for selection of the respondents. Where there were male and female adolescents in a single household both could be interviewed separately, but the preference was to have only one respondent selected from a household in case there were more than one adolescents of the same gender, but the attention was drawn to select both gender, factoring in aspects of vulnerability and economic poverty. So, particular care was taken to avoid targeting the same individuals in the household questionnaires for the structured interviews under the Focus Groups. The entire sampling methodology was guided by the 2015/2016 updated population data. The selection of parishes and village locations was based on those where there were presumably larger populations of slum dwellers within the selected divisions, bearing in mind that roughly 54% of the population in Kampala live in slum households. Youth and adolescents who had lived in the households for at least three months were the ones eligible for selection in anticipation that these would have a better idea of the context and availability of RHS in the areas.

Table 2: Selected sites for the sampled populations

Division	**Parish**	**Villages (Clusters)**
Nakawa	Banda	Acholi quarters, Banda 2 and Banda 3.
	Mutungo	Kasokoso, Kitintale and Biina
	Mbuya	Kinawataka, Katoogo and Mukago
Rubaga	Nakulabye	Musiro, Nakulabye West and Susana
	Mutundwe	Kitebi, Kitawuluzi, and Nyanama, Wankulukuku & Kabawo
	Kasubi	Kawala, Kasubi market and Masiro/West Church zone
Makindye	Makindye	Luwafu, Konge and Boston, Katuuso, Mubaraka, Salama
	Katwe I	Lufula, Nawanku, Kasule & Nkeere
	Kibuye I	Madirisa, Kategula and Kirundu

2.4 Qualitative data

For qualitative data, participants for Key Informant Interviews (KIIs) and focus group discussions were purposively selected. At least four key informant interviews will be conducted in each of the three sites. These involved service providers (health workers), KCCA officials/Ministry of Health staff, youth support NGOs and any other authorities involved with reproductive health services within those localities.

For the Focus Group Discussions (FGDs), 9 clusters were targeted from the 30 clusters formed out of the study three study sites. Each Focus Group was composed of about 7 – 15 adolescents and youths to make a minimum of 70 participants for the entire survey area, although the numbers turned out to be more in some groups. Out of the Focus Groups, effort was made to have specific groups of (one male only and one female only and one mixed group), hence the 3 groups for each specific cluster. The Focus Group Discussions were conducted to assess the

qualitative opinions of the adolescents and youth on the; information, availability, quality and accessibility of RHS among others, on addition to exploration of aspects of decent work as well as access to financial services for the youth. A total of 303 participants were engaged in the FGDs.

Table 3: Participants in FGDs for the respective sites

Division	**Parish**	**Female**	**Male**	**Total**
Nakawa	Banda	20	16	**36**
	Mutungo	10	12	**22**
	Mbuya	14	7	**21**
Rubaga	Nakulabye	22	11	**33**
	Mutundwe	10	15	**25**
	Kasubi	19	14	**33**
Makindye	Makindye	28	20	**48**
	Katwe I	32	19	**51**
	Kibuye I	14	20	**34**

Figure 1: Participants in female FGD in Katwe.

2.5 Methods of Data Collection

I. Review of Documents and records

As one of the first steps in data collection, a number of documents were reviewed for available information on youth access to RHS in the locations, the demand and associated provision as the economic status. Of particular importance were the following;

- Ministerial Commitment on Sexuality Education, Sexual Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa (ESA commitments).
- The Uganda Vision 2040,
- The Gender in Education Policy and Strategic Plan 2017,
- National Strategy for Girls' Education in Uganda (2014-2019),
- National Sexuality Education Framework 2018-2022
- Draft School Health Policy
- Naguru Teenage Information and Health Centre Strategic Plan 2015-20

The document reviews centered on the situational analysis reports on the factors that informed the design of the EASY - U25 Project. Periodic reports by different providers of Youth friendly reproductive health services indicating gaps and challenges. Ministry of Health reports on aggregated data from the HMIS was also reviewed to corroborate the raw data collected. Reports on the livelihood funds by the youth offices were accessed and reviewed to determine youth access to affordable financial services as well as employment opportunities with KCCA.

II. Structured interviews

The structured interviews involved 789 respondents from among adolescents and youths in the three sites out of the five divisions of Kampala (as above indicated in the proposed sample), to collect data on knowledge and awareness of the range and nature of service options available for adolescents and youths in the localities. The interview tool was designed by the consultants and shared with the client for their approval before it was administered to the respondents. The structured interviews were useful in generating information for quantitative monitoring indicators to be used by the EASY U-25 project. A draft questionnaire is annexed to this report.

III. Key Informant Interviews

These were undertaken with relevant providers of Reproductive Health Services, Advocates, Spiritual counsellors, and Authorities charged with monitoring service provision for young people. Youth officers at the divisions and contacts within the respective offices were interviewed to seek their views on youth access to decent work opportunities and affordable financial services. Additionally, staff of UYDEL and LWF, and other partners were engaged and some interviewed as key informants. Some of the local leaders were interviewed in the six sites as well. These are expected to provide information on available services and opportunities to youth, the unmet demand for services and the challenges faced by youth in accessing the available services etc. A copy of the interview guide is also attached as an annex to this report.

IV. Focus Group Discussions

A total of twenty-seven Focus Group Discussions (FGDs) were conducted with adolescents and youth in the three sites and basing on the sampled clusters. Participants in the FGDs were purposively selected with support from local leaders. Effort was made to reach out to groups of vulnerable youths and those considered to be engaged in risky sexual behaviors. These helped to generate qualitative information about their hopes and aspirations, their social perceptions and attitudes towards the services, the stereotypes, and other socio-cultural aspects that are presumed to influence access to the Reproductive Health Services among youths – including gender. The survey also used these FDGs to explore the options for job placement and decent work. A copy of the interview guide is attached to this report.

V. Observations

Using a checklist specifically designed for the survey, observations were carried out at community level to assess the quality of services at selected Health facilities from where the young people obtained Health Services. Visits were conducted to youth drop-in centers, safe spaces and community outreach service centers where an attempt was made to gauge the convenience and flexibility of the reported services. A number of social interactions were also held with the youth themselves and owners of some of the facilities where the youth are commonly found including bars, eateries and other recreational facilities.

2.6 Data Analysis and Quality Control

Data collected during the baseline survey comprised of a combination of quantitative and qualitative statistics. The quantitative data analysis primarily focused on data collected through face-to-face interviews by use of a standard household questionnaire. Raw data collected from the field was checked for completeness and accuracy, then coded and validated manually before entry. Using a double-entry method, data was entered in pre-designed data-entry screens in both ACCESS and Epi-data software. The data entry clerks had earlier on been trained comprehensively, and during data entry they were directly supervised by an IT supervisor and the lead consultant. To ensure quality, data cleaning was thoroughly done before exporting the data into SPSS for analysis.

Quantitative Data

The Quantitative data was then entered into computer software and analyzed using STATA software (Stata Corp LP, 4905 Lakeway Drive, College Station, TX, USA). Logistic regression models were used to assess univariate associations between the dependent variable (knowledge, awareness, accessing and utilizing health care services) and the independent variables including socio-demographic factors. Aspects such as cost, availability of services and gender of the youth were important variables during the analysis.

The analysis generated frequency distributions and trends in line with the key baseline objectives and other variables of interest. Specifically, the quantitative data analysis measured the relevant background characteristics of the respondents and their relationships with Sexual Reproductive Health and Decent work issues. The analysis also measured levels of coverage, the health

patterns of the respondents, their access to health services as well as knowledge of prevention and control measures. Aspects of information on behavior change and attitude towards utilization of contraceptive commodities were explored and this information corroborated with data from qualitative interviews.

Qualitative data

Qualitative data from FGDs and KIIs was transcribed and word-processed to enable easy handling and in preparation for further analysis. The process for qualitative data analysis identified relevant themes that guided the categorization and analysis. In this regard, data collected through FGDs and key informants, was properly checked, filtered, coded and appropriately categorized alongside seven critical themes of the study. The qualitative aspects of the study were primarily measured alongside those seven themes. They included, namely:

- Sexuality Education and knowledge
- SRH Service needs, demands, and utilization including contraceptive Use
- Quality of and access to SHR Counselling including competencies of service providers
- Perceptions and Beliefs around Adolescent SRH services
- Age specific SRH services
- Beliefs and Perceptions around SRH
- Decent work situation and work satisfaction

Analysis was then done using the content thematic analysis approach, with outcomes of the qualitative study used to explain the patterns that were generated by the quantitative data. The information gathered through qualitative inquiry was measured using appropriate triangulation techniques so as to strengthen the integrity and credibility of the study findings reflected as opinions, ideas and thoughts, all obtained on the basis of primary qualitative data collection. The results from qualitative data were double-checked and cross-referenced to ensure consistency and appropriateness based on the baseline study objectives.

2.7 Quality Control Procedures

The study considered several quality control procedures to ensure that the whole exercise including data and findings were of high quality particularly in terms of validity and reliability. The following quality control measures were used:

- The survey tools were shared with the client where comments were generated and incorporated. Continuous verifications, discussions and validations were further undertaken between the survey team and the client to allow for appropriate peer reviews and cross-referencing.
- There was close supervision of the survey team especially the enumerators and the data entry clerks. Regular spot-checks were conducted during the entire data collection exercise
- Data collected by individual research assistants in the field was immediately sent to a central server and daily checks were made on the same to determine consistency and completeness of the questionnaires. Computerized data checks were also installed in the data entry screens especially for quantitative data management.

- Data collection and data entry were done concurrently to ensure that any errors identified in the process could be corrected immediately, even if it meant going back to the field.
- Presenting and discussing preliminary results with the clients' team is also planned, as a direct referencing mechanism and if resources allow, a validation workshop with the stakeholders will be held.

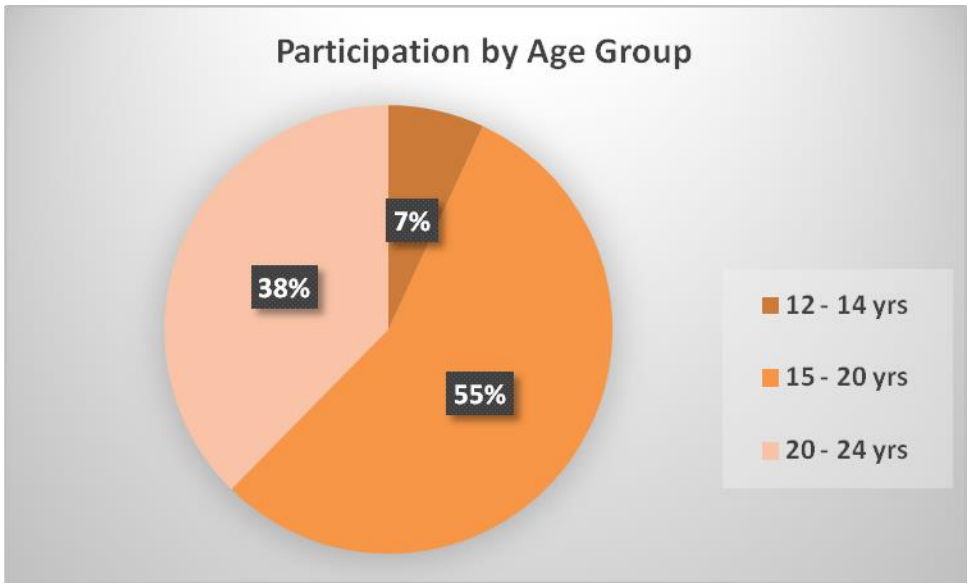
3.0 FINDINGS

This chapter presents the findings, analysis and interpretation of the data from the survey. An attempt has been made to use both quantitative and qualitative data in drawing patterns of the themes earlier defined following the survey objectives. This section will look at seven themes out of which conclusions shall be drawn and recommendations made for the project implementation process.

3.1. Socio demographic characteristics of adolescents and youth in Project area

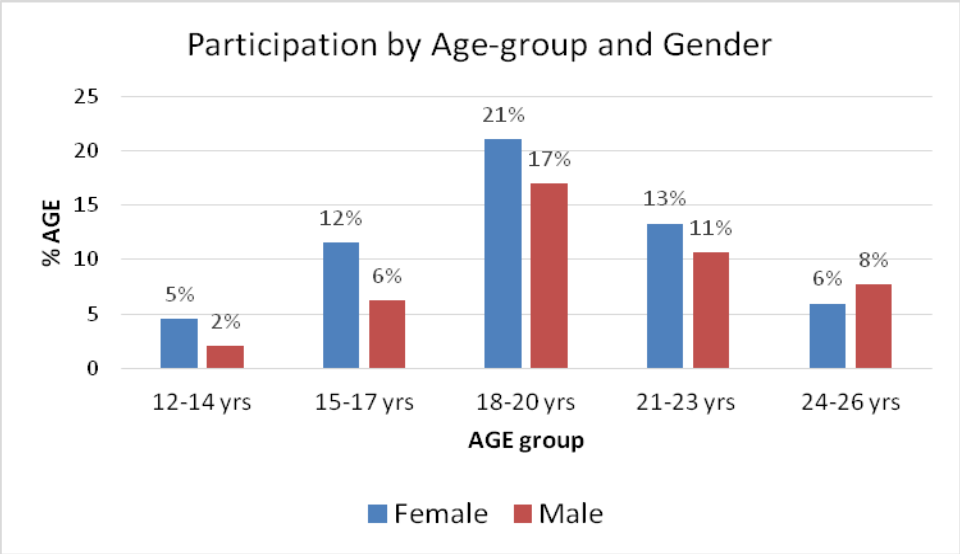
Generally, the population of Uganda is predominantly young with approximately 60% of the population below 20 years as indicated in the statistics above. Slum populations in Kampala are characterized by high proportions of young people many of whom are migrant and refugee communities.

For the household survey, a total of 789 respondents were interviewed during the survey which covered three divisions of Kampala Capital City, namely: Nakawa, Makindye and Rubaga. Out of these 305 respondents (39%) were selected from Makindye Division. The other two divisions of Rubaga and Nakawa contributed 284 (36%) and 200 (25%) respectively. Makindye division provided the greater number of participants because of the concentrations of young people in the slums of Katwe and Kibuye and these locations were selected because they did not present a separate facility that specifically targeted youth friendly sexual and reproductive health services as observed from secondary data reviewed. The majority of the respondents (55%) were in the age bracket 15 – 20 years. These are the more productive and more independent of parental control and therefore were more relevant for the issues that were being discussed. Below is the graph showing the population responses of the face to face interviews by age group for the three divisions.



Gender segregation

The study design had intended to have a 50:50 gender distribution of the study participants, but as it turned out to be, more females than males were available for both the face to face interviews and the focus group discussions. Out of these 789 participants in the household interviews, 445 of these respondents (representing 56%) were female and 344 (44%) were male. According to the 2014 population and housing survey, females constitute 51% of the Ugandan population so the selection was fairly representative of the reality in the sample compared to their proportion nationally.



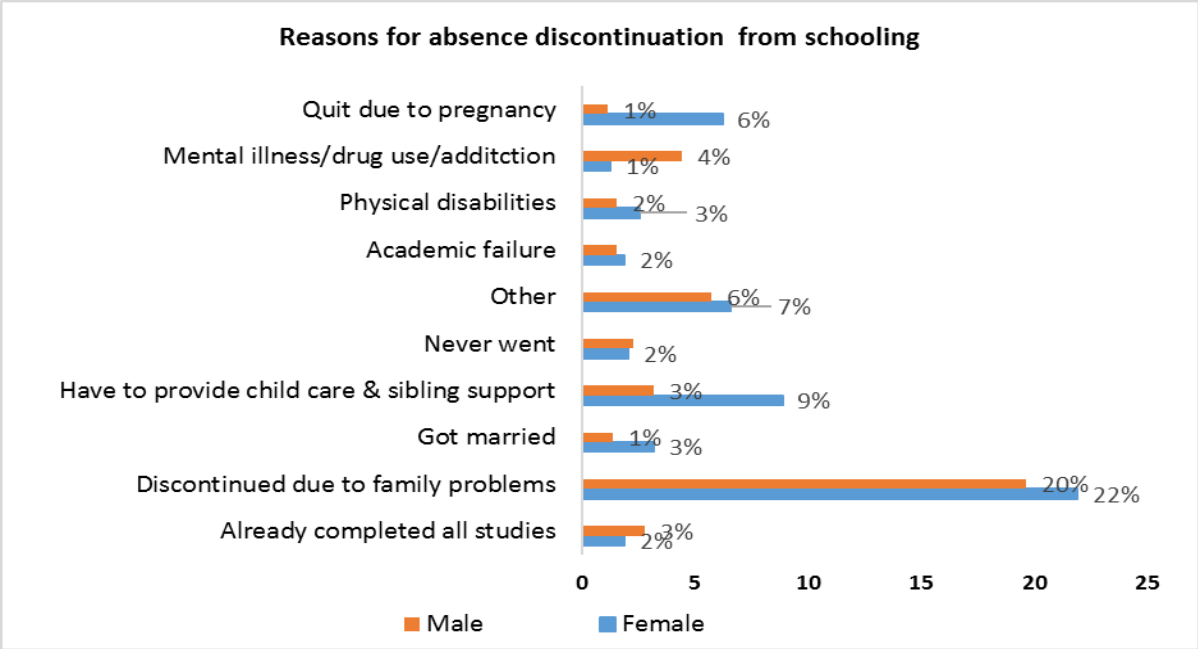
Religious affiliation

In terms of religion of the respondents, the Catholics dominated the population representing 37% followed by Muslims at 30%. The Protestants and Pentecostals followed with 18% and 6% respectively. This attribute was important for the survey because previous research and the Uganda Demographic and Health Survey have found some religious affiliations with acceptance and utilization of SRH services while others haven't. Therefore the survey explored if religion had a bearing on the acceptance of the SRH services and whether there was any support provided to the adolescents and youth by their respective religious or spiritual heads. Discussions during the FGDs pointed to the fact that some guidance about abstinence and life skills for girls, is given to the youth as the Mosques and in some Christian denominations (especially the Anglican and Pentecostal churches), however, none of these faiths was known to promote of provide information about reproductive health for the adolescent and the youth. the message is about abstinence until one gets married and those with spouses are instructed to keep faithful to their partners.

> *"After Juma prayers we the young people are asked to remain behind and we are given some tips on how to avoid HIV as well as live health lives. They encourage us to get permanent partners and be faithful to them."* **Saidi, youth in Katwe**.

Educational attainment

Most of the participants in both the household interviews as well as the FGDs indicated that they considered it important to attain a good education. This corresponded with the other data - 94% of the respondents indicated that they had ever attended school, but 65% (483 of those who had attended school) indicted that they were no longer in school. 35% of the respondents were still in formal school or in some form of vocational institute or training. This was an important parameter to consider in the survey given that the majority of respondents were in the age group 15 – 20 years as indicated above and under normal circumstances, would still be under the care of their benefactors or parents and therefore, in formal education. When asked about the highest level of educational attainment, 115 respondents (15%) had attained a qualification in a tertiary institution after secondary school, 420 respondents (53%) indicated that they had only completed secondary school as their highest level of educational attainment, while 254 (32%) indicated primary school as their highest level of educational attainment. When probed for the reasons for non-completion or for not being in school, a number of reasons were given as represented in the graph below;



The majority, 42% of the respondents that were not in school indicated that they had discontinued studies due to family problems (the gender is almost balanced in this category at 20:22% although the number of females is slightly higher), which are majorly socio-economic and these included; unstable families, delinquency related to being fascinated by the pleasures and fancy things in the urban environment, lack of adolescent support (mainly for adolescent girls) and sex based harassment, burden of home support where the demanding situations on adolescents where especially girl children are asked or looked upon as a helping hand to the family, lack of finances including tuition and maintenance, inadequate facilities at home to support school attendance, among others. As expected, girls being the highest culprits of

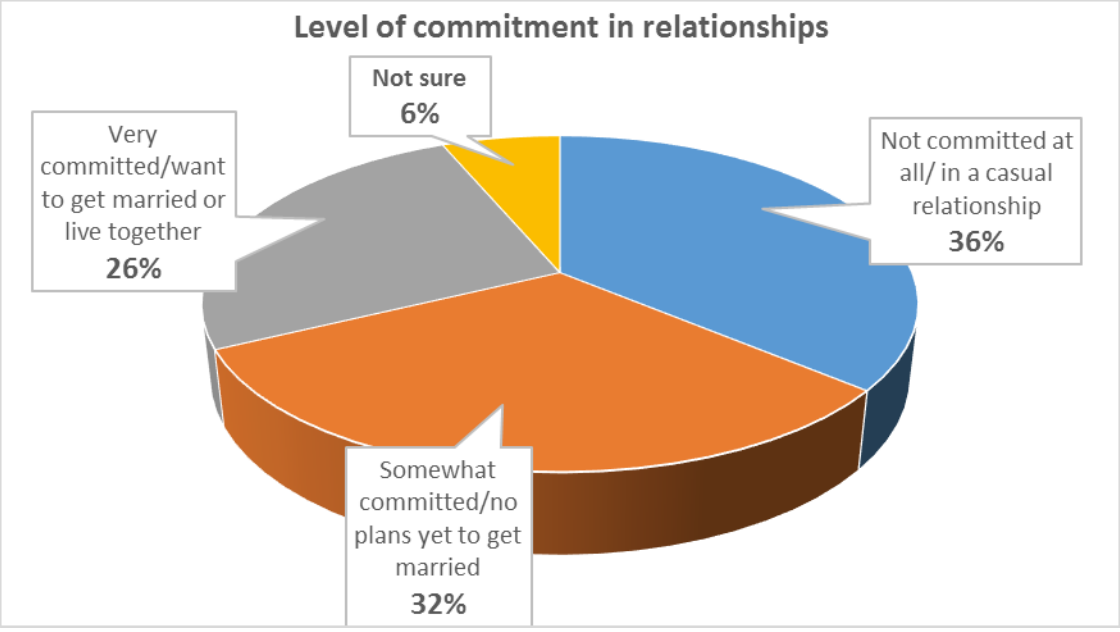
pregnancy, 6% of females quit school due to pregnancy related reasons compared to only 1% of boys. The other reasons were largely scored within the same ranges, in percentages below 10% and almost all related to the nature of families. Of particular interest in that category was mental illness, drug use and addiction which especially the boys in the FGDs were indicating as causing headaches that affect them a lot and in a number of cases affect their studies and overall general wellbeing;

> "*Ffe abalenzi, olussi emitwe, gituluma nnyo negitulemessa no'kusoma. Era ye'mu kunsonga etutwala mu malwaliro, olusii no'kuviraddala musomero."* **Participant in Male Youth FGD in Katwe.**

This translates as "we boys, sometimes complain of severe headaches and even fail to attend school. This is one of the reasons we visit hospitals or health facilities or even abandon school.

Relationships

On the question of inter sex relations, the participants in the survey were asked if they had partners as boy or girl friends or actual spouses. The survey revealed that 643 of them (82%) had had a boy or girl friend and only 19% indicated that they had not had one. Out of those who had ever engaged in sexual relationships, 494 (77%) were still in active relationship and 129 (23%) were not in a relationship. This therefore pointed to the fact that a number of the young people may be in active sexual relations. However, when asked about how committed they were in the relationships, the results below show the status;



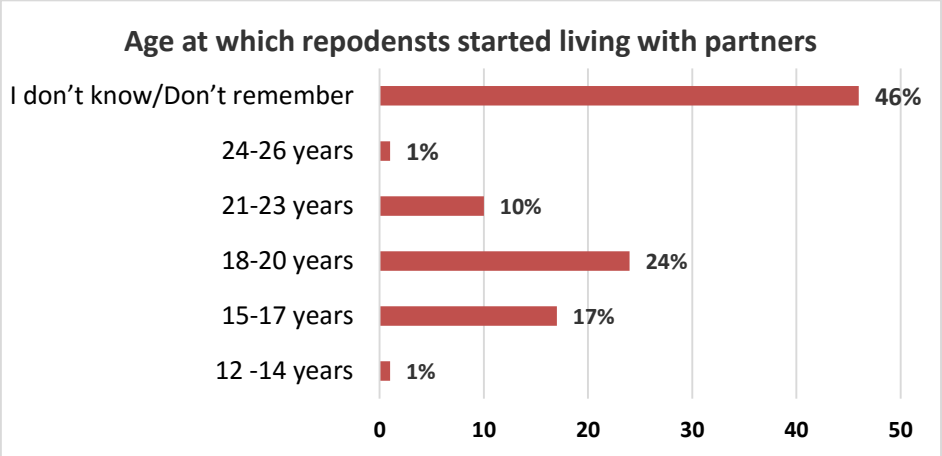
232 respondents (36%) in the face to face interviews indicated that they were not committed to the relationships and confirmed that theirs were largely casual and for convenience. Twenty-six percent (26%) of the respondents in these relationships indicated that they were committed to

them and therefore willing to get married or live together. Outcomes from the focus group discussions also revealed that most of the young people engaged in trial marriages starting with temporary relationships that later grow into permanent stays and families.

> *"Sometimes you befriend a girl, she becomes your lover and slowly the relationship grows. If she proves to be trustworthy you get ahead and stay together. Otherwise, she is forced to move in with you when she gets pregnant."* **Male Youth in FGD, Kasubi**.

When asked if they had ever lived with a boyfriend, girlfriend or partner, 393 (61%) indicated that they had never and only 250 out of those in relationships said they had, which proved the finding from the FGD above that these long stays are more circumstantial than planned. It also indicated that most of the relationships were not yet marriages or did not plan to become marriages in the near future, given the settings.

The survey also went ahead to ask about the age at which respondents started to live with boyfriends or girlfriends and almost half of them were none committal as they simply said they did not know or did not remember (which was accepted given the sensitivity of the question). The age groups 12 – 14 years and 20 – 24 years had fewer respondents which also showed that most of them had lived with the partners in these relationships or temporary marriages between the ages of 15 – 23 years. The results correlate well with the 2016 UDHS which stipulated that for women **aged** 20–49, the **median age at first marriage** was 17.8. The graph below shows the pattern;



3.2. Sexuality Education and knowledge

Available literature indicates that Sexuality Education positively impacts the lives of adolescents and young people through increasing their knowledge and improving their attitudes related to sexual and reproductive health and behaviors[3]. Sexuality education has the ability to equip young people with skills, attitudes and values that: empower them to realize their health, well-

[3] Why comprehensive sexuality education is important. UNESCO. Feb 2018.

being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives.

The survey therefore explored ways in which young people make informed decisions about relationships and sexuality, early and unintended pregnancies, HIV and other sexually transmitted infections (STIs) and other aspects of their health and well-being. An attempt was also made to inquire about what was considered to be age and developmentally appropriate sexuality and relationship education without making them (children and young people) vulnerable to harmful sexual behaviors and sexual exploitation.

It was observed that there were mixed messages and inconsistences in knowledge and practices, determined from the responses that young people made in regard to questions about SRH and contraceptive use. For instance, 666 respondents (56% female and 44% male) confirmed that they were aware that a girl was able to conceive after puberty, while 57% of the females and 43% of the males indicated that they knew about how to avoid pregnancy with the majority confirming that the condom was the most effective means to prevent unwanted pregnancy. The survey however went on to reveal that 70% of the female respondents believed that carrying a condom was associated with promiscuity and therefore 60% of them never used protection during sexual encounters since they had either not carried one or could not force their partners to use one. This situation was not helped by the messages they reportedly received from the churches and the elders in the community, about the negative attitude resentment towards adolescents' access to and use of contraceptives. This portrays the confusing and conflicting information about relationships and sex as they make the transition from childhood to adulthood, and therefore calls for an increasing demand from young people for reliable information, which prepares them for a safe, productive and fulfilling life.

Sexual activity, pregnancy and disease prevention

A study on adolescents in Uganda published under the "Protecting the Next Generation Research series 2015", indicated that adolescents and youth engage in sex at a relatively low age with the median age for the first sexual encounter estimated at 16 years. This corresponds with the UNFPA quick facts report that indicates that 22% of adolescents in Uganda have ever had sexual intercourse and 10% of the sexually active adolescents aged 15-19 years had their first sexual encounter before age 15. In the same vein, results are consistent with the 2016 UDHS which revealed that the **median age at first** intercourse was 16.6 years.

The survey findings reveal that many young people are sexually active and are at risk or are already struggling with the consequences of an unplanned pregnancy or a sexually transmitted infection (STI), including HIV/AIDS. 64% of the respondents in the face to face interviews indicated they had a boy or girlfriend although only 18% of the respondents from the same group indicated that they had ever gotten married. This therefore confirmed that majority of these

young people engage in pre-marital and casual sex, both for pleasure and for the demands from partnering as adolescents but also for the economic benefits derived from the favors and gifts especially from the boy friends.

Of 494 respondents that reported having been sexually active, 145 (29%) reported having had sexual intercourse in the last 12 months preceding the survey, and the prevalence was significantly higher among girls than boys. The discussions in focus groups indicated that the prevalence was also less among those still at school when compared to those in the workforce Among males, the number of sexual partners was closely associated with employment status and income, with lower numbers of sexual partners associated with being unemployed.

> "*Abalenzi ba muno abasinga bayaye, tebalina kyebakola. Kale abakwana bava bwelu, bajjamu kiiro". Boys in this area are mainly redundant and idlers. So those boys we befriend come here from elsewhere and come in the night*. **Female FGD, Kiyaye, West Zone, Kasubi.**

Discussions with participants in FGDs indicated that the children in slums start to pair up sexually at a much lower age, some as young as 10 years. This is partly attributed to the exposure they have to social media and the influences of the TVs and radio but also to the family settings where parental control and guidance is limited, yet peer influence is so strong.

> *"I can tell you that most of the girl children in this community have had a boyfriend beyond Primary six. They participate in Kariooke dances in night halls that expose them to boys, they are attracted to goodies for which the boys entice them for sexual favours and most of them have chance to meet with boys away from the preying eyes of their parents."* **Female, FGD participant. Kasubi.**

According to the UNFPA[4], one in four teenage girls in Uganda aged 15-19 have had a child or are pregnant, yet 42% of all the pregnancies among adolescents in Uganda are unintended. The UDHS 2018, recorded the **median age at first** birth as 18.7 years. Therefore, the survey explored the respondent's practices and perception towards pregnancy. When asked about whether they knew when a girl was most likely to get pregnant, 84% indicated they were aware that a girl was most likely to get pregnant after puberty and this was similar across sex. 95% of the respondents indicated they knew how to prevent pregnancy, with the majority from both male and female indicating the condom as the most effective means. The girls mentioned the contraceptive pill and injectables as the most convenient for them. There was however marked reluctance amongst the boys to engage in preventive measures as they do not consider it their responsibility to prevent the unwanted pregnancies.

> *There is a friend of mine I want to bring to this center. She was deceived by a boy to engage in unprotected sex and she is now pregnant. The boy now says he never*

[4] Uganda's youthful population. Quick facts. UNFPA, Uganda. Nov 2017.

bargained for that, so he is not responsible. The girl is stuck. She stays with a sister who is also equally helpless. **Girl in FGD, Katwe.**

The survey inquired about whether the respondents were interested in having children when still teenagers, giving options like; having a baby to love and care for, moving out of the parents' house, proving maturity and fertility, among others. However, 85% indicated that there was nothing valuable for them to have children when still young. Most of them were able to confirm that this affects educational attainment, jeopardizes their future and may have serious health repercussions for the young mothers and the new born child.

In terms of disease prevention, the Uganda Demographic and Health Survey, 2016 indicates that 94% of adolescents are aware about HIV and its complications, but only about 43% adolescents have ever tested for HIV yet every year 9,600 young people aged 15- 19 years are newly infected with HIV and 66% of all the new HIV infections are concentrated among adolescent girls. There was a general consciousness about the dangers of unprotected sex which leads to STIs and HIV but there was no clear indication of a similar level of caution being taken to prevent diseases.

When asked about the common diseases, most of the participants in the survey indicated, UTIs and STDs, Malaria, HIV and in some cases Gonorrhea. In terms of knowledge of diseases, 97% of the respondents knew about HIV, 70% knew about Gonorrhea and Syphilis, while very few (all under 10%) indicated they were aware about Hepatitis B, Cervical Cancer and Genital herpes. The UTIs they say, are attributed to the poor hygiene in the shared sanitation facilities which most girls had complaints and concerns about. They however were quick to add that there is family and peer support in providing guidance on how these infections can be dealt with. The more serious diseases associated with STIs seemed to lack proper handling mechanisms. The girls are the main culprits for this as they contract a lot of these diseases from their sexual partners who in many cases do not want to take responsibility for the mess. Besides they usually become afraid to discuss the conditions with their parents and often share with peers when the situations worsen. Although the level of awareness towards STDs treatment and management has largely improved among the young people, given the increasing numbers of providers and support from the public and private health facilities, there is more consciousness about prevention of pregnancy than contracting diseases.

"Nze nkubuliire, abawala belalikirira nnyo okufunna olubutto okusinga okufunna silimu. I tell you, girls in this community are more worried about getting pregnant than even contracting HIV". ***Girl in FDG, Katwe.***

The reasons the participants in the survey give for the above position is that a pregnancy affects your immediate survival. The girls are most vulnerable, as a student one is likely to drop out of school, as an adolescent staying with your parents or relative, they will want to stop providing for you, since they consider you a burden through the antenatal and postnatal period, yet when you contract a disease you may remain without the disclosure and lead a near normal life and there could be possibility of accessing HIV/AIDs drugs in the long run.

This therefore portrays the level of danger for the young people living within such communities. Most of the efforts by the girls is at preventing a pregnancy which they can manage through the known contraceptive methods.

Information dissemination and knowledge of family planning and contraceptive use

Knowledge of reproductive health and available services has a great bearing on the utilization of those services. Experts confirm that young people with high levels of knowledge are nearly twice as likely to utilize adolescent reproductive health services compared to those with low levels of knowledge. However, youth face multiple barriers to accessing sexual and reproductive health information and services. Sometimes services may not exist at all or where they exist, the services are not affordable or the access is opposed by adults.

The survey revealed that adolescents get SRH information from both traditional and modern sources. Many female participants in the FGDs pointed to the Senga (a traditional channel for sex education to be passed from older women to younger women) that still exists, although in a weakened form. Many girls say they are still sent back to their female relatives for this kind of guidance but given the disintegration of families, this practice is no longer dependable. Other parental information given is quite limited and is in line with menstrual hygiene and sanitation to avoid UTIs, maintaining one's virginity before marriage, labia elongation and abstinence from sex. However, issues such as family planning, risk practices for HIV and other STDs are rarely discussed.

> *"The maternal aunties and other female elderly relatives provide some guidance on how to prevent diseases, how to relate with the opposite sex and how to avoid pregnancies. Some of them are not exactly our relatives but just volunteer this information so they are not very much dedicated to the training us".* ***Female participant in FGD, Rubaga****.*

Since these traditional systems of communicating information about sex are weakening, peer groups, schools, churches, the media, traditional health practitioners, and NGOs have emerged as the most prominent sources of health information for young people within the study communities.

During group discussions with the youth, the main sources of information about sexual education and reproductive health issues were reported to be school teachers for those in school and even those that are out of school for they claimed that most of what they know they learnt at the schools. The female youth claimed especially the environment was more conducive and the information was usually properly selected for the respective age groups. The health centers, clinics and staff therein were also reported to be a good source of information and guidance on matters of reproductive health and contraceptive use. Other sources of information are reported to be the media (radio, TVs, films, books, magazines and newspapers) and other public information avenues.

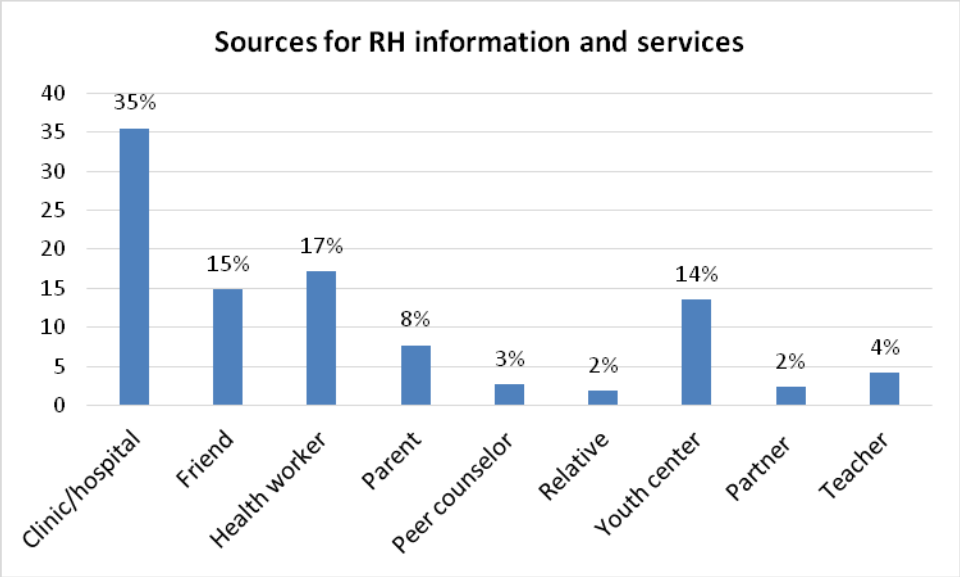
For the out of school youth and adolescents, the survey revealed that most of the information is obtained from the locations where the services are provided. In the same way, the youth resort to parents, relatives and friends at those moments when they have a problem and need a solution and that is how most information comes by their way. The youth reported that most parents don't have time for these discussions or are even shy to talk about them. The survey revealed that the young people rarely receive information or help from their parents, partners or relatives.

> *"Sometimes we listen into the elders' conversations about disease prevention and contraceptive use. We then take up the options from there. Otherwise not many parents talk to us directly".* **Female adolescent in Rubaga**.

The parents normally insist on abstinence and give guidance on disease prevention and proper hygiene, but rarely provide support for contraceptive use except for cases where the girls have already left school and are being helped to space children or avoid the unwanted pregnancies, hence the 8% represented in the graph below.

> *"My mother cannot mention anything about contraceptives. She usually tells us never to engage in sexual relations but to completely abstain. But my father has been helpful in guiding us. He even took our 13-year-old sister to receive the injection from the clinic".* **Nabatanzi, a female youth FGD, Kasubi.**

Youth centers, where they exist, were reported to be good sources of information and reliable suppliers of contraceptive commodities. The same was mentioned for the clinics and hospitals where this information is readily available and some commodities like condoms, contraceptive pills and the injectables are normally provided free, which accounts for the 35% in the graph below.



Participants were asked some basic questions to test their knowledge of SRH, contraceptive use and disease prevention. 90% of the male respondents and 82% of the females in the fact to face interviews were able to confirm that the male condom (when properly used) was the most effective means of disease and pregnancy prevention, although they agree that there is reluctance amongst the males to use the condoms effectively and yet the girls have not much control in this process. The girls rarely influence the use nor have the ability to supply them which makes them (girls) very vulnerable. The majority of the girls in the FGDs mentioned injectables as the most convenient means of contraception and most of them indicated ignorance about the supply or use of the female condom, which they also confirm is not popular among the women. The females were more familiar with the STIs and boys mainly referred to Gonorrhea as the major STD affecting young people in the community, yet the female were able to generate a long list, ranging from syphilis, candida, cervical cancer, among others. There was more consciousness about diseases among the females than the males who in most cases thought they had an upper hand in matters of sex.

From the discussions, there was evidence of universal awareness of HIV and AIDS among adolescents. Over 95% of male and 85% of female adolescents knew of condoms and over 95% of adolescents, both males and females knew that limiting the number of sexual partners were ways of avoiding HIV/AIDS. They also were able to confirm that a healthy looking person can have the AIDS virus. 83% of the participants knew that it is not possible to cure AIDS and 63% believed that anti-retroviral drugs are effective at treating HIV/AIDS. When asked about whether they had had an HIV test in the past 12 months, 65% of the respondents indicated they had not. However, the majority, 576 of the study participants (73%) affirmed that they were aware about the pre- and post-test counseling services if they were to undertake an HIV test, and 74% affirmed that they would be able to safely disclose the result of their HIV test to their partner.

67% of the participants in the face to face interviews and about half of the participants in FGDs indicated that they were aware about HIV treatment, care and support services in their community to serve those who become HIV+ and were sure they would benefit from the services themselves if they required them.

NTIHC plus the associated KCCA division centers, RHU and other NGOs were mentioned as having played a part in dissemination of information mainly through the outreaches to the communities and arranging for Youth friendly centers within the respective facilities. These outreaches and youth friendly centers avail young people the opportunity to interact freely and before they have been infected hence are given the chance to be more conscious in the decisions they make.

Overall, all the participants in the survey confirmed that in Kampala, adolescents aged 15–19 have some awareness of STIs and HIV. At least two thirds of young women and young men who participated in the FGDs as well as the face to face interviews were able to name another STI although a number of them could not differentiate between the UTIs and STIs. Most of the girls

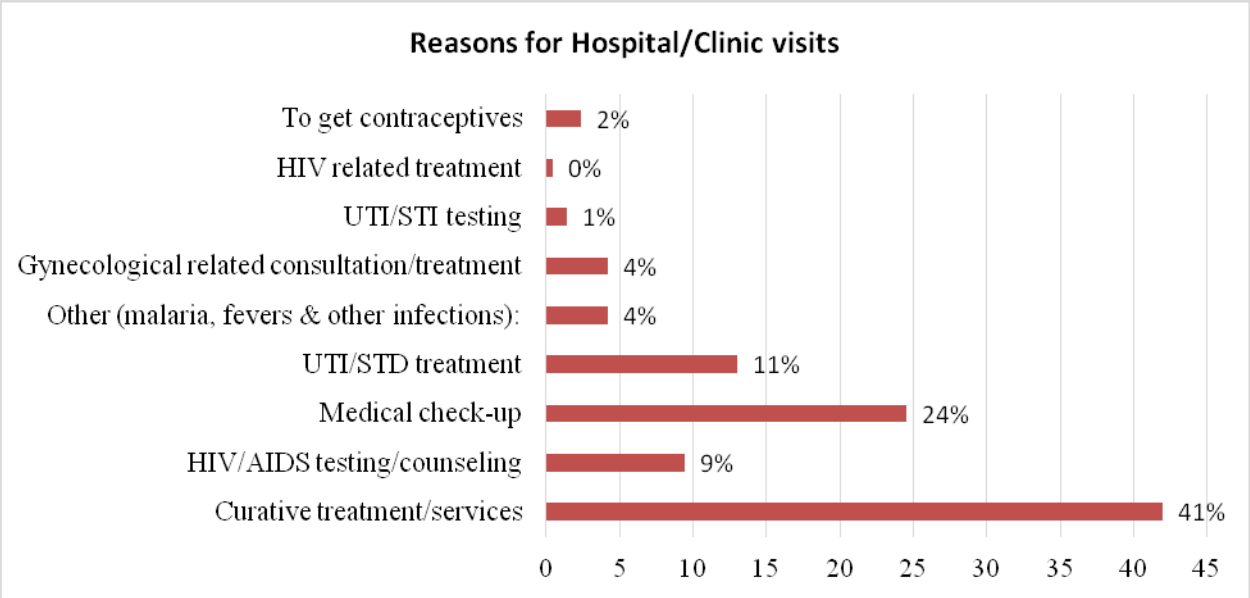
reported to have had a UTI but were non-committal about experiences with STIs or STD symptoms in the 12 months prior to the survey and this was corroborated with data from the NTIHC, where they report that 64% of all clinical problems at that facility were related to STIs. The boys were quick to mention that Gonorrhea is a common ailment amongst them especially those that did not have permanent sexual partners but they were also aware of how to treat the disease and or where to seek help.

SRH service utilization

The survey established that all the five divisions of Kampala have provision for Youth Friendly Services provided within the respective Division Health Centers with support from NTIHC, the Embassy of Sweden and KCCA (the quality of service and level of client satisfaction notwithstanding). These centers include; Kiswa (the location for NTIHC) for Nakawa, Kisugu for Makindye, Kitebi for Rubaga, Kisenyi for Central and Kawaala which serves Kawempe following the expansion and changes in space allocation at Kawempe Health Centre and this serves part of Rubaga division.

However, during the face to face interviews, the participants were asked about whether they had visited any clinic or health facility in the past six months but only 21% indicated they had, 63% of the respondents indicated they had not, and the rest were non-committal. The survey further explored the reasons for which respondents visited the clinics or health facilities and apart from the curative care visits and medical checks ups, UTIs/STIs and HIV/AIDs testing and counseling stood out quite strongly for the females while the boys largely reported STDs and other ailments like malaria. It was interesting to note the Safe Medical Circumcision (SMC) was one of the reasons reported for visiting the facilities, which confirms the fair percentage presented before, under HIV testing and counseling.

The respondents were asked what generally constituted the reasons for their visits to hospitals or clinics and these responses are presented in the graph below.



From the focus group discussions, it emerged that there is a lot of self-medication obtained from the local drug stores and clinics. There are also peer to peer consultations and sharing of advice about how and where to obtain services. A number of pregnant mothers also reported getting support from these facilities. There was recognition that Kisenyi Health Centre, Kawala and Kiswa (NTHIC) were favorable providers or youth friendly services. Free treatment was also mentioned to be obtained from the Makindye Barracks facility, Nsambya Home Care (specifically for HIV testing and treatment), Kiruddu for general treatment and care (although the services were reportedly not youth specific and friendly). In these centers, the major complaint was about corruption which translates into failure to obtain service should one fail to raise the required kickbacks.

> *"In Kiruddu, you might be the first on the queue but you are not considered until you cough something to the attendants. Someone with money comes from behind, pays and overtakes all those waiting, so he receives service before all those without bribes".*
> **Male youth in FGD, Katwe**.

The youth also mentioned that they often benefit from outreaches and NGO services that are brought into the communities targeting youth and other populations with ailments. These are not many and whenever they are organized, their demand is overwhelming and the services are limited. According the data available, the numbers of youth accessing services have been growing over the years. It was interesting to note from the discussions, that the visits to the HCs are largely by females and there are bigger numbers of males in the outreaches. This confirms that the demand exists but utilization of services is influenced by a number of factors.

> *"We use available data to gauge access to services and I can confirm that the numbers are telling a good story. There are young people that may shun the services provided at*

the centers and youth friendly corners, but the outreaches take the services closer to them and they have been seen to benefit". **Key informant from NTIHC.**

Family planning was explored in the context of the unmet need for services by mainly the sexually active unmarried youth. The discussions revealed the bias that exists between the demands by male and female. The males are more concerned about their pleasure and are quick to denounce responsibility for the outcomes of their recklessness in sexual encounters. Male youth expressed satisfaction that the male condoms are available in all public health facilities and in some places of entertainment, but they are quick to add that that quality is not the best.

"There is a fear that the condoms on the market especially those supplied by government facilities have holes in them. We are no longer using them"! **Youth in male FGD, Nakawa.**

The female youth are however faced with a number of challenges and these impede their access and utilization of contraceptive services. These challenges range from; limitation to access of information, the side effects, the stigma associated with the services (particularly for the unmarried but sexually active) and other social cultural issues regarding utilization of contraceptive services. The problem is more compounded for the adolescents that are both in and out of school but sexually active.

The services offered at the public HCs were reportedly of poorer quality compared to those by NGOs and private providers. Specifically, the concern was about the failure to provide the relevant and essential drugs that are needed for the more comprehensive treatment of the STIs. Discussions with NTIHC indicated that they have now engaged in partnerships with a number of NGOs from which they get drugs (especially STD drugs) and send them to the public HCs in Kampala, however as expected the demand is usually higher than the supply so there will always be cries for additions.

Contraceptive methods were classified as modern and or traditional methods. The modern methods discussed included; female sterilization, male sterilization, the pill, the intrauterine contraceptive device (IUD), implants, injectables, male condoms, female condoms, emergency contraception, standard days method (SDM), and lactation amenorrhea method (LAM). Methods such as rhythm, withdrawal, and folk methods are grouped as traditional and these are no longer popular among the young people. From the FGD with the females, about 40% of the participants indicated they were using a method of family planning. The most popular methods they mentioned were the injectables, implants and male condoms.

3.3 Need, Demand and Quality of SHR services

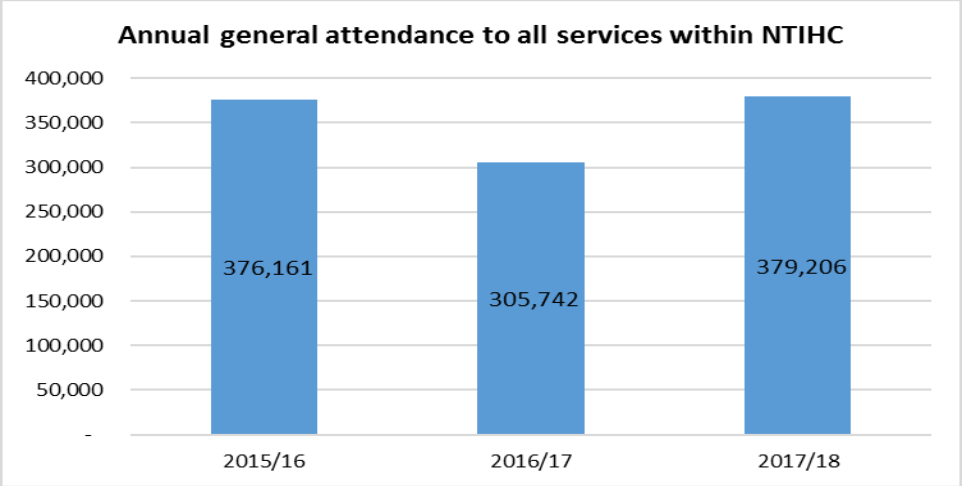
The 2016 UDHS report shows that 96% of 15–19 year-old females know of at least one contraceptive method, however only 30% of them have ever used a method. This was confirmed in the survey which acknowledges that there is a fairly high level of knowledge on contraceptives, however the survey found out that the level of actual use among sexually active

adolescents was reportedly low, reported to be about 48% among the respondents, more especially among the lower age groups of 12-19. This poses a series of problems for disease spread and prevention of unwanted pregnancies. Specifically, the survey explored a number of themes in a bid to determine the need, and quality of RHS for the adolescents. These included the following;

Information on and access to HIV and AIDS drugs/support

There was fair knowledge about the causes and prevention measures for HIV, although there is concern with the gap between knowledge of safe sex behavior and actual behavior among especially the unmarried but sexually active adolescents and youth. The information available and the support provided does not specifically target adolescents and young people. Often times, service providers separate the other reproductive health services from HIV and AIDS support. Most of the public hhealth facilities in the divisions within KCCA tend to address STD treatment needs and refer the HIV related cases to stations that may not necessarily be youth friendly. Knowledge of other STIs is much lower than knowledge about HIV/AIDS and this cuts across male and female. The youth we talked too, mentioned NTIHC in Nakawa, as the major provider of comprehensive services that are exclusively youth friendly. Kisenyi Health Center in the central division was also mentioned to be providing services but the young people reported that the personnel in this facility were not quite friendly.

It is reported that during the year 2018, NTIHC offered HIV counseling and testing to 9,550 clients, of which 67% females (almost 4 times) the number of males and a total of 368 clients were tested as couples. From the total HIV tests conducted, 153 tested positive of which females accounted for 84%. All the positive young people were counseled and successfully enrolled for ART services. The NTIHC annual report for 2018 however reports that the annual figures for access to all their services have stagnated in the 300,000 as shown in the graph below;



Source: NTIHC annual report 2018.

Voluntary HIV and STD testing and counselling

Discussions with authorities in the Kisenyi HC, Kampala revealed that a great number of those who come for VCT are youths. However, overall the proportion of youths who reported having been tested from among the participants in the face to face interviews was far short of the reported demand. Most of the adolescents say they are willing to get tested. Among the participants in the face to face interviews, 85% of male and 90% of female adolescents reported they wanted to be tested but have never been tested. The female adolescents indicated that they were more willing to take the tests. There were no particular reasons given for their failure to take the tests, because when probed if they would take the tests when services were brought closure, they all indicated answered in the affirmative. Females also benefit from free STI testing and treatment as part of the ante natal package, but this is rarely extended to the male youth. These centers depend on donations for the especially the test kits and it is common that there are stock outs of both the kits and drugs.

Safe abortion

In Uganda, abortion is highly restricted by law, although it is practiced clandestinely. Hence it is difficult to obtain complete information on abortion using direct questioning, as was the case with this survey. Despite the legal restrictions, the young people expressed need for safe abortions. The reasons they give are that failure to provide the service prompts the young people to resort to crude methods, since many usually want to terminate the pregnancies resulting from rape, broken relationships and ill health. According to the mainly female respondents, induced abortions were mainly performed using local methods such as taking herbs and resorting to cheap health facilities that normally worsen their health.

When asked about whether they are in support of an abortion, 12% of male respondents in the face to face interviews indicated they would support an abortion (e.g., helping their girlfriends to abort in case they fell pregnant), while 9% of female adolescents who indicated were sexually active reported that they had ever had an abortion. However, given the likelihood of under reporting abortion in face to face interviews, these are probably underestimates of actual proportions. High rates of maternal mortality and morbidity as well as increased school dropouts, violence and expulsion from home have been associated with high rates of induced unsafe abortion.

3.4 Perceptions and beliefs around Adolescent SRH services

In 2018, Government of Uganda launched the National Sexuality Education Framework following a lot of rope pulling and extensive discussions with the different stakeholders. In this framework, government recognizes that sexuality education is essential in equipping young people with information about sexuality so as to enable them to make healthy choices about their sexual and reproductive health, and utilize life-skills in developing values, attitudes and relationships that maximize their God-given potential. However, there is still divergence between what is written in the framework and what is actually practiced.

Social and cultural norms have largely prohibited parents and children from directly discussing sex. Most of the parents we came across in the study area were very protective of the youth and they try to ensure that the young people do not get exposure to sexuality education, contraceptives of even access to information on sexuality. During the baseline survey, a number of interviews with adolescents were cut short when parents thought that the discussion or interviews were crossing the bar for what they considered to be appropriate information for young people. In some cases, the parents insisted that they attend the interviews with the adolescents just to be sure about what was being asked (or told to the young ones).

Condom supply has greatly improved in most of the study area since these are supplied at all health facilities (especially for the male condom). However, condom stigma still exists given the strong opposition against the promotion of condoms by religious groups and parents arguing that condom availability promotes promiscuity among unmarried youth. There is increased acceptance and uptake of the Safe Male Circumcision as a measure for preventing disease spread. There is good publicity for the operation which is provided free and is accessible in most of the health facilities in Kampala.

The study revealed that young people have been equipped with knowledge on risks of unwanted pregnancies and sexually transmitted infections, and their access to SRH services has in some cases increased, however the young peoples' capacity to be in control of and negotiate their preferences and wishes around sexual and reproductive health is still a problem. For instance, many of the female youth and adolescents when asked if they could carry a condom when visiting their partner, expressed fear.

> *"I once was found with a condom in my handbag by my partner and he was very bitter with me"!* **Fauzia , FGD Makindye.**

> *"The female condoms are not easy to come by and many of us do not even know how to use them. Yet when you carry a male condom when visiting your partner, they think you are loose".* **Adolescent girl in Katwe, FGD**.

A similar response was given when the adolescents were asked if they would freely purchase condoms from the pharmacies or drug stores. Many reported that they do that clandestinely and most prefer to go to places where they are not easily noticed or from peers. When the adolescents were asked if sometimes they end up having sex without protection with a partner because they can't find a way to stop it, 60% of the respondents agreed with this statement. It emerged that the youth are not very much interested in the condoms that are supplied free of charge as they consider them to be of inferior quality.

The survey found out that young women use male condoms for preventing pregnancy or both pregnancy and STIs, while young men primarily use male condoms to prevent STIs. A number of the female participants in the FGDs indicated that they used the male condoms to prevent STIs, and preferred to use the injectables and pills to prevent pregnancy. This was because with

the latter, they felt in control and could only insist on the condom if they did not trust the health status of the male partner which was easy to accept by the partner.

Despite the wide spread knowledge of HIV regarding the modes of spreading it and the available prevention measures, the survey revealed that the underlying barriers to behavioral change are rooted within the economic, social and cultural context of young people's lives. There is perception that one can still live on with AIDs even when they acquired it but it is hard to survive in the urban communities without a job or a source of income so most of the young people resort to unsafe relationships that predispose them to the virus and other risks.

Available reports indicate that there is improved awareness about STD management given the increased responses to outreaches and the Health Centers within the study communities. Data from NTHC shows that STI management is still the main medical problem that young people present at the youth center. However, talking to the young people in focus group discussions, many of them indicated that it calls for a lot of determination for one to go into the center when they first realize they have an STD. A number of young people first try out self-medication with pain killers before they venture out to the center.

The Programmes Manager at the NTIHC however expressed opportunism, indicating that the attitude is changing. There are more youth that come in freely to get tested and receive treatment, many more attend the outreaches. An increased number of parents are referring and even escorting their children to the center.

Peer pressure was also reported as a significant force that helps shape adolescents' and youth's behavior, attitudes, values, and knowledge as they grow up. The role of peers was reported to increase in importance as parental guidance diminishes. Because of the weak role that parents now play in communicating with their adolescent sons and daughters about sexual matters, many of them have developed the wrong attitude towards their parents and now young people have developed greater trust in their peers with whom they share interests including the risky behaviors. This is worsened by the influences of the media and other social groups in the urban communities where the adolescents dwell. During the face to face interviews, when asked about where they would seek support in case they found out they had an infection, 72% of females and 56% of males indicated that they would turn to their peers. When asked about if they were pressured by peers to engage in sexual activity, 80% of the females responded to the affirmative and 90% of the males indicated that the peer pressure and influence from social relations pushed them to engage in sexual activity.

3.5 Age appropriate and adolescent/youth friendly services

Young people need youth friendly services and information which could help them have protected sex or to postpone sex as well as avoid its adverse negative consequences. Most services in the country are generally offered to all people, with just a few units that have services focused on youth. Even when services are offered, adolescents are not accessing the services due

to lack of confidentiality, rudeness among service providers, ignorance about the existence of these services and fear of embarrassment.

"Youth-friendly" services are therefore the reproductive health services prepared for, are convenient and are utilized by youth and adolescents to include counseling, contraceptive services, post-abortion care, VCT, and STI information and management, as well as referrals. The different categories of young people (adolescents and youth) have different needs for information and services within their different categories.

The National Sexuality Education Framework groups the learners into five categories namely:

- Early Childhood (3 to 5 years);
- Lower Primary (6 to 9 years);
- Upper Primary (10 to 12 years);
- Lower Secondary (13 to 16 years); and,
- A-level/Tertiary Institutions (17+).

Accordingly, for each level of learning, relevant areas to be covered by development messages essential for the learners to know and the associated values and skills have been identified under each key topic within a theme. This is the national guideline for sexuality education and ideally the practice to be used by all stakeholders for their programs with adolescents and youths. Putting this framework into practice is an uphill task that requires concerted effort. There is therefore need to have a common understanding about what the young people need and what can be provided within the framework so that an honest discussion is held.

Discussions with the youth during the survey indicated that most of the sexual and reproductive health services accessed by them were not youth friendly and have therefore not attracted many adolescent clients. Anecdotal studies have indicated that regardless of where the adolescent and youth friendly services are provided; clinical setting, teenage center, informal avenues, school or community center, it is essential for them to have certain youth-friendly characteristics, in a minimum package which typically includes:

- information and counseling on safe sex and reproductive health
- contraception and protective method provision (with emphasis on dual protection)
- STI diagnosis and management
- HIV counseling (and referral for testing and care)
- pregnancy testing, antenatal, delivery and post-natal care
- counseling on sexual violence and abuse (referral for needed services)
- post abortion care, counseling and contraception (providing referral where necessary)
- service providers oriented to render youth-friendly services.

Reports by Child Rights advocates indicate that, today, adolescents are vulnerable to HIV infection mainly through sexual abuse and, for females, early marriage including commercial sexual exploitation, which is very common in the study area. School-going children, especially girls, are vulnerable to male teachers while most who are out of school are either child laborers

or are married off by their parents/guardians, which accounted for the big numbers of the out of school respondents we found in the study area.

Interactions with the young people called for early interventions targeting this age group (12 – 15 years) through school-based programs for health, guidance on relationships and disease prevention, especially STDs and HIV. Programs focused on integrating HIV/AIDS in school curricula and building the capacity of teachers to handle topics related to HIV/AIDS and body changes in the adolescents would be most appropriate.

> *"Today young girls have problems like adults yet they are not aware about how to deal with these problems. They start their periods early and some may not know how to manage. Then many of them get advances from older boys or their peers. They need to be helped".* **Female youth in FGD, Nakawa.**

Additionally, the survey revealed that programs such as free hot lines, phone-in radio programs, internet and print media have been initiated, targeted at both school-going and out of school children. These have helped adolescents to get answers about various issues surrounding sex and sexuality in a confidential manner. In addition, several community-based programs have integrated child rights protection awareness into their programs to empower children and parents to fight child abuse. But there is concern about the out of school adolescents and youth who have limited or no access to print media or are not interested in reading. When asked about where they got their information, only 12% of the respondents indicated that they ever obtained SRH information from newspapers, while 56% indicated they received information from radios and TVs. They preferred that this information is provided through more friendly avenues like peer groups and outreaches. They need to be targeted through the entertainment centers where they are most frequent or through peers that influence their thinking and practices.

The survey revealed that there are several innovative, peer support interventions being implemented, mainly in secondary schools and tertiary institutions. Some of these programs emphasized the formation of AIDS Challenge clubs (which hold interschool debates on HIV/AIDS topics), the provision of youth-friendly information, education and communication materials and the training of peer leaders and counsellors.

For the age groups 15 – 19 both in and out of school, their preference is to enhance their skills in communication, sexual negotiation, responding to peer pressure and developing positive relationships with the opposite sex. Some of them also need to engage in programs that enable them to acquire life skills for use in actual situations such as responding to sexual advances, avoiding an attempted rape and making life long development plans.
During discussions with youth in Nakulabye, they advocated for interventions that teach them improved decision making and problem solving with regard to AIDS, sexuality and health as opposed to the general messages that emphasize abstinence until marriage (A), faithfulness for those in relationships (B) and use of condoms if the first two fail (C)—the ABC approach.

"Health services for adolescents are most times targeted to schools where a big number of us no longer attend. There, you find all information on curing and preventing disease as well as access to services and information, education and communication on growth and development through film shows, plays, seminars and talks. Yet there are other locations of service provision beyond the school. We are with parents that are afraid to face the truth with us, so they are not helpful". **Nabatanzi, a youth in Kibuye**.

There was also concern among mainly the youth aged 15 – 19 years that the information, education and communication programs found in schools, health units and the few within religious institutions mainly focus on HIV/AIDS and other STIs prevention, with limited bits on sex education, growth and development, life skills education and behavior change yet issues of contraceptive use are largely ignored. A number of young people who participated in the survey also indicated that they were not actually benefiting from these services at health units because of the unfriendliness of the health staff who in some cases brand the youth irresponsible when they present their health problems. There was also concern about the lack of pregnancy testing services and support for unwanted pregnancies which is on high demand as no cases of abortion are welcome or encouraged. As a result, more adolescents were limiting their visits to access services from the only youth-friendly sites like: NTIHC, Kisenyi Health Center and Kawala, than those at non-youth-friendly sites. Adolescents accessing services from the youth friendly sites were more knowledgeable about adolescent health problems and the factors that contribute to these problems, contraceptive methods and HIV and other STIs. However, the inconsistent supply of some preferred contraceptives and STI drugs were a major impediment to the quality of services offered at these locations. NTIHC was applauded for their medical services covering STIs, pregnancy testing and care, and general medical problems, as well as VCT, condom distribution and referrals. The young people also indicated that they were in need of IEC materials that they could refer to continuously.

"Make user friendly stickers with relevant information. If I get a sticker and put it on my TV and it sticks, it will remind me and my partner about the need to take care every day!" **Female youth in Katwe.**

3.6 Special Groups at Risk

Anecdotal information indicates that in Uganda, there are a number of special groups of adolescents at risk and these include; street children/adolescents, young sex workers, orphans, adolescents in and post-war and refugee situations now migrating to towns, HIV-infected youth and adolescents working in the informal sector.

The civil strife in many of the upcountry areas has led to movements of families and young people into the urban areas. A number of families have also disintegration and broken up. This on addition to the scourge of AIDS with the associated morbidity and mortality within the families and lack of basic necessities at home and the general poverty, have combined to

exacerbate the predicament of street children and adolescents in slums who are singled out as the most at risk.

The reason given is that street children and their adolescent counterparts survive through manual labor such as carrying loads for business people, stealing, pick pocketing, and prostitution (for girls) all of which predispose them to crime and vulnerability. They are also vulnerable to voluntary sexual activity as well as rape, and are therefore at risk for unwanted pregnancies, abortions and often abandon their children. These categories are also known to use psychoactive substances like marijuana, alcohol and petroleum fuel which increases their risks of engaging in dangerous sexual behavior, an avenue for contracting and transmitting HIV and other STDs.

Adolescent Commercial Sex Workers are also known to be many (majority of whom are trafficked into the city with promises for; an education, jobs, or a better future) but often don't have much bargaining or negotiating power to force their clients to use condoms, and therefore become vulnerable to HIV/AIDS and unwanted pregnancy.

When asked whether they thought their friends were at risk of contracting STDs including HIV, 563 (71%) of the respondents in the face to face interviews responded in the affirmative. Out of those, 312 (55%) were male and 215 (45%) were female. The particular categories of those they considered to be most at risk included: girls working in bars, in eateries or restaurants, young mothers, those working as housemaids and those working in roadside markets.

> *"Apart from the sexual feelings, adolescent girls are attracted to the eats being sold, dresses in shops and markets as they want to be smartly dressed, they are impressed by the boys' smartness and also easily fall in the traps by boys".* **Girl in Katwe.**

The boda boda riders and chapatti makers were also considered to be at risk as they are known to easily jump into relationships and are the main seducers of both the young school going girls but also engage with older youths. They have easy money from a regular income, hence misuse it

> *"Some girls think they are smart. They tap favors from us and then want to disappear, we also have to lay traps for them to recoup our investments".* **Boy in Male FGD, Makindye.**

The survey discovered that there was no special attention or assistance given to young people with disabilities. Often times they are left out when services are offered and yet they too are quite vulnerable to abuse by the abled persons.

3.7 Decent work situation options and access to Affordable Financial Services

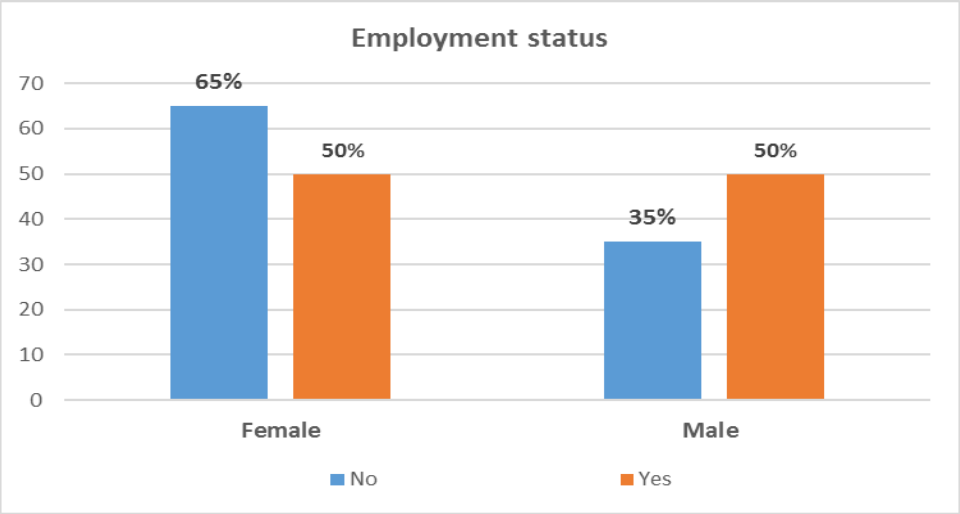
According to the International Labour Organization (ILO), Decent work involves opportunities for work that are productive and deliver a fair income, security in the workplace and social protection for families. It provides for better prospects for personal development and social integration, freedom of expression of worker concerns, ability to organize and participate in the

decisions that affect their lives and equality of opportunity and treatment for all women and men. Access to appropriate financial services, coupled with financial education, can be a key enabler for the young peoples' move toward economic independence.

One of the objectives of the EASY U-25 project is to ensure that the young people in the study communities have access to decent work and employment opportunities on addition to accessing convenient and affordable financial services in order to better their livelihoods. The Survey therefore explored the opportunities available for youth employment, the skill sets available and level of training on addition to the conditions under which the young people earn a living.

Employment status

The survey therefore asked the respondents if they were actually employed. In response, an equal percentage (50%) from among the males and females indicated they were employed (responded YES). Among the reportedly unemployed, a relatively larger percentage i.e. 65% were female and 35% were male. This implied that the males if not in school cannot afford to be idle without any income generating venture while the females are known to stay at home and depend on relatives and other well-wishers. Below is the graph that shows this representation:



85% of the employed youth said that they would prefer self-employment as a means to manage their own affairs and liberate themselves.

> *"Employment in this community is scarce, except for things you know in your head such as making bags, beating stones, working in the salon, selling eats in kiosks and frying eats".* **Farida, youth in Banda.**

Majority of the young people are therefore engaged in the informal sector. Most of them however confessed that the work is given out on a segregated basis. There is no standard means of employment and the conditions are therefore highly compromised. There are no known Labour rights observances in practice and they too have no recourse to the law when they feel aggrieved or mistreated in any way so most of the young people are working under very

difficult conditions and unsuitable conditions. The young people talked too, however consider themselves lucky to be engaged in some form of money earning venture even if the conditions are not exactly favorable. Below is a table showing the trades and employment strands for the youth and adolescents:

The survey revealed that most of the young people are employed in the evening markets where they engage in chapatti, mandazi and fries, while selling these eats along road sides, they are also engaged in vending of vegetables and other groceries. A sizeable number work in eateries (restaurants or vend cooked food), others work in bars and restaurants and boys work as porters on construction sites. The interesting statistic was that of those that fell in the category of other trades. These classify themselves as entertainers, or they take on any piece of work available to afford them an earning, some of which might not be illegal. The dominant category of these were the bar tenders and those working in entertainment parlors. The participants in the FGDs pointed out the exploitation they undergo in these jobs.

> *"Sometimes we negotiate for a certain pay for a particular task, but when the work is done, the rich man dodges you, refuses to pay or decides to pay just a portion of the earlier negotiated amounts. So with that action he knows you will leave the construction site and he gets another employee to whom they will do the same thing".* **Joram, male youth in Katwe.**

Work conditions

All of the participants in the FGDs also alluded to the hard conditions under which they work. Those working in the evening markets say they are exposed to the cold conditions of the night, the rain and the risks of travelling back home in the dark nights along unlit streets. Others talked about the harsh law enforcement officers from the KCCA who confiscate their

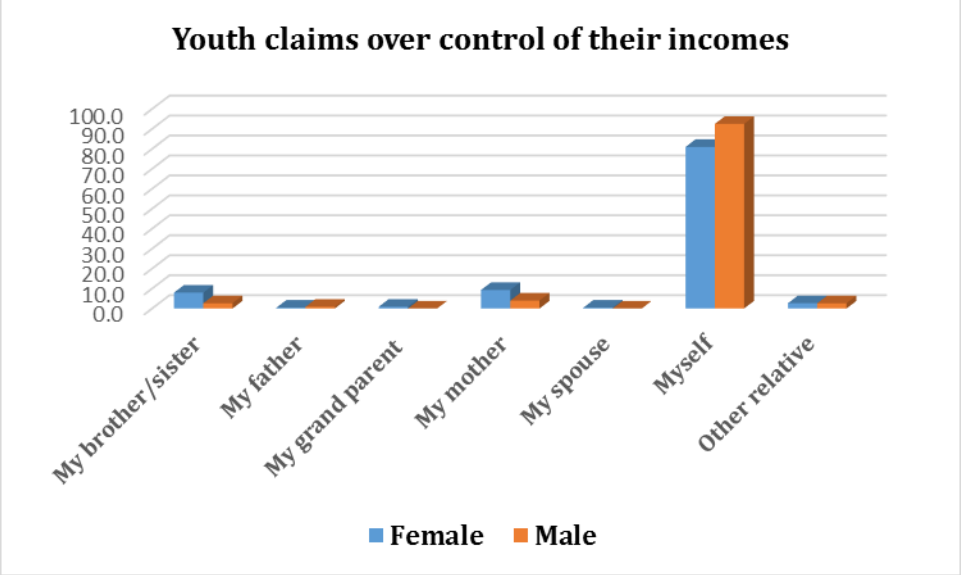
merchandise or arrest them and ask for bribes, while those in bars and eateries talked about the sexual abuse and exploitation to which they are exposed by the clients with no support from their employers. The youth especially girls working in restaurants, those working as domestic workers and as helpers in salons reportedly go for many months without pay, yet there are no avenues to complain or legal redress.
There was also a category of the younger youth and adolescents engaged in garbage collection, scrap metal and plastics who are known to undertake these ventures without protective gear yet the conditions are very unhygienic and dangerous for their health.

The situation is worse for those working in the eateries and bars where their wages are tagged to daily sales. Any losses incurred due to non-payment by clients or customers including spoilage and breakages of utensils are charged on them. They lose the day's pay for every day that passes and there is a lot of abuse by the prospective clients, for especially the girls.

> *"Sometimes after serving food to people in the garages, when you come to collect your pay, they ask that you meet them in the dark, hidden corners from where they want to sleep with you forcefully. Our bosses do not want to hear any stories. They want their money so you are expected to do whatever it takes in order to get their money".* **Female youth in FGD, Rubaga**.

Gains from employment

Basing on the above trends, the survey explored from the youth, their perceived potential to grow basing on the incomes they derived from their sweat. This was because it had been reported that a number of them are made to work and are not paid, while some have their incomes controlled by their spouses, parents or even elder relatives. They were therefore asked about who controlled their monies/income and the graph below shows the responses.



It was gratifying to learn that 93% of the employed males and 81% of the females confirmed that they controlled their income. There were however cases of youth that had their parents controlling their incomes. The notable trend was that 9% of the females reported that their mothers controlled their incomes while 8% reported that their other siblings (sister or brother controlled it). The story was different amongst the males, as 4% and 3% reported to have their parents and siblings, respectively, controlling their incomes,

That aside, there was mention of acts of sexual exploitation of adolescent girls who are brought in from villages with promises for good jobs and they later end up in brothels or nightclubs. A big number of them also get exploited by their employers since they are expected to entice customers in these bars, which includes sleeping with them.

Access to Affordable financial services

When asked about access to convenient and affordable financial services, the majority of the young people indicated that government funds are not accessible to them, so they depend on the private providers who are usually expensive and their terms and conditions rather unfavorable. For the government Youth Livelihood Programme, there is a requirement for the youth to group themselves up and operate similar businesses before they can access the Youth Livelihood Funds. The processes are not transparent and yet the effort you put in is way too big with no sign for clear returns.

> *It appears that this money is meant for the big shots like the counselors. It never reaches the poor. On a number of occasions, they have asked us to fill application forms, submit long lists of requirements but at the end of it all you never get to see the money.* **Male youth in Rubaga.**

The youth with disabilities are even worst affected. A number of them are left on their own without any family or community support so this becomes very difficult for have a meaningful living. Some have been lucky to join vocational training centers where they are trained in shoe making and other crafts but when they graduate they too have to battle with KCCA when they fail to find a suitable place to work from. There are no special loan schemes for them so they compete with the able bodied ones.

4.0 Discussion and Conclusions

This section summarizes some of the key findings providing the consultants' views on the issues discussed and drawing some conclusions basing on the data presented above. The consultants' viewpoints are a mixture of their experience on the subject matter and the corroboration with secondary data from a variety of sources. The discussion below therefore highlights a number of themes out of which conclusions have been drawn.

4.1 Demographic characteristics of the study population

The majority of the respondents from the survey were the age group 15-20 years and a great number of these were either single mothers, unmarried young ladies or male youth without permanent spouses. There was a sizeable number that were out of school but still depended on or lived with their parents especially among the females, although most men were living independently and therefore fending for themselves. The survey found out that there was a reasonable level of education attainment reported to be at 94% for those that have ever attended school save for the reportedly low completion rates. This is a good statistic in that, with some level of literacy and numeracy, uptake of new messages can be better and appreciation of issues like contraception and management of infections and other diseases can be better. This is more so, given the youth presence within an urban setting and their exposure to a wide variety of media and sources of information. The challenge with this population is however associated with the mass poverty, unemployment for both the youth themselves and their care givers which makes them vulnerable to unhealthy sexual encounters and other practices that compromise their health. The absence from school or non-completion of school by over 40% of the respondents in this category is largely attributed to family problems (including early pregnancy and the need to provide care to family) which when probed further also points to poverty in the homes.

4.2 Sexuality education, information and knowledge

The survey reveals that the school is the principle avenue for sexuality education, with about half of the surveyed young people indicating that they attained their sexuality education mainly through the school. The problem with this avenue is that this leaves a large proportion of young people with no formal sexuality education since they have been reported to drop out early and not much can be or is actually given at the lower levels of school. This could be the explanation for the low and inconsistent levels of sexuality knowledge among the young people. The survey indicated that the young people have particularly limited knowledge on women's fertility patterns, male contraception, and other forms of STDs management other than HIV.

This therefore calls for increased investment in sexuality education to increase its coverage and quality for the young people in and most especially out of school. There is also concern about the inadequacy and quality of information, the unfriendliness and uneasiness of some of the health providers to talk about sexuality with young people which contributes to widening the information gap. With a significantly higher percentage of participants in the study reporting awareness about HIV, the proponents of improved knowledge and information on SHR could

copy a leaf from the efforts in the fight and information dissemination on HIV related issues. It is also important the youth friendly avenues or channels like; Television, physical IEC materials/handouts at entertainment centers and youth friendly corners at health facilities should be used for information and education communication.

4.3 Sexual activity and related outcomes

The survey revealed that 64% of the young people aged 15-24 years were engaging in sexual activity outside of marriage. Although most of them have reportedly delayed their actual marriages, majority of them start to engage in sexual activity at a very young age and many of them engage in casual relationships with very limited uptake of contraceptives which exposes them to risks of unwanted pregnancies and STDs, given that the level of care they take to protect themselves from diseases is also limited. Therefore, there is a fairly high percentage of adolescent girls that actually get pregnant and this was reported as one of the reasons many of them fall out of school, while the male youth consider it a females' responsibility to play safe.

The survey also reports adverse experiences of sexual exploitation and sexual violence towards young people (especially the girls) in some forms of employment while a number are also forced into acts of commercial sex. The girls also reported that they had low self-efficacy perception in negotiating sexual intercourse including using protection against pregnancy and STIs. The levels of reported gender-based violence can be put in perspective by this apparent failure of women to stand up against male dominance. A third of the women felt they did not have the power/self-efficacy to negotiate their wishes with regards to sexual intercourse.

4.4. Knowledge and use of modern contraception

The survey revealed that there is fair information among the female respondents with regard to modern contraceptive methods, although the males have fairly limited knowledge focusing on the male condom as the most known and common contraceptive method among the sexually active young people. Knowledge was quite low among the age groups 12 – 15 who would be the schooling age, but are also sexually active and are exposed to the dangers of sexual activity. The school from where most of the young people attain knowledge on sexual education does not provide much, yet the family structures are no longer supportive either. The next resort is therefore the health facilities as the main source of information on contraception so if the services are not friendly, this explains the inadequacy in knowledge on modern contraception among the young people.

Family planning (especially the oral pill) was reported to be common among the single female youth or those in relationships, but not yet living with their partners. However, there is a sizeable number of them who are non-users and therefore at risk of unwanted pregnancies and/or STDs. The limited ability for the females to supply or decide when to use a condom by a male partner during sexual intercourse poses a particular risk to them all. Knowledge about reproductive health with the male youth is also reportedly low and this is tagged to the attitude problem that they have about sexual education. They are in control and the females are expected to take care.

4.5. Perceived attitudes and beliefs about SRH

The traditional family support system has broken down and no longer delivers on the age old role of parental education and child upbringing. There is still stigma related to pregnancy outside of marriage and use of contraceptives by young unmarried people. Many of the older people and religious leaders still have very strong and conservative religious values and views about SRH issues including education and family planning practice for the young people. The elders emphasize abstinence for the young people. There is the perception that, if a girl gets pregnant, then it is her own fault so she is shunned by the community including her peers, yet no one came around to help talk to her on how to avoid the pregnancy, pretending to look aside and ignoring the fact that the young people have feelings and actually engage in sexual intercourse. Because about half of the young people interviewed thought that the use of contraception encouraged infidelity, this may be put in the perspective of their perceived capacities to negotiate protection during sexual intercourse, rated negatively by more than 50% of the respondents at the face to face interviews.

4.6. Health provider support and SRH FP counselling

The survey revealed discrepancies in family planning service provision between public health facilities and the private providers as well as clinics that were mentioned to have specific youth friendly services within KCCA facilities. The quality and friendliness of staff was also a key determinant for repeat visits or uptake of referrals by the young people. The young people reported that despite the fact that most professionals provided services in the field of SRH and have guidelines for those services, they report relatively low confidence in their knowledge and skills to provide the required services. In a similar vein, key informants reported that in some facilities, the health service providers were known to have low confidence, insufficient knowledge and patience to sensitize young people on SRH and in knowing how to communicate with them about benefits and risks linked to the services. This is a good explanation for the limited repeat visits by the young people to these facilities especially if no proper guidance is given to them at the first few visits.

4.7. Access to and Utilization of adequate and age appropriate SRH services

The survey confirmed that young people face significant barriers to accessing SRH services and these barriers can be different from those experienced by older women and men of reproductive age. Access to services for young people can also greatly depend on the support they receive from their social networks such as parents and other adults in the community to access services. As mentioned earlier, the self-rated self-efficacy to negotiate use of protection during sex or abstinence with a partner was rather low. This hints towards potential discrepancies between knowledge and practice, as many reportedly knew the dangers associated with failure to use protection during intercourse but could not live up to the guidelines. There are youth friendly centers in all the divisions of Kampala and although reports indicate an increase in the uptake and utilization of the SHR services by the youth, the services offered in these centers are limited. The divisions are wide spread and the populations therein are big so these facilities are not necessarily in easy proximity to the intended users. Many of the young people talked too during

the survey were not able to name one such facility in their neighborhood, even if they could refer to another, say in the nearby division, which showed that the distant ones were more favorable. The different categories of young people have specific requirements for information, knowledge and services. However, there is a tendency to think that the adolescents are too young for any knowledge on sexuality, yet they are so exposed to the evils that are meted on them by the society that fails to equip them with the skills to fight the vices. The outreach sessions by SRH service providers are reported to be yielding better results in the services rendered and numbers reached, especially among the largely shy youth who may find visits to the health facilities a bit intimidating.

4.8. Decent work options and access to affordable financial services

Majority of the young people in the study area are employed in the informal sector, but working under very unfavorable conditions and facing a lot of exploitation and risk to their health and lives in general. Being the informal sector, the aspects of decent work like insurance, job security, or even growth or expansion of their businesses is a challenge. Many of them lack the necessary skill sets to move to another level or engage in more innovative and lucrative trades. This could be explained by the limited opportunities for vocational training, where there are no facilities in the vicinities, or where they exist, the young people might not have the financial resources required of them to enroll. The exploitative working conditions could be explained by the weak regulatory and enforcement regime but also the mass poverty in the study area which pushing young people in all trades whether legal or illegal, with some endangering their lives.

The vulnerable categories of the young people are not helped out in any way as they face the same difficulties that the entire population faces on addition to their other disabilities. Access to affordable financial services is another serious impendent and this could be explained by the limited appetite by the traditional financial service providers to work with the young people who might not have the necessary experience and collaterals to manage and secure business loans.

Financial services provision brings about Financial inclusion for the poor youth. It is not an end in itself, but rather a means to work towards the alleviation of poverty and, ultimately, more inclusive economic development. Financial inclusion therefore means that excluded individuals, households and small businesses have access to and use a range of appropriate financial services. "Appropriate," in the sense that financial services, such as savings, insurance and credit, must be relevant to poor young people[5]. These financial services must also be provided responsibly, sustainably and in a well regulated environment but targeting the majority of the young and mostly unemployed youth to enable them startup business ventures ultimately build wealth.

In conclusion, the reportedly early initiation into sexual activity and non-use of contraception have increased the risk for early and none marital pregnancy and exposure to STDs, which beyond the repercussions on young individuals and their families impose a heavy cost on society.

[5] Financial Services for young people: prospects and challenges. The MasterCard Foundation. The Boston Consulting Group. 2017.

However, the health sector environment also still poses some structural and policy challenges for the delivery of SRH services for adolescents and youth as there are contradictions between the written documents and sexuality education framework and the actual practice. These challenges range from; controversies about what is deemed to be age appropriate for the young people, ambiguity about the stand points on matters of health and disease prevention alongside values and moral standards, and complete silence about the demands and needs of young people and the vulnerable populations within their age-groups. This has heavily but negatively impacted the good will and service delivery by a number of stakeholders. Commodity security for essential drugs is also reported to be a problem in many of the public facilities serving the poor youth in the urban slums and this has greatly limited the integration of youth friendly services in public health facilities.

5.0. Recommendations

The most effective actions to improve adolescent sexual and reproductive health take a multifaceted and coordinated approach and provide access to services that are non-discriminatory; medically accurate; and developmentally, culturally age-appropriate. Decent work conditions for young people also come out of a deliberate effort to reform the legal and regulatory environment but also programmes that empower the youth to focus on skills improvement, innovation and enterprise development.

The following bullets point to some approaches that should be incorporated in any programming to address the issues raised by this baseline survey:

- Improve access to age-appropriate comprehensive sexuality education and high-quality SRH services for both in and out-of-school young people with particular attention to the current needs and prevailing dangers to them.
- There is need for ongoing reinforcement of clear messages on risky behaviors while providing basic and accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse. This could be complemented by activities that address social pressure on sexual behaviors since it is reported that peers are a key influencer.
- Proponents should work towards increased access to quality integrated SRH services for disabled and vulnerable adolescents and young people living in the urban slum communities where there are no public health facilities but with lots of private providers of usually exorbitantly priced services. Also, forging partnerships with private clinics has proven potential for improving contraceptive uptake and information dissemination to the young people since the providers of these services are fairly close to them.
- The above intervention should be followed with investment in public-private partnerships whereby privately run clinics are supported by the government or other non for profit agencies to provide high-quality, youth-friendly SRH services.
- Engage in evidence based policy advocacy targeting specific decision makers and duty bearers to improve policy and secure resources for information dissemination and implementation of key SRHR policies. The end goal should be to institute policies that promote access to SRH information, education and services.
- Focus on and invest in outreach sessions as these were reported to be convenient and very much appreciated by the young people.
- On addition, conduct mass media and social marketing campaigns to gain stakeholder and other adult support for discussions with, and activities and services for, young people.
- Address antecedents that contribute to youth SRH risks, such as dropping out of school, gender inequity, early marriages, unemployment and lack of marketable skills, the sex industry and drug and alcohol consumption. This should be undertaken on addition to improving other sectors in related areas, such as female education and vocational training.

- Work to overcome resistance to providing SRH information and services to young people, and ensure that these services are affordable. Address the cultural and religious barriers.
- Collaborations between CSOs and NGOs have great delivery potential for reaching more young people and influencing commitments for SRH services for the young people. It is known that there are many players aiming at the same goal but scattering resources rather widely but thinly.
- Staff in the health facilities should be trained to work with youth in a respectful manner, according them privacy, confidentiality and adequate time for interaction between the client and provider. Where resources permit, peer counselors should be available to complement.
- To promote knowledge on SRH issues, educational materials should be availed on site, with the chance to carry them home. Create space for the groups and provide for alternative ways to access information, counseling and services outside of a formal health facility.
- Because the majority of the youth prefer to be self-employed with the preference to start up and manage their own businesses, vocational skills training is of great necessity but it is also important that consideration is made to provide some basic business skills training in book keeping, stock management and customer care to enable them manage the businesses or trades that they start.
- Financial services for the poor urban youth should be more than just providing access to services and products. Efforts must be holistic, helping to address issues related to income-generation, the development of sustainable livelihoods and economic development so that the provision of financial services coincides with better financial trajectories.
- Disabled youth are a more vulnerable lot with no particular support. Effort ought to be made to fish them out and special projects undertaken with some form of affirmative action.

6.0. Annexes

6.1. Baseline benchmark indicators

Indicator	Baseline	Logframe
Adolescent youth accessing age appropriate SRHR information in the slums of Kampala (Makindye, Rubaga and Nakawa)		
• % age of youth/adolescents that access sexuality education, information and knowledge	65 %	
• % of females with knowledge on and use of modern contraception	6 2 %	
• % of males with knowledge on and use of modern contraception	56 %	
• Youth satisfaction with sources and quality of information on RHS	48 %	
Adolescent/youth accessing and utilizing age – appropriate SRH services		
• % age of elders with negative attitudes, perceptions and beliefs about SRH (especially use of contraceptives)	82 %	
• % age of young people with negative attitudes, perceptions and beliefs about SRH (especially use of contraceptives): Female Male	47 % 65 %	
• % Health services providers with knowledge and are supporting SRH services for young people – including FP counselling	67 %	
• % of young people accessing and utilizing adequate and age appropriate SRH services	48 %	
Adolescents and youths reporting reduced engagement in risky sexual behaviors and negative coping mechanisms		
• % age of youth in active sexual relations (with boy/girlfriend)	64 %	
• % age of youth in serious relationships/ committed for marriage	26 %	
• Median age at first marriage	15– 23 yrs	
• % of youth in risky sexual behaviours	60 %	
• % age of male youth reporting negative peer influence to engage in sexual activity: Male Female	90 % 80 %	
• % of young people with awareness about pre and post test services	73 %	
• % of youth/adolescents HIV tested at the time of the interview	35 %	
Access to Decent work options and affordable financial services		
% Adolescents/youth with employable skills and in gainful employment (including self-employment)	50 %	
% of youth in need to change or dis-satisfied with present employment	75 %	
% of youth in need of vocational training and skills for employment creation	77 %	
% of adolescent youth with access to affordable financial services (especially formal or government programmes)	09 %	
% of youth/adolescents engaging in formal savings activities	12 %	

6.2. Face to Face/Household Questionnaire

Enhancing Age-appropriate Adolescents Sexual Reproductive Health Services for Young People below 25 Years (EASY-U25)

INDIVIDUAL QUESTIONNAIRE

Introduction

Good morning/afternoon, my name is _____ and I represent UYDEL. We are conducting a survey within Makindye, Nakawa and Rubaga Divisions of Kampala. The purpose of this survey is to learn what young people understand about Sexual and Reproductive Health and practices appropriate for their age bracket. We would like to explore the context, magnitude Knowledge, Attitude and Practices as well as challenges that vulnerable adolescents face in regard to: their access to and utilization of appropriate SRH information and services; and access to decent work opportunities in Kampala.

Regarding this, I would like to ask you some questions. Some of the questions are personal, but the answers you give will not be shown to anyone. They will only assist us in learning more about the behavior, beliefs and practices of young people in general. We especially want your answers because if everyone who is selected participates, our information will be more useful.

Do I have your permission to continue? (If YES Interviewer arranges for a private setting to conduct interview if NO End the interview).

Section 1: Background, Education and Decent Work related Information

1. Sex of respondent (Circle the sex of the respondent. Please do not ask.)
   1Male 2Female
2. How old were you on your last birthday? Age: _____ years Don't know
3. What is your religious denomination?
   1 None
   2 Catholic
   3 Protestant
   4 Moslem
   5 Pentecostal
   6 Traditional 7 Other (Specify): _____
4. What is the highest level of school you have attained?
   None/Never went
   1 Primary
   2 Secondary
   3 Technical/vocational school
   4 University/college
   5 Post-university/graduate school
   6 Don't know
5. What is your current occupation?
   student
   Nothing
   2 Employed
   3 Selling goods/small-scale business
   4 Casual laborer
   5 Farming
   6 Other (specify): _____
   If not in school, why is it that you are not currently attending a school, tertiary institution or university?1 Never went
   2 Already completed all studies

3 Got married
4 Quit due to pregnancy
5 Have to provide child care
6 Family problems
7 Other (specify): _____
8 Financial problems

6. What have you done in the last month to earn money for yourself? (If more than one activity, ask which is the main activity, and circle that response)
   1 Self-employed (crafts, baking, tailoring, welding, car wash, etc.)
   2 Working in a bar, restaurant, house help
   3 Formal employments (teaching, shop attendant, etc)
   4 Transfers from a partner (boyfriend/girlfriend/spouse)
7. Who is responsible for the money that you earn?
   1 Myself
   2 My brother/sister
   3 My mother
   4 My father
   5 My boyfriend/girlfriend
   6 My spouse
   7 My grandmother/father
   8 Other relative (specify): _____
8. Are you part of a saving group?
   a. If yes, how much do you save and what are your intentions for saving? Where do you keep your money?
9. If engaged in economic activity/working, What economic activities/trades are you engaged in?
   1 Carpentry and wood works
   2 Electrical installations and repairs
   3 Hair dressing and hair products
   4 Tailoring and dress making
   5 Washing peoples' clothes or house helping
   6 Catering and Eatery services
   7 Chapatti/Mandazi/Fries making
   8 General retail shop and off road stalls
   9 Mobile money services
   10 Plumbing services
   11 Welding and product designs
   12 Working on construction sites (Pottering)
   13 Formal employment (specify)
10. What Challenges have you faced in undertaking this job?
    Hard work
    Long hours of work
    Low pay
    Sexual harassment
    Accidents
    Diseases
    Harassment at the job
    Others
    a. How did you deal with these challenges/strategies used to overcome the challenges?

11. If you were given a chance to change from your present trade/employment, what alternative economic activity would you prefer? ……
    Indicate alternative from list below:
    1 Carpentry and wood works

2 Electrical installations and repairs
3 Hair dressing and hair products
4 Tailoring and dress making
5 Washing peoples' clothes or house helping
6 Catering and Eatery services
7 Chapatti/Manadzi/Fries making
8 General retail shop and off road stalls
9 Mobile money services
10 Plumbing services
11 Welding and product designs
12 Working on construction sites (Pottering)
13 Formal employment (specify)

12. Why would you like to change? ……

Section 2: Relationship related questions

13. Are you currently in a sexual relationship?
    1. 1. No
    2. Yes, I am married
    3. Yes I am living with a partner (boyfriend/girlfriend)?

    If No **Skip to Q. 20**
14. Which of the following attitudes best describes your plans about having sexual intercourse in the future? (Read out loud.)
    1 I plan to wait until marriage before having sex.
    2 I plan to wait until I am engaged before having sex.
    3 I plan to wait until I find someone I love before having sex.
    4 I plan to wait until I'm at least 19 before having sex.
    5 I plan to wait until I'm at least 17 before having sex.
    6 I plan to have sex as soon as possible.
    7 I plan to have sex whenever an opportunity comes along.
    8 Having sex isn't something you can plan; it just happens.
    9 I plan to have sex whenever my partner wants to have sex.
15. Which of the following attitudes best describes your plans about going to see a reproductive health provider for information, advice and/or services? (Read out loud.)
    1 I do not plan to see a provider at all.
    2 I may see a provider for some information.
    3 I may see a provider for services.
    4 I definitely plan to see a provider for information.
    5 I definitely plan to see a provider for services.
    6 I definitely plan to see a provider for services and information.
16. How old were you when you first had a partner (boyfriend/girlfriend)?
    1 Less than 15 years old
    2 15 years old
    3 16 years old
    4 17 years old
    5 18 years or older
17. How committed are you to your current partner (boyfriend/girlfriend)?
    1 Very committed/want to get married or live together
    2 Somewhat committed/no plans yet to get married or live together
    3 Not committed at all/casual relationship
18. Have you ever lived with your partner (boyfriend/girlfriend?

    1 Yes 2 No **If no skip to Q. 20**
19. How old were you when you started living with a partner (boyfriend/girlfriend)?

Age: _____ years
Don't know/don't remember

Section 3: Reproductive Health Knowledge

20. Can a girl get pregnant the first time she has sex?
    1 Yes
    2 No
    3 Don't know/don't remember
21. During which part of the monthly cycle does a woman have the greatest chance of becoming pregnant?
    1 During her period
    2 In the middle of her cycle
    3 Right after her period ends
    4 Just before her period begins
    5 Other (specify): _____
    6 Don't know/don't remember
22. How old does a girl need to be to get pregnant?
    Age: ____ 1 After puberty 2 Don't know/don't remember
23. What ways do you know to avoid getting pregnant? (Probe by asking, "Anything else?" and circle all that apply.)

	Yes	No
None/don't know		
Pills	1	2
IUD	1	2
Injectable/Depo-Provera	1	2
Diaphragm/foam tablets/jelly/cream	1	2
Condom	1	2
Norplant	1	2
Contraceptive (unspecified)	1	2
Traditional method (specify): _____	1	2
Non-penetrative sex	1	2
Herbs	1	2
Male sterilization	1	2
Female sterilization	1	2
Safe days/abstinence	1	2
Emergency contraception	1	2
Nat. family planning/billing method	1	2
Withdrawal	1	2
Douching	1	2
Other (specify): _____		

24. Which modern contraceptive method is the most effective?
    1. Pills
    2. IUD
    3. Injectable/Depo-Provera
    4. Diaphragm/foam tablets/jelly/cream
    5. Condom
    6. Norplant
    7. Male sterilization
    8. Female sterilization
    9. Don't know /don't remember
25. If you wanted to find out more about ways to avoid pregnancy, whom would you talk to? (Probe by asking, "Anyone else?" and circle all that apply.)

	Yes	**No**

Brother	1	2
Sister	1	2
Aunt/Uncle	1	2
Female adult	1	2
Male adult	1	2
Female friend	1	2
Male friend	1	2
Female peer educator at clinic	1	2
Male peer educator at clinic	1	2
Boyfriend	1	2
Girlfriend	1	2
Doctor	1	2
Religious leader	1	2
Male adult counselor/Peer educator	1	2
Female adult counselor/Peer educator	1	2
Teacher	1	2
Grandparent	1	2
Nurse	1	2

26. What are the good things about having a child while you are a teenager? (Probe by asking, "Anything else?" and circle all that apply.)

	Yes	**No**
None		
Having a baby to love	1	2
Having a child's love	1	2
Moving out of parent's house	1	2
Getting married early	1	2
Proving your fertility	1	2
Showing your maturity	1	2
Enjoying them growing up	1	2
Having a partner to love	1	2
Having security during old age	1	2
Proving you are a man/woman	1	2
Other (specify): _____		

27. Are there any reasons why pregnancy/childbirth should be avoided when you are a teenager?

1	Yes	
2	No	**Skip to Q. 30**
3	Don't know/don't remember	**Skip to Q. 30**

28. What are the reasons? (Probe by asking, "Anything else?" and circle all that apply.)

		Yes	**No**
Mother could die		1	2
Baby could be unhealthy	1	2	
Children are too costly		1	2
Father could be thrown out of family		1	2
Mother could be thrown out of family		1	2
Affects mother's educational chances		1	2
Child could die		1	2
Mother alone cannot take care of child		1	2
Mother and father together cannot take care of child	1	2	
Other (specify): _____			

29. What would be the ideal number of children for you?

1 None
2 One
3 Two

4 Three
5 Four or more
6 Don't know

30. What does "safe sex" mean to you? (Probe by asking "Anything else?" and circle all responses.)

	Yes	No
Abstaining from sex	1	2
Using condom	1	2
Avoiding multiple sex partners	1	2
Avoiding sex with prostitutes	1	2
Avoiding anal sex	1	2

Other (specify): _____
Don't know

31. If you had a reproductive health problem or question, where would you go for help? (Probe by asking, "Anyplace else?" and circle all that apply.)

(Note for interviewers: Reproductive health problems are problems associated with the reproductive health organs, such as pregnancy, contraceptive concerns, HIV/AIDS, STIs, abortion, etc.)

1 Clinic/hospital
2 Health worker
3 Peer counselor
4 Youth center
5 Friend
6 Parent
7 Relative
8 Teacher
9 Other (specify): _____
10 Don't know

32. If you wanted to buy contraceptives, do you know where you would go? (Probe by asking, "Anyplace else?" and circle all that apply.)

1 Clinic/hospital
2 Health worker
3 Peer counselor
4 Youth center
5 Friend
6 Health worker
7 Relative
8 Teacher
9 Bar
10 Place were sporting events are held
12 Pharmacy
13 Other (specify): _____
14 Don't know

(Please note if it a Girl or boy respondent) Now I am going to read some statements. After I read each statement, please tell me if you agree or disagree.

Indicate 1. Boy 2. Girl.

33. A woman must use the pill every day for it to be effective.
1 Agree 2 Disagree 3 Don't know
34. Side effects from the pill, such as nausea, go away a few months after a girl starts using it.
1 Agree 2 Disagree 3 Don't know
35. The pill can cause infertility.
1 Agree 2 Disagree 3 Don't know
36. Taking the pill is riskier than getting pregnant.

1 Agree
2 Disagree
3 Don't know

Section 4: Knowledge related to STI/HIV/AIDS infections and prevention

37. Which infections do you know a person can get through sexual intercourse?? (Probe by asking, "Any others?" and circle all that apply.)

	Yes	No
HIV/AIDS	1	2
Gonorrhea	1	2
Syphilis	1	2
Chancroid	1	2
Genital warts	1	2
Genital herpes	1	2
Hepatitis B	1	2
Vaginitis	1	2
Cervical cancer	1	2
Other (specify): _____		Don't know/don't remember

38. Have you ever had any sexually transmitted infections (STIs)?
    1 Yes
    2 No **Skip to Q. 45**
    3 Don't know/don't remember **Skip to Q. 45**
39. How did you know you had a sexually transmitted infection (STI)?
    1 Was diagnosed
    2 Thought by myself
    3 Friend/relative told me
    4 Other (specify): _____
    5 Don't know/don't remember
40. Did you receive treatment for the STI?
    1 Yes 2 No 3 Don't know/don't remember

41. Whom did you discuss this problem with? (Probe by asking, "Anyone else?" and circle all that apply.)

	Yes	No
No one	1	2
Spouse	1	2
Boyfriend/girlfriend	1	2
Peer educator/counselor	1	2
Adult counselor	1	2
Grandfather	1	2
Grandmother	1	2
Traditional healer	1	2
Friend	1	2
Mother	1	2
Father	1	2
Sister	1	2
Brother	1	2
Aunt	1	2
Uncle	1	2
Cousin	1	2
Nurse	1	2
Doctor	1	2
Other (specify): _____		

42. Where did you seek advice or treatment? (Probe by asking, "Anyplace else?" and circle all that apply.)

	Yes	No
Did not go for treatment	1	2
Treated myself	1	2
Youth center	1	2
Drug store	1	2
Hospital/clinic	1	2
Traditional healer	1	2
Friends/relatives	1	2
Other (specify): _____		

43. When you had the STI, what did you do to prevent infecting your partner?

1 Did not have sex
2 Used condoms
3 Got treated
4 Nothing
5 Advised my sexual partner to seek treatment
6 Other (specify): _____

44. Is there anything a person can do to avoid getting STIs? (Probe by asking, "Anything else?" and circle all that apply.)

	Yes	No
Non-penetrative sex	1	2
Use of condom	1	2
Washing/douching	1	2
Avoiding casual partners	1	2
Abstinence	1	2
Avoiding commercial sex workers	1	2
Using herbs	1	2
Other (specify): _____		

HIV/AIDS

45. Please mention all the ways in which you believe a person can get HIV. (Probe by asking, "Anything else?" and circle all that apply.)

	Yes	No
Sexual intercourse	1	2
Sharing needles/unclean medical equipment	1	2
Blood transfusions	1	2
During pregnancy	1	2
Mother to child during birth	1	2
Mosquito or other insect bites	1	2
Through breast milk	1	2
Casual contact with infected person (e.g., sharing food, shaving equipment, cup or glass; handshake, cough or sneeze)	1	2
Other (specify): _____	Don't know	

46. What can a person do? (Probe by asking, "Anything else?" and circle all that apply.)

	Yes	No
Nothing		
Avoid sex completely/ abstinence	1	2
Stay faithful to partner	1	2
Encourage partner to stay faithful	1	2
Avoid contaminated blood	1	2
Use condoms for every act of sexual intercourse	1	2
Avoid sharing needles	1	2

Avoid commercial sex workers	1	2
Avoid casual sex	1	2
Avoid circumcision at unauthorized places	1	2

Other (specify): _____

47. Do you think you or your partner (boyfriend/girl friend) are at risk of getting the HIV virus in the next 12 months?

1 Yes 2 No 3 Don't know

If yes, why do you think so?

.....

48. A healthy-looking person can be infected with HIV.

1 Agree 2 Disagree 3 Don't know

49. A person can get HIV/AIDS the first time he or she has sex.

1 Agree 2 Disagree 3 Don't know

50. A woman who has HIV can give birth to a child with HIV.

1 Agree 2 Disagree 3 Don't know

51. A person can get AIDS through circumcision.

1 Agree 2 Disagree 3 Don't know

Section 5: Attitudes, Beliefs and Values

52. How likely or unlikely do you think it is that someone can force you to have sexual intercourse?

1 I'm sure this won't happen
2 This probably won't happen
3 I'm not sure whether this will happen or not
4 This probably will happen
5 I'm sure this will happen

53. If someone did try to force you to have sexual intercourse, what would you do?

1 I definitely would not do it
2 I probably would not do it
3 I'm not sure whether I would do it or not
4 I probably would do it
5 I definitely would do it

54. What are the advantages of using condoms?

	Yes	No
No advantages	1	2
Pregnancy prevention only	1	2
Less worry	1	2
STI and pregnancy prevention	1	2
AIDS and pregnancy prevention	1	2
AIDS prevention only	1	2
Less mess/clean/neat	1	2
Feel safer/protected	1	2

Other (specify): _____

Don't know

55. When would you use condoms? (Probe by asking, "Any other time?" and circle all that apply.)

	Yes	No
Never	1	2
For casual sex	1	2
In a stable boy-girl relationship	1	2
When having sex with prostitutes	1	2
For protection against STIs	1	2
To avoid pregnancy	1	2
In a husband-wife relationship	1	2

When one has multiple sexual partners	1	2
If partner has STI	1	2
Other (specify): _____	1	2
Don't know	1	2

56. In your opinion, what is the ideal age for a girl to have sex for the first time?
    Age: ____ years
    1 After marriage
    2 Other (specify): _____
    3 Don't know
57. In your opinion, what is the ideal age for a boy to have sex for the first time?
    Age: ____ years
    1 After marriage
    2 Other (specify): _____
    3 Don't know
58. How easy is it for boys to obtain contraceptive methods?
    1 Easy
    2 Difficult **If so skip to Q. 64**
    3 Don't know **If so skip to Q. 64**
59. Why is it difficult for boys to obtain contraceptive methods? (Circle all that apply.)

	Yes	No
Money	1	2
Difficult to find	1	2
Provider/seller disapproves	1	2
Parents/elders disapprove	1	2
Other (specify): _____		
Don't know		

60. How easy is it for girls to obtain contraceptive methods?
    1 Easy 2 Difficult **If easy skip to Q. 64** 3 Don't know **Skip to Q. 64**
61. Why is it difficult for girls to obtain contraceptive methods? (Circle all that apply.)

	Yes	No
Money	1	2
Difficult to find	1	2
Provider/seller disapproves	1	2
Parents/elders disapprove	1	2
Other (specify): _____		
Don't know		

62. What can be done for young people to obtain contraceptive methods?
    .....
63. what are the advantages of discussing contraceptives with young people ?
    .....
64. What are the disadvantages of discussing contraceptives with young people ?
    .....

Section 6: Social Influences

65. Do other girls or other community members encourage other girls to have sex with boys or older men?
    1 Yes 2 No 3 Don't know
    Please mention who these members are that do this.
66. Where do boys and girls get support regarding sexual relationships?
    1 No support at all
    2 Friends/peers
    3 Parents/relatives
    4 Community

5. Health workers
6. Religious leaders
7. Teachers
8. Others (Specify).....

67. What kind of support do they get?
    a. 1. Counseling and advise
    b. Sexuality Information
    c. Information on having good relationship
    d. Information on contraception
    e. Information on health
    f. Accessing services
    g. Others .. (Specify) .....

Section 7: Leisure and religious activities

68. What are the common leisure activities for you among this community?
    a. Church
    b. Sports
    c. Music/Discos
    d. Leisure parks
    e. In door games
    f. Betting
    g. Watching films
    h. Other (Specify).....

Section 8: Media Influence

69. How often do you listen to the radio?
    1 Every day or almost every day
    2 At least once per week
    3 At least once per month
4 Less than once per month
    5 Not at all
70. How often do you watch television? Would
    1 Every day or almost every day
    2 At least once per week
    3 At least once per monthLess than once per month
    4 Never Skip
71. How often do you read a newspaper? Would you say (read list and circle only one answer):
    1 Every day or almost every day
    2 At least once per week
    3 At least once per month
    4 Less than once per month
    5 Never Skip Other (specify): _____
72. Do you own a mobile phone? A Yes or No
73. Do you use the mobile phone for any financial transactions?
74. In the last 12 months, have you used the internet?
    Yes or No

Section 9: Health-Seeking Behaviors

75. Have you visited a clinic in the past six months to obtain contraceptives or other RH services?
    1 Yes 2 No If no skip to end 3 Don't know/don't remember If so skip to end
76. How many times have you visited a clinic in the last six months?
    Number of times: _____ 2 Don't know/don't remember
77. What was the name of the clinic you visited the last time?

Name of clinic: _____ Don't know/don't remember

78. How did you hear about the clinic?

1 Radio
2 TV
3 Newspaper
4 Relative
5 Friend
6 Teacher
7 Pharmacist
8 Poster
9 Pamphlet/brochure
10 Other (specify): _____
11 Don't know/don't remember

79. What was your reason for visiting the clinic the last time? (Circle all that apply.)

	Yes	No
Medical check-up	1	2
STI treatment	1	2
HIV/AIDS testing/counseling	1	2
Curative treatment/services	1	2
To get contraceptives	1	2
Other (specify): _____		

80. Who did you talk to or see at the clinic the last time? (Probe by asking, "What type of service provider?" and circle all that apply.)

1 Doctor
2 Nurse
3 Health aide
4 Peer educator/counselor
3 Other (specify): _____
4 Don't know/don't remember

81. Was the service provider

		Yes	No
Knowledgeable		1	2
Friendly	1	2	
Interested in you	1	2	
Well-qualified		1	2
A good communicator		1	2
Respectful		1	2
Polite		1	2
Caring about your privacy/ confidentiality	1	2	
Honest and direct		1	2
A good listener		1	2
Able to help you	1	2	

82. Would you return again to seek advice/treatment from this person?

1 Yes **Skip to 106** 2 No 3 Don't know **Skip to Q. 106**

83. Why wouldn't you return? (Circle all that apply.)

		Yes	No
Needed parent's permission		1	2
Needed spouse's permission		1	2
Made me feel unwelcome	1	2	
Scolded me		1	2
Made me feel ashamed		1	2
Did not provide me with the necessary treatment/drugs		1	2
Did not seem knowledgeable		1	2

Did not seem interested in working with me	1	2
Was rude	1	2
Did not provide me with the information I needed	1	2

Other (specify): _____

84. Would you return to the clinic again?

1 Yes 2 **No Skip to Q. 107** 3 Don't know **Skip to end**

85. Why would you return to seek advice/treatment from this person? (Circle all that apply.)

	Yes	No
Friendly/caring staff	1	2
Short waiting time	1	2
Youth corner	1	2
Place to talk with peer educators 1	2	
Convenient	1	2
Had a nice experience	1	2
For any other health problem	1	2
For pregnancy care	1	2
For STI treatment	1	2

Other (specify): _____

86. Why would you not return to the clinic? (Circle all that apply.)

	Yes	No
Needed parent's permission	1	2
Needed spouse's permission	1	2
Unfriendly/rude staff	1	2
Staff does not welcome/ approve of young people 1	2	
Lack of privacy	1	2
Embarrassed to go there 1	2	
Long waiting time	1	2
Too expensive	1	2
Might be asked to bring partner 1	2	
No drugs dispensed at clinic	1	2
Prefer to go to the traditional healer	1	2
No health problems	1	2
Too far	1	2
Prefer another clinic	1	2

Other (specify): _____

Thank you very much for your time and help!

6.3. Key Informant Interview Guide

KEY INFORMANT INTERVIEW GUIDE

Decent work and Economic opportunities

1. How would you describe the current work situation in this community with regard to;
    a. Employment and Decent work conditions,
    b. Labour Rights and promotion of safe and secure working environments for young women and men? (Describe decent work as legal, gainful/paying, and harmless work)
2. In your view, what are the challenges that hinder availability of decent work opportunities for young women and men aged 15—25 in this community?
    a. How can these challenges be addressed?
3. What are the opportunities for informal or self-employment for youth in this community?
4. What are the skill sets/trainings required by youth to tap into those opportunities?
    a. What challenges do you believe hinder acquisition of these market-driven skills by young women and men aged 15—25 to enable them access decent job opportunities in the informal sector?
    a. In what ways do you believe that these challenges can be addressed?
5. Are there civil society organizations operating in this area which support youth employment?
    b. Please provide name and sector details of organization.
6. Do the youth have easy access to micro finance services and information, in the community?
    a. Are the government funds and information adequately targeting the youth? ***Probe for availability of services to youth with disabilities.***

Sexual and reproductive health services and information

6. What are the main reasons young people visit health facilities? (***Probe for: Contraceptive counseling, purchases, Prenatal care, Pregnancy tests, STI screening & treatment, Peer counseling, HIV/AIDS test, Gynecological exam, Abortion-related services, Infertility consultation, General health service (non-RH oriented)***

7. What are the Reproductive health services provided to the young people in this community?
   Probe for appropriateness for age groups, privacy, cost, ease of access, repeated visits.
    a. Are the young people told about/given chance to make return visits, are they followed up? How do the young people get to know about the facilities/services? Probe for; Radio, referrals, posters, drive through communities, etc.
8. Who is responsible for dissemination of reproductive health information to young people in the community?
9. Are there any educational materials provided to the young people? What are the subject(s) covered in this material (probe for maternal health, contraception, STIs, HIV/AIDS, Abortion, Drugs/alcohol abuse?)
10. What is the role of the religious/spiritual leaders in the guidance for youth aged 15 – 25 years?

Attitudes and knowledge about Adolescent Reproductive Health

1. What are the avenues through which youth get information about reproductive health services? ***Probe for the different ages and the available spaces.***
2. In your view, what is the community perception about presence/absence of reproductive health services for the young people in this community?
   Probe for leadership support, religious leader objection and youth perception of the services.
3. Are there many young mothers in this community? Probe for the causes; effect to families; community support mechanisms; acceptance/rejection and the peer support systems?
4. What is the level and caliber of staffing in the health facilities where youth obtain the services?
    a. Probe for qualifications/competencies, numbers, customer care, etc.
    b. Do the young people have access to reproductive health commodities? Probe for age specific supplies and availability/presence of Community Based Distributor (CBD) for contraceptive commodities?
5. What do you consider to be the appropriate interventions, information, or support services for the adolescents and youth in the following categories:
        i. – 14 years, 15 – 20 years, 21 – 25 years
6. What are the monitoring tools, indicators that you use to measure access, attitude, age appropriateness?

6.4. Focus Group Discussion Guide

FGD INFORMANT INTERVIEW GUIDE

Decent work and Economic opportunities

5. How would you describe the current work situation in this community with regard to;
    a. Employment and Decent work conditions,
    b. Labour Rights and promotion of safe and secure working environments for young women and men? ***(Describe decent work as legal, gainful/paying, and harmless work)***
6. In your view, what are the challenges that hinder availability of decent work opportunities for young women and men aged 15—25 in this community?
    a. How can these challenges be addressed?
7. What are the opportunities for informal or self-employment for youth in this community?
8. What are the skill sets/trainings required by youth to tap into those opportunities?
    a. What challenges do you believe hinder acquisition of these market-driven skills by young women and men aged 15—25 to enable them access decent job opportunities in the informal sector?
    c. In what ways do you believe that these challenges can be addressed?
7. Do the youth have easy access to micro finance services and information, in your community?
    a. Are the government funds and information adequately targeting the youth?
8. What challenges do adolescents living with disabilities face in accessing decent work opportunities and skills? Are there specific facilities and personnel to support this group of vulnerable youth?

Sexual and reproductive health services and information

9. What is the reason young people visit health facilities? ***(Probe for: Contraceptive counseling, Contraceptive purchasing, Prenatal care, Pregnancy test, STI screening, STI treatment, HIV/AIDS test, Gynecological exam, Peer counseling, Abortion-related services, Infertility consultation, General health service (non-RH oriented).***
    a. How do they get to know about the facilities/services? Radio, referrals, posters, etc.
10. Who do you consider to be the most at risk adolescent and youth? ***Probe for: house helps, workers in eateries, boda boda riders, commercial sex workers, etc. Take note of the gender.***
    a. What support do they have in accessing information and health care services?
11. Are there any educational materials provided to the young people? What are the subject(s) covered in this material ***(probe for maternal health, contraception, STIs, HIV/AIDS, Abortion, Drugs/alcohol abuse, etc.)***
    a. Are the young people told/given chance to return, or are they followed up?
    b. Are you (as young people) satisfied with the services offered? Would you return to the facility if need arises/in the future? What is the reason young people do/do not go there or return to the facility? ***Probe for; free from stigma and discrimination, safe & secure environment, expensive services, no drugs available, long waiting hours, knowledgeable and competent staff Convenience of opening times, distance to get there, quality services, availability of services, privacy and need for anonymity, cost, lack of information about services provided, etc.)***
12. Are youth in your community provided with services to prevent pregnancy? Probe for knowledge of services/types.
    a. Are youth given access to means to protect themselves from sexually transmitted infections, including HIV/AIDS?

Reproductive health knowledge, attitudes and practices

11. Which are the facilities in your neighborhood/community that provide reproductive health services? ***Name and classify them; government, private, faith based and services.***
    a. What are the services offered at these facilities? (quote nearest or familiar facility). Probe for services like; insurance, laboratory testing, diagnosis, STI treatment, referrals for diagnosis/treatment, provide/refer for counseling, issue a contact or partner notification slip, etc.)
    b. Who provide these services? Probe for the level of training of the service provides? doctor, nurse, peer educator, etc.
    c. Do the health service providers physically examine you when you visit the Health facilities? ***Probe for privacy of consultation, customer care, if results are explained to them after examination, etc.***
12. Who are the most in need of Reproductive Health services in your community? Probe for boys and Girls?
13. What are the common services that are provided to young people in the age brackets?

a. 12 to 15 years?
b. 15 to 20 years?
c. 20 to 25 years?

14. What challenges do adolescents living with disabilities face in accessing sexual reproductive health and rights? Are there specific facilities and personnel to support this group of vulnerable youth?
15. Do you get parental/guardian support in the seeking and in the provision of reproductive services to a youth client?
16. Are there spiritual counsellors in your community? What services do they offer young people?

6.5. Observation Guide

HEALTH FACILITY OBSERVATION CHECKLIST

1. Level of facility where observation took place, e.g. Health Centre III, IV, Hospital
2. Type of facility: Government/Ministry of Health, Government/other, Family planning association, Other – NGO/Missionary, Private
3. Structure of facility: Youth-only facility, Youth-only facility hours, Integrated services,
4. Provider of counselling service: Qualification and gender
5. Provider attitude and client care
6. Privacy for consultation or youth friendly center?!
7. Availability of educational materials
8. Numbers, age and type of clients visiting the facility
9. Inquire about affordability of services and consultation fees
10. Inquire about availability of health insurance services
11. Inquire about availability of logistics and drugs
12. Inquire about opening and closing time
13. Look for or assess the availability of youth friendly corner/specialized services for vulnerable youth and adolescents

7.0 References

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