MAPPING OF THE RISKY BEHAVIOURS AMONG ADOLESCENTS IN NAKAWA, MAKINDYE AND LUBAGA DIVISIONS, KAMPALA CITY

Study report for

UGANDA YOUTH DEVELOPMENT LINK (UYDEL)

in association with

THE LUTHERAN WORLD FEDERATION

and

BREAD FOR THE WORLD

Study Team
Badru Bukenya, PhD
John Mulo Mugwanya
Jacqueline Nakaiza

Address
Team Initiatives Limited (TIL)
P. O. Box 3963, Kampala.
Teachers' House, Plot 28/30, Bombo Road.
Tel: +256782673107 /0772 403 991
Email: teaminitiatives@gmail.com

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1. Introduction

This consultancy was commissioned by Uganda Youth Development Link (UYDEL) to produce a contextualized understanding of the risky behaviours among adolescents in Uganda's capital Kampala to enhance the feasibility of the Enhancing Age-appropriate Adolescents Sexual Reproductive Health Services for Young People below 25 Years (EASY-U25). EASY-U25 is a project implemented by UYDEL with funding from the Lutheran World Federation (LWF). The study and this report were managed by consultants from Team Initiatives Limited (TIL). The report is organised as follows: it starts with a quick overview of the sexual and reproductive health situation for young people in Uganda. It then outlines the methodological approach to the study. This is followed by the concurrent presentation and discussion of the findings, which are organised as per the study objectives. It ends with drawing conclusions and making recommendations that UYDEL can adopt to improve its programming for HIV/AIDS and SRH services.

1.1 Context of Risky Sexual Behaviours among young people in Uganda

World over, the age bracket 10-24 years is considered to be a critical stage in human development. The transition from adolescence to adulthood that is characteristic of this stage involves tremendous behavioural, psychological and physiological changes, which coupled with other factors such as poverty and low education, make young people susceptible to engaging in risky behaviours (MoH, 2019). Such risky behaviours include early sexual debut, multiple partners, unprotected sexual intercourse, transactional or coerced sex, inter-generational sex, sex under the influence of alcohol or drugs, and drug abuse (Ruark, 2015; Swahn et al 2018). Bukenya et al (2020) argue that such risky behaviours expose adolescents to negative outcomes including unintended and early pregnancies, sexually transmitted infections (STIs), and potentially death. UNAIDS identifies adolescents and young people as a "key population" category at great risk of HIV/AIDS.

These high-risk behaviours and associated outcomes are a reality in Uganda where 34.8% of the total population are young people aged 10-24 (UBOS 2016). Uganda has a high proportion of adolescents giving birth before the age of 20 reported to be at 25% nationally and 30% in Kampala (Uganda Demographic Health Survey (UDHS), 2016). Early childbirth increases the risk of pregnancy complications, low birth weight, and maternal and infant mortality. MoH (2019) reports that almost 3 in 10 (28%) maternal deaths in Uganda occur in young women aged 15 - 24 years.

While addressing the SRH rights of adolescents and young people is critical to improving health outcomes, little is known about the prevalence of the high-risk behaviours and their drivers especially among urban-based young people in Uganda (Bwambale, et al 2021; Tuhebwe et al 2021). Yet, understanding risky behaviours and associated factors is central to enabling policymakers to develop feasible SRH programmes for adolescents and young people (Bukenya et al 2020) – and an essential intervention for meeting the 2030 Sustainable Development Goal (SDG) targets related to sexual and reproductive health and rights for all adolescents (Tuhebwe et al 2021). As part of the Enhancing Age-appropriate Adolescents Sexual Reproductive Health Services for Young People below 25 Years (EASY-U25) the Uganda Youth Development Link (UYDEL), and its partners Lutheran World Federation and Bread for the World, commissioned the current study to map the risky behaviours of adolescents and young people (aged 10–24 years) in the three Divisions of Lubaga, Makindye and Nakawa.

1.2 Purpose of the Study

The purpose of this study is to diversify UYDEL and its partners' understanding of the risky behaviours among the Youths in Nakawa, Makindye, and Lubaga division in Kampala. It intends to disaggregate the various risky behaviours and practices among the youths, examine the various reinforcements to such risky behaviours, and the role of youths in countering these behaviours. In so doing the mapping exercise will assist UYDEL and partners to:

i) Identify priority areas of change, for action and advocacy initiatives with and by young people in regard to access and challenges youth face in utilizing SRHR services with public and private service providers.
ii) Identify risks and improve public risk awareness and mitigation measures.
iii) Support youth to understand the consequences of risky behaviour so they can make better choices and avoid negative consequences.

1.3 The specific objectives

The specific objectives of the assignment are three-fold:

1. To find out the risky behaviours and practices among the Youth in Nakawa, Makindye and Lubaga divisions, in Kampala City.
2. To understand the drivers of risky behaviours and practices among the Youths in Nakawa, Makindye and Lubaga divisions, in Kampala City.
3. To ascertain the role of Youths in countering the risky behaviours and practices in their communities.

2. Methodology

2.1 Study design

To diversely apprehend risky behaviours and practices among young people in Nakawa, Makindye, and Lubaga Divisions, in Kampala City this study employed a cross-sectional survey design drawing on both quantitative and qualitative methods of data collection. Quantitative methods involved administering a standardized interviewer-guided questionnaire to randomly sampled young people aged 10-24 years. Qualitatively, we conducted Focus Group Discussions with adolescents and young people to explore the risky behaviours and practices in-depth and give context to key aspects from the quantitative findings. We also engaged in a critical review of the existing literature on risky behaviours among young people in urban areas and how they influence HIV and SRH issues.

2.2 Study Area

As noted earlier, this study was conducted in Lubaga, Makindye and Nakawa Divisions, in Kampala City. Being the focus areas of the EASY-U25 project the three Divisions were pre-determined in the Terms of Reference (ToR) for the assignment. Care was taken to ensure that respondents are drawn from the EASY-U25 priority parishes as summarized in Table 1.

2.3. Sample Size and sampling strategy

The number of female and male adolescents and young people aged between 10-24 years was scientifically determined with the assistance of Roasoft – a web-based software for determining sample sizes[1]. With a 95% confidence level, 5% margin of error and from an estimated population of 527,478 young people in Kampala (35% of the total population of 1.5 million residents (UBOS 2016)), a minimum sample of 384 young people was expected for this study.

Given that we could not obtain a complete and up-to-date list of households within each parish let alone village it was not possible to use simple random sampling to select respondents. Instead, we used systematic random sampling to select households (sampling unit). A research assistant (RA) was assigned to work in one village every day. Research assistants were told to choose every 10th household along the main road that dissects through the village. To easily navigate the different villages RAs were advised to work with local leaders. The starting point for data collection was determined every morning at the Local Council 1 residence or that of the youth chairperson (whoever was available to work with RAs). Where a sampled household was unavailable for interview it was replaced by the next immediate household. Using this strategy, we covered a total of 20 parishes: seven parishes in Lubaga Division, eight in Makindye and five in Nakawa (see Table 1 for the breakdown).

[1] http://www.raosoft.com/samplesize.html

Table 1: Respondents distribution by Division and Parish (N=570[2])

Lubaga	Number	%	Makindye	Number	%	Nakawa	Number	%
Busega	13	2.27	Bukasa	14	2.46	Banda	36	6.28
Kabowa	26	4.54	Buziga	13	2.27	Kitintale	52	9.08
Lubaga	56	9.79	Kibuye 2	18	3.14	Mbuya	25	4.37
Lungujja	40	6.98	Makindye	26	4.54	Mutungo	24	4.2
Mutundwe	24	4.19	Munyonyo	13	2.27	Naguru	27	4.71
Nateete	68	11.87	Nsambya	46	8.04			
Ndeeba	12	2.1	Salaama	26	4.54			
			Wabigalo	14	2.45			

From the qualitative angle, six focus group discussions were held with young people to aid the triangulation of quantitative data. In each division we held two FGDs (one for male and another for female participants). On average, each of the six FGDs had 10 young people.

2.4 Quality Control, Data Management and Analysis

This study adapted a standardised questionnaire developed by Uganda AIDS Commission, United Nations Uganda, PACK and Irish Aid (2016). While we kept most of its original items, the tool was modified in consultation with UYDEL officials to suit the urban study context of the current study. The tool included questions on age of sexual debut, number of sexual partners, condom and alcohol use during sex, transactional sex (receiving money, transport, food, drink or other goods in exchange for sex), and attitudes about gender-based violence among other variables. The questionnaire was uploaded on handheld tablets using the KoboCollect toolbox. We inbuilt quality checks in KoboCollect toolbox to ensure consistency during data collection. RAs together with their supervisors crosschecked for errors in the data while still in the field.

Data was collected by a team of twelve well-trained research assistants (RAs) and three supervisors. These RAs received training on research ethics to ensure that the study

[2]One respondent had missing information about their location/Division.

complied with the principles of ‘do no harm’ to children and young people participating in the study. We allocated 4 RAs and 1 supervisor per Division. Fieldwork was conducted from April 24 to May 3, 2021.

After the data collection exercise, data was downloaded from the server and exported into Stata for further analysis. In Stata quantitative analysis involved the following:

- Data exploration and management to identify missing data, label variables, re-coding, rename, etc
- Undertake descriptive analysis with frequency tables for categorical variables
- Univariate analysis using frequency tables, summary stats, i.e., demographic and sexual behavioural characteristics
- Bivariate analysis with 2xn tables, chi-square stats by respondent’s sex and age category and residence.
- The level of statistical significance was set at a probability of $P < 0.05$ for all tests.

Qualitative data management: FGDs were audio recorded in the local language and later transcribed in English. Through a highly iterative process, the consultants carefully studied the scripts and coded them into themes and sub-themes related to the objectives of the mapping. As noted in the next chapter, qualitative findings were used to triangulate and provide context to the quantitative data.

3. Presentation and discussion of findings

A total of 571 adolescents and young people took part in the quantitative component of the study of which 49% were females and 51% males. The average age of the sample was 16.78 years with the majority (54%) educated up to secondary level. Majority of the respondents were drawn from Lubaga Division (42%) with Nakawa and Makindye splitting the balance by 28% and 30% respectively. Majority of the respondents were Christians Catholics (33%), Anglicans (17.2%) and Born-Again Christians (18.7%) while Muslims constituted 26% of the sample. More information on these and more sociodemographic variables is captured in Table 2.

Table 2: Socio-demographic characteristics of respondents

Characteristic	Females, n(%)	Males, n(%)	Lubaga n(%)	Makindye n(%)	Nakawa n(%)	Total
All	277 (48.5)	294 (51.5)	238 (41.8)	169 (29.7)	163 (28.6)	571
Age group						
10-14	53 (19.1)	29 (9.9)	29 (12.2)	14 (8.3)	39 (23.9)	82 (14.4)
15-19	132 (47.7)	104 (35.4)	101 (42.4)	82 (48.5)	53 (32.5)	236 (41.3)
20-24	92 (33.2)	161 (54.8)	108 (45.4)	73 (43.2)	71 (43.6)	253 (44.3)
Marital status						
Currently married/Cohabiting	37 (13.4)	33 (11.2)	32 (13.5)	8 (4.7)	30 (18.4)	70 (12.3)
Currently not married	240 (86.6)	261 (88.8)	206 (86.6)	161 (95.3)	133 (81.6)	501 (87.7)
Highest education level						
Primary	100 (37.7)	92 (32.6)	78 (34.8)	51 (30.7)	63 (40.4)	192 (35.1)
Secondary	139 (52.5)	154 (54.6)	127 (56.7)	94 (56.6)	71 (45.5)	293 (53.6)
Post-secondary	26 (9.8)	36 (12.8)	19 (8.5)	21 (12.7)	22 (14.1)	62 (11.3)
Religion						
Catholic	98 (35.4)	89 (30.3)	77 (32.4)	61 (36.1)	49 (30.1)	187 (32.8)
Moslem	59 (21.3)	87 (29.6)	63 (26.5)	38 (22.5)	44 (27.0)	146 (25.6)
Anglican	51 (18.4)	47 (16.0)	44 (18.5)	33 (19.5)	21 (12.9)	98 (17.2)
Born again	56 (20.2)	51 (17.4)	42 (17.7)	30 (17.8)	35 (21.5)	107 (18.7)
Others	13 (4.7)	20 (6.8)	12 (5.0)	7 (4.1)	14 (8.6)	33 (5.8)
Occupation						
Casual worker or student	84 (30.3)	69 (23.5)	80 (33.6)	41 (24.3)	32 (19.6)	153 (26.8)
Artisan skilled technician	10 (3.6)	44 (15.0)	29 (12.2)	14 (8.3)	11 (6.8)	54 (9.5)

Characteristic	Females, n(%)	Males, n(%)	Lubaga n(%)	Makindye n(%)	Nakawa n(%)	Total
Trader/Business	37 (13.4)	60 (20.4)	40 (16.8)	33 (19.5)	23 (14.1)	97 (17.0)
Others	146 (52.7)	121 (41.2)	89 (37.4)	81 (47.9)	97 (59.5)	267 (46.8)

The findings below are organised following the three research objectives outlined earlier.

3.1 High-risk behaviours among adolescents and young people in Kampala

Table 3 provides a summary of the high-risk behaviours that young people in Kampala engaged in. We discuss each of them at a time.

Sexual activeness

Almost 6 in 10 (58% or 332/571) of the respondents were sexually active – a figure comparable to 62% reported by Renzaho et al (2017) among young people in the areas of Lubaga and Makindye, Kampala. Disaggregated by gender, a higher proportion of boys (69.4%) was sexually active than that of girls (46.2%) in the sample – and the differences were statistically significant (see Table 2). This finding is at variant with most previous studies which report girls as more sexually active among young people below the age of 25 years. Similar to other studies, however, sexual activity was positively related to age with 9 in 10 of the older participants in our sample (i.e., those aged 20-24 years) reporting that they were sexually active. Analysed by location, the proportion of sexually active respondents were 58%, 56.2% and 60.1% in Lubaga, Makindye and Nakawa Division respectively (the differences between the three locations were not statistically significant).

Age of sex debut

The average age of sexual debut was 17 years. This is similar to the national average of 17.1 years as reported by the 2016 Uganda Demographic and Health Survey and comparable to that reported by studies in the same area (see, Renzaho et al. 2017 who report 16.4 years). It is important to note however that in our sample males reported to start indulging in sexual activities earlier (16.9 years) than females (17.5 years) and these differences are statistically significant (P=0.0509). With statistical significance (P=0.002), this study finds that participants in Nakawa reported earlier sex debut (16.7

years) than their counterparts in Lubaga (16.9 years) and Makindye (17.9 years). The existence of programmes for young people by NGOs such as UYDEL which could explain the delay in sex debut in Makindye.

Of the 293 respondents that had never engaged in sex, the study established that only 28.2% were willing to delay sexual initiation until marriage. This low percentage can in part be attributed to the fact that the environment in which respondents are raised is generally permissive to sexual activities among young people. For instance, almost half (47.8%) of the surveyed respondents reported that their peers/friends think they should have sex; 37.1% agreed that adults approve people of their age to having sex while 23.8% said their parents wouldn't be upset/bothered if they found out that they are having sex. These findings imply greater inclination for young people to engage in sexual practices at quite an early age. Similar to UAC et.al, (2016) this study illustrates that the social environment influences young people's decisions to engage in pre-marital sexual practices.

Table 3: Risky behaviours by respondent's sex, age category and residence

Characteristic	Sex of respondent		P-value	Age category			p-value	Division			p-value
	Female n(%)	Male n(%)		10-14 n(%)	15-19 n(%)	20-24 n(%)		Lubaga n(%)	Makindye n(%)	Nakawa n(%)	
All	277 (48.5)	294 (51.5)		82 (14.4)	236 (41.3)	253 (44.3)		238 (41.8)	169 (29.7)	163 (28.6)	
Ever had sex											
No	149 (53.8)	90 (30.6)	**<0.0001**	79 (96.3)	144 (61.0)	16 (6.3)	**<0.0001**	100 (42.0)	74 (43.8)	65 (39.9)	0.770
Yes	128 (46.2)	204 (69.4)		3 (3.7)	92 (39.0)	237 (93.7)		138 (58.0)	95 (56.2)	98 (60.1)	
Condom use											
No	86 (67.2)	137 (67.2)	0.995	2 (66.8)	50 (54.4)	171 (72.2)	**0.009**	101 (73.2)	61 (64.2)	61 (62.2)	0.155
Yes	42 (32.8)	67 (32.8)		1 (33.3)	42 (45.6)	66 (27.9)		37 (26.8)	34 (35.8)	37 (37.8)	
Multiple sexual partners											
No	82 (64.1)	115 (56.7)	0.181	2 (66.7)	51 (55.4)	144 (61.0)	0.631	79 (57.7)	64 (67.4)	53 (54.1)	0.148
Yes	46 (35.9)	88 (43.4)		1 (33.3)	41 (44.6)	92 (39.0)		58 (42.3)	31 (32.6)	45 (45.9)	
Awareness of partner's HIV status											
No	31 (31.6)	59 (41.0)		0 (0)	30 (50.0)	60 (33.2)		37 (34.9)	32 (44.4)	21 (32.8)	0.304
Yes	67 (68.4)	85 (59.0)	0.140	1 (100)	30 (50.0)	121 (66.9)	**0.0480**	69 (65.1)	40 (55.6)	43 (67.2)	
Transactional sex											
No	92 (71.9)	174 (85.7)	**0.002**	3 (100)	74 (80.4)	189 (80.1)	0.689	108 (78.8)	77 (81.1)	80 (81.6)	0.848
Yes	36 (28.1)	29 (14.3)		0 (0.0)	18 (19.6)	47 (19.9)		29 (21.2)	18 (19.0)	18 (18.4)	
Age of sex debut, mean (SD)	17.5 (2.4)	16.9 (2.8)	0.0509	11 (3.6)	15.6 (1.7)	17.8 (2.6)	**<0.0001**	16.9 (2.7)	17.9 (2.01)	16.7 (3.0)	**0.002**
Sex under alcohol influence											
No	110 (85.9)	172 (84.3)		3 (100)	85 (92.4)	194 (81.9)		122 (88.4)	73 (76.8)	86 (87.8)	**0.034**
Yes	18 (14.1)	32 (15.7)	0.687	0 (0.0)	7 (7.6)	43 (18.1)	**0.043**	16 (11.6)	22 (23.2)	12 (12.2)	
STI											
No	53 (41.4)	165 (80.9)		3 (100)	58 (63.0)	157 (66.2)		102 (73.9)	66 (69.5)	49 (50.0)	**<0.0001**
Yes	75 (58.6)	39 (19.1)	<0.0001	0 (0.0)	34 (37.0)	80 (33.8)	0.390	36 (26.1)	29 (30.5)	49 (50.0)	
Forced sex/rape											
No	109 (76.2)	186 (88.6)	**0.002**	2 (16.7)	77 (76.2)	216 (90.0)	**<0.0001**	124 (86.7)	90 (90.9)	80 (72.7)	**0.001**
Yes	34 (23.8)	24 (11.4)		10 (83.3)	24 (23.8)	24 (23.8)		19 (13.3)	9 (9.1)	30 (27.3)	
Wife is justified to refuse having sex with her husband											
Agree	209 (50.1)	208 (49.9)		52 (12.5)	166 (39.8)	199 (47.7)		177 (74.4)	127 (75.2)	112 (68.7)	0.258
Disagree	50 (39.7)	76 (60.3)	**0.028**	18 (14.3)	57 (45.2)	51 (40.5)	**<0.0001**	54 (22.7)	33 (19.5)	39 (23.9)	

Condom use

Consistent condom use was low among the sexually active young people in our sample. Merely 3 in 10 (33% of the 332) young people consistently use condoms for both male and female study participants. This percentage is considerably lower than that reported by Renzaho et al. (2017) with 54.1% condom utilisation among young people in the slum areas of Lubaga and Makindye. However, the finding is comparable to the 33.8% reported by Swahn et al (2018) among young people in the slum areas of Kampala. These findings should be less surprising considering that only 40.6% of the young people in this study reported to have received sensitization on how to use a condom. Surprisingly young people in the 15-19 age bracket were more likely to use condoms (46%) compared to the older age group of 20-24 years (28%) - and the differences between the two groups are statistically significant. Analysis by location suggests no statistical differences among respondents in the three divisions.

Multiple sexual partners

Data in Table 3 further reveals that 4 in 10 (40%) of the sexually active respondents (134/331) had more than one sexual partner. This rate was slightly lower than the 44.9% reported by Swahn et al (2018) among young people in the slum areas of Kampala and 44% reported in the 2017 National Cross-Sectional Study on adolescent health risk behaviours in Uganda (MoH et al 2017) but quite comparable to the 41.1% rate reported by Renzaho et al. (2017) among young people in Lubaga and Makindye. Male participants (43%) are more likely to have multiple sexual partners than the female participants (36%) although the differences between these two is not statistically significant (P=0.009). While not statistically significant, participants in the 15-19 age group were more likely to report multiple sex relationships compared to other age groups. By location, the rate of multiple sexual relationships was lower in Makindye at 32.6%, 42.3% in Lubaga, and 45.9% in Nakawa but these differences were not statistically significant.

Awareness of partner's HIV status

About 6 in 10 (63%) of the sexually active respondents reported being aware of their partners' HIV/AIDS status. Compared to males (59%), more female participants (68%) reported awareness of their partners HIV/AIDS status, but the differences were not

statistically significant. Participants in the older age group (20-24 years) indicated greater awareness of their partners' HIV status than the 15-19 years age group. As argued by Ssebunya et al (2019:7), such findings have far reaching "implications for HIV transmission among adolescents especially if one of the partners was already infected with HIV". That almost 4 in 10 (37%) respondents are not aware of their partners' HIV status should be of great concern to UYDEL and partners given the low uptake of condoms earlier reported. No statistical differences between the three divisions were noted with regards to respondent's self-reported awareness of partners' HIV status. In Lubaga the proportion aware was 65.1%, 55.6% in Makindye and 67.2% in Nakawa.

Transactional sex

One in five sexually active adolescents and young people (19.6%) confessed to have engaged in transactional sex at some point in their lives. This rate is slightly lower than the 23.2% reported by Swahn et al (2018) among young people in Kampala slum areas. However, similar to Swahn's analysis our study finds that more female respondents (28%) made this confession compared to their male counterparts (14%) and the differences here were statistically significant. Participants in focus group discussions (FGDs) reported that women expect men to provide for them: "all that girls care about is money" (23-year-old male FGD participant Lubaga). No statistical differences between respondents in the three divisions were noted with regards to transactional sex.

Alcohol abuse

This study established that a significant number of respondents use alcohol in ways that put their health at risk. For instance, 15.1% reported that they had had their last sex encounter under the influence of alcohol. More respondents in Makindye admitted to engaging in sexual activities under the influence of alcohol compared to their counterparts in Lubaga and Nakawa (P=0.034). In addition, this habit was more common among respondents in the older age categories of 20-24 years (P=0.043) but no gender differences between male and female respondents were noted here (P=0.687). These findings are comparable to those reported by UAC et al., (2016) who found 18.8% of young people in Karamoja sub-region having engaged in sexual intercourse under the influence of alcohol. Internalization on alcohol as a driver of risky

behaviours and practices centers on, the incapacitating mental effects it imposes to young people and/or their partners to make logically safe decisions about sexual practices such as using condoms.

Sexually transmitted infections and treatment

Three in ten (34.3%) sexually active young people reported STIs-like symptoms. Worryingly, 16% of the respondents with STI-like symptoms did not seek medical treatment. Given the high rates of non-condom use, this implies heightened risks of passing on STIs to their partners. STI-like symptoms were predominantly among female than male respondents ($P<0.0001$). Half of the respondents in Nakawa Division reported STI-like symptoms compared to 30.5% in Makindye and 26.1% in Lubaga. The differences between the three divisions were highly significant ($P<0.0001$). However, we did not observe differences among respondents reporting STI-like symptoms on the basis of age.

Gender-based violence

We studied the attitudes of our respondents towards gender-based violence (GBV). One in ten (10%) respondents felt that men are justified to beat their partners. However, this wasn't a one-way affair as a similar proportion of respondents (9.8%) reported that women are justified to hit their men.

Two in ten (22%) respondents believed that women have no reason to deny sex their partners. While no statistical differences between the three divisions were noted, it is important to note that more male respondents 6 in 10 (60.3%) compared to 4 in 10 (39.7%) females had this view and these differences were statistically significant ($P=0.028$).

Young people in this study felt that there is high level of violence against HIV/AIDS positive women in the community. About 7 in 10 (69.87%) agreed with the statement that women experience violence from their partners after sharing their HIV positive status. Interventions that encourage HIV/AIDS testing as couples could reduce such

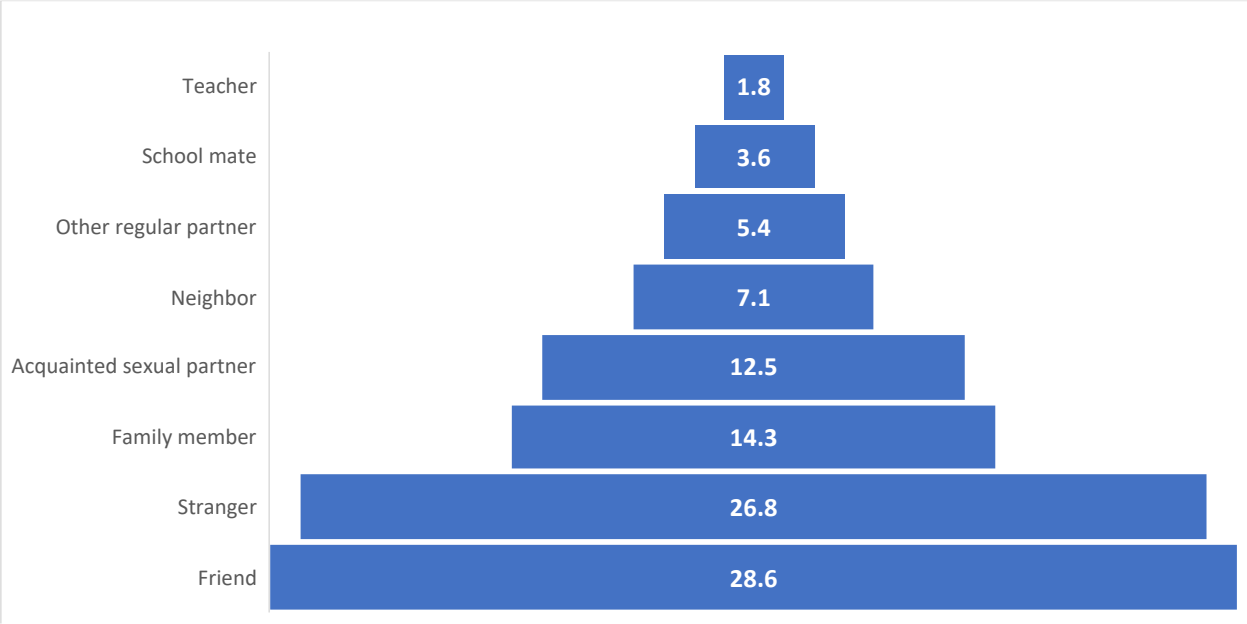
practices. This is because partners would be prepared by professional counsellors before obtaining their HIV test results.

Sexual violence

About 16% of the young people reported experiencing forced sex. Of those, half (51.7%), indicated that they had been coerced in the 12 months preceding the survey. Similar to the findings of the Uganda violence against children survey (MGLSD 2018) this study finds a gender dimension to sexual violence whereby female participants reported higher rate (23.8%) of sexual coercion compared to their male counterparts (11.4%) and the differences were statistically significant (P=0.002). A large body of evidence from both developing and industrialized countries suggests that sexual coercion in childhood and early adolescence is associated with high-risk behaviours later in life. It is suggested that coercion into sex is linked to low condom use, unwanted pregnancy, and HIV/AIDS (Kouyoumdjian et al., 2013, Wagman et al., 2009). There is further evidence to suggest that young females coerced into sex tend to engage in risky sexual behaviours such as having multiple sexual partners (Stöckl et al., 2014, Wagman et al., 2009, Bott, 2010, Pilgrim et al., 2013, Elwange and G.O., 2017). The main explanation for this is psychological: the stigma and trauma associated with sexual abuse can diminish a girl's sense of self-worth and reduce her motivation to protect herself against pregnancy or disease (Geary et al., 2008). Other risky behaviours engaged in by female and male survivors of sexual abuse are substance abuse, multiple sex partners, choosing abusive sexual partners, and lower rates of contraceptive use (Bott, 2010).

As shown in Figure 1, the majority of surveyed respondents reported that they were coerced by their friends, strangers and family members. Our evidence is consistent with Lundgren and Amin (2015) who observe that sexual violence "can occur at any age—including childhood—and can be perpetrated by parents, family members, teachers, peers, acquaintances and strangers, as well as intimate partners".

Figure 1: Self-reported perpetrators of sexual violence



3.2 Drivers of high-risk behaviours among young people

Many factors in young people's environments influence risky behaviours and practices. Below we summarise what study participants identified as the main factors that push them and/or their peers into risky behaviours.

Inadequate HIV/AIDS knowledge

Several studies acknowledge that young people engage in risky behaviours such as inconsistent condom use due to limited knowledge on HIV/AIDS transmission (Bukenya 2018; Swahn et al 2018; Swahn, M. H., Tuhebwe et al 2021). We assessed the level of HIV knowledge by generating an aggregate score from 10 factual questions on the subject. Worryingly, only 35% of respondents had adequate HIV/AIDS knowledge. The proportion of male and female participants with adequate knowledge was 39% and 31% respectively. These figures are worrisome because they are below the national average reported over six years ago by UAC (2015). According to UAC (2015:18) the percentage of young women and men aged 15-24 who as of December 2014 correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission was 38.5% (42.3% for men and 35.7% for women).

Such lack of information reduces young people's perception of the risk of acquiring deadly diseases like HIV (Palomino-González et al 2019; UAC 2015). As one FGD participant observed "people are playing with their lives out there …we need to remind and sensitize the community that HIV is real and kills … " (Female FGD Makindye). In another FGD, participants reported that young people have forgotten that HIV/AIDS kills: "Because we are still young many of us think that we are invincible" (FGD with young men in Nakawa).

Poverty and related economic hardships

Swahn et al. (2018) analysis of the correlates of risky behaviours in Kampala slums indicates that poverty and related economic hardship among the urban-based adolescents and young people exacerbate the likelihood of engaging in risky behaviors. In Nakawa Division female FGD participants attributed transaction sex to the biting poverty in the area alongside non-availability of income earning opportunities. Relatedly, participants observed that the COVID-19 pandemic has aggravated the economic challenges of young people which pushed them into adopting dangerous survival strategies.

> "Many girls in this community have resorted to sex work which is dangerous to their lives. Sex work is done to act as a source of income, this is due to the high poverty levels in the community, which has increased due to the Covid 19 restrictions like the lockdown (20-year-old female FGD participant Banda).

However, in one FGD respondents indicated that other girls are into commercial sex not by their will but by force or due to trafficking

> Where I stay there are some children live with their distant relatives. These got them from the village and brought them to Kampala not knowing what they are going to do. Girls are being told to sell their bodies (engage in sex work). For boys, they force them to sell drugs and steal things ... (23-year-old FGD participant Lukuli Makindye).

Alcoholism and substance abuse

Previous research demonstrates that alcohol use and misuse among youth is a significant concern in Uganda especially in the slums of Kampala (Swahn et al. 2018). Our respondents made a clear link between alcoholism and gender-based violence (GBV). About 9 in 10 of the young people interviewed argued that men who regularly take alcohol are more likely to use violence on their partners. This finding relates closely to Swahn et al (2015) who report that drunkenness was strongly correlated to sexual violence among girls and young women in Kampala slums.

Through FGDs participants reported how being intoxicated with alcohol leads one into risky behaviours:

> Alcohol makes one become foolish… you end up getting a girl. When this happens, you end up not putting a condom because you are drunk, and you don't know what is going on. You wake up when you have been infected with the virus (21-year-old male FGD participant Banda 3/5/2021).

> when the vibes are high in some instances when you have taken in your "*torrero*" [Cheap high content alcoholic gin], there is no way you can resist going into sex with that girl (FGD with male participants, Lubaga).

Similar to Ssebunya et al (2019), drug and substance abuse were identified by respondents in this study as drivers of behaviours that put young people and their peers at risk of acquiring HIV and negative SRH outcomes. According to one FGD:

> Young people use drugs to get vibes [mental stimulation] to the maximum. One might use excess of them and in the end, they engage in acts that could lead them to be "*bitten by the dog*" [slung for contracting HIV/AIDS] (24-year-old male, Lubaga).

In another FGD participants explained how they get so attracted to women when they are high on drugs.

> I had some friends who were addicted to some drugs. For them they would do their things when they are not sober, they end up buying prostitutes when they can no longer understand (21-year-old Nakawa).

Weak parental guidance

Some risk behaviours were attributed to the weaking parental guidance leading to unregulated access to TVs and pornographic content on the internet among young people. Study participants reported that their parents are either shy or ignorant about SRH issues: "for some of us our parents are shy. They can't tell us how HIV is transmitted and yet getting SRH services is also hard" (FGD with female participants, Nakawa). The alternative for young people with shy parents is to learn from their peers, TVs and/or the internet. Young people reported that they "get vibes to practice what they see on TV and the internet with whatsoever person they find that could quench their urges" (FGD with young male participants in Lubaga Division). Inspired by the TV and internet celebrities "[young women] put on things that even expose their nickers, which in most cases attract many men to make advances to such young women…" (FGD with young men Lubaga). Indecent/provocative dressing and related acts were identified by Bukenya and Mugumya (2019) as key drivers of sexual abuse among high-

risk adolescent girls and young women in the districts of Gomba, Lyantonde, Luwero, Mityana, Mukono and Sembabule districts. Meanwhile all this happens in the presence of the Anti-pornography Act 2014 and a fully-fledged Pornography Control Committee.

Inadequate information on available services

While majority (84%) of survey respondents reported that they ever received information on HIV/AIDS and SRH, young people's awareness about HIV/AIDS and SRH services available in their community was in a wanting state. Almost half (45.8%) of all respondents claimed that they were not aware of HIV/AIDS services available in their area.

> "News about HIV/AIDS and SRH services is rare to come by in our community. For example, I stay in Kasenyi, we don't hear anything about hospitals or clinics where people can access these services. For us we are in a totally different world altogether (male FGD participant Banda).
>
> "These services are not accessible because people do not have information on these services. If people were getting HIV/AIDS services from a certain provider, we would know that such a service is provided in this place, but we do not have information on the existence of such services" (18-year-old male FGD participant Kabowa Parish, Lubaga Division 3/5/2021).

Young people also pointed to information asymmetries between the learned and semi-illiterate and between the rich and poor. "For us who stay in the slums we are ignorant, we don't receive this HIV/AIDS and SRH information" (19-year-old male participant, Makindye).

The lack of information on available services limits SRH services like STI detection and treatment among young people in urban areas (Bwambale et al. 2021). For instance, 6.4% of our survey respondents indicated that reason for not taking an HIV test was that they didn't know where to the test.

Low access to youth friendly HIV/AIDS and SRH services

A significant number of respondents (44%) indicated that young people who need HIV/AIDS and SRH services do not have access to them! This challenge reflects in many guises.

One aspect relates to the nature of service providers. According to young people:

> In most cases youths fear going to places where they can get services on HIV/AIDS and SRH services and finding there those people that are by far older than them (23-year-old male FGD participant 3/5/2021).

Others reported that young people avoid services like male circumcision if the providers are not chosen carefully to appeal to young people. As one participant observed: “I would avoid [seeking for services] if it is a female young person that is in charge of safe male circumcision” (16-year-old male FGD participant 3/5/2021).

Young people reported that services like “condoms are in most cases put in large health facilities, yet where they are mostly needed are community clinics in Sserwadda zone which are nearer to people in communities” (18-year-old male FGD participant 3/5/2021).

FGD participants in Nakawa and Makindye identified some youth friendly spaces such as Naguru Teenage Center. However, they also noted that such facilities are few and congested: “the challenge with such spaces is that you find a lot of people, you can go like at 10:00 am then you end up finishing at 3:00 pm” (19-year-old male FGD participant Banda). Young people end up getting very tired and if the waiting continues, they may leave in frustration without accessing the services (17-year-old male participant from Makindye West).

Young people are discouraged by unfriendly/rude service providers. A participant in one of the FGDs summed up the quality of workers in public facilities as follows: “Hatred, rudeness, arrogance and selfishness are the order of the day from the government health workers” (Female FGD participant Nakawa). The following excerpts from FGDs further illustrate this point:

> I am a peer educator. Most youth tell us the conditions they find in hospitals; that some health workers are harsh. If you say something bad to the youth, he will go to his friends and tell them that hospital is not friendly, and it may lead many youths to boycott that hospital (21-year-old male participant Makindye).

A female FGD participant in Lubaga shared her terrible experience of seeking SRH services in a public health facility.

> I went there to give birth, but they were just abusing me. They also asked me annoying questions like who told me to open my legs for a man yet am a coward I cannot stand giving birth. They told me that if I don't shut me up they won't work on me but remember I was having labour pains so I couldn't shut up not until they slapped me and I gave birth (24 year old FGD participant Lubaga).

Peer/group influence

The cost associated with obtaining services

The expenses involved in obtaining services were cited by some participants as inhibiting access even although most HIV/AIDS and SRH services are meant to be freely provided in public facilities. According to young people "most of the centers we have around the community we have to pay for each and everything including condoms, testing or check-ups and even treatment of STDS" (22-year-old male participant from Makindye West). In Nakawa FGD participants observed that "payments are expected regardless of the economic status of the individual [or] seeking treatment from a public or private service provider" (female FGD Nakawa). In another FGD, a participant shared his experience as follows: "I went for HIV testing and they asked me for 10,000 UGX yet I thought it was free" (19-year-old male participant from Makindye West).

Where services are free young people claimed that government distributes poor quality products which are less appealing to them. One FGD participant in Nakawa Division had this to say: "the free condoms distributed by government tear easily and have bad smell" (24-year-old female FGD participant Banda 3/5/2021).

Religious influence

Recent research done in Kampala confirm that religious and cultural beliefs are strong impediments to heavy behaviours like condom use among young people (Bwambale et al 2021). In some areas young people reported that they are misled by religious clerics sheiks and pastors who tell people that deadly diseases like HIV/AIDS can be healed by through prayer. Ignorantly, some people abandon their treatment (ARVs) (male FGD participant Lubaga). In another FGD, a participant observed as follows:

> "I am sorry to say but o religious people have played a big role in the spread of the virus especially among the born-again Christians. They say that that they can pray for an HIV patient and he/she gets healed. That is why most people don't bother to

protect themselves saying that the blood of Jesus is enough" (female FGD participant Lubaga).

Stigma

It is important to acknowledge that HIV/AIDS is still a stigmatizing disease (Ayiga et al 2013). Several young people reported that they avoid going to places where HIV/AIDS and SRH services are provided to avoid the stigma attached:

> "when someone sees you going for HIV/AIDS services like testing they may think that actually you are infected with in virus and may start *tormenting* you that you are living with HIV/AIDS yet in actual sense you might not be living with it" (24-year-old male FGD participant 3/5/2021).

Relatedly, another participant observed as follows:

> "it becomes hard for us to go and test for HIV fearing what our friends would say. [This is] because we assume if our friends found out about our visit to a nearby health centre to test for HIV, they would think we already have it [HIV] …" (Female participant, Makindye west).

Similarly, one female FGD participant noted that:

> "young people fear that their friends will laugh at them or even isolate them if they found out that they have been infected by the HIV/AIDS virus" (19-year-old female FGD participant Banda 3/5/2021).

Thus, this study confirms that like case is for adults (Ayiga et al 2013), the stigma that surround HIV is a barrier to seeking HIV/AIDS related services including testing for STIs and buying condoms among young people.

3.4 The role of adolescents and young people in countering the risky behaviours

The third objective of the study was to establish the role of adolescents and young people in countering the risky behaviours and practices in their communities.

Our findings indicate that despite the existence of strategies such as the National Child Participation Strategy (2017/18-2021/2022) public programmes for children and young people still take a top-down approach in Uganda (Government of Uganda and United Nations 2017). Formal initiatives where adolescent and young people have been able to have their voices heard on key issues that affect their wellbeing and development are countable. Indeed, when we asked survey respondents whether they have participated in any activity (e.g., campaign) for promoting access and/or uptake of HIV/AIDS and SRH services among young people in their community, about 15% answered in the affirmative. As Table 4 illustrates, those who participated mainly engaged in MDD activities, volunteering, meeting service providers and campaigning.

Table 4: Young people's participation in HIV/AIDS and SRH activities (n=85)

Activities	Lubaga N (%)	Makindye N (%)	Nakawa N (%)
MDD	4 (4.6)	9 (10.5)	14 (16.3)
Volunteering	7 (8.1)	9 (10.5)	8 (9.3)
Campaign	2 (2.3)	2 (2.3)	8 (9.3)
Meeting service providers	2 (2.3)	1 (1.2)	8 (9.3)
Meeting with local leaders	1 (1.2)	0	1 (1.2)
Other	7 (8.1)	1 (1.2)	1(1.2)

Excerpts from FGDs illustrate the nature of activities young people participated in.

> "I am a peer educator and I reach out to very many youths. I get condoms from the health facility and distribute to them" (18-year-old male FGD participant Banda 3/5/2021).
>
> "I report to local leaders whenever I hear youth trying to organize sex parties" (20-year-old female FGD participant Banda 3/5/2021).

Many of the activities/events mentioned by young people (e.g., Kabaka birthday run) are irregular (held on rare occasions), limited in scope (targeting affluent citizens) and their impact is not yet well documented. Yet, according to Government of Uganda and United Nations (2017:33), for participation to be meaningful it "must be integrated into the fabric of adolescents' [and young people's] lives, in order to provide them with the widest range of experience and prepare them to take up the rights and responsibilities of full citizenship" in order to contributes to the society's well-being.

Majority of the study participants indicated that their participation is at a personal level e.g. through following the ABC approach.

> "Me for now am abstaining until when the right time comes. Even then, we shall have to first go to the hospital for checking [do blood testing to ascertain HIV status]" (20-year-old male FGD participant Banda).
>
> "If I really can't help it, I always make sure my boyfriend uses protection" (19-year-old female FGD participant Banda).

Some young people reported that the role of addressing SRH issues is for the elected youth representatives who occupy formal spaces right from the village to national levels. As some FGD participants report:

> The government helped us to elect youth leaders. Just like you have seen we have a youth chairperson who mobilize us and voices out issues that affect us (18-year-old male FGD participant Lubaga 3/5/2021). Another young person added that "I cannot go to the zone chairperson because he is old. I take my issues to the youth leader with whom we share perceptions" (19-year-old male FGD participant Lubaga 3/5/2021).

However, FGD participants in Nakawa Division accused their youth leaders of being partial in their work: "We have youth leaders, but they only listen to their friends and ignore ideas from people that are not close friends" (22-year-old female FGD participant Banda 3/5/2021).

The formal youth structures suffer from structural weaknesses due to the fact that their formation is spearheaded by the governments of the day that have little incentive to

strengthen such structures. Moreover, it is apparent that the goal of their creation is to manipulate these institutions to support certain political agendas.

Young people also reported that their leaders mostly focused on economic activities such as credit and savings and getting them IGAs. HIV and SRH issues are currently not prioritised by young people's representatives. However, during a group discussion with young males in Lubaga participants explained that economic activities indirectly help them to avoid some risky behaviours.

> The truth is that [our chairman] has not been so involved in SRH and HIV/AIDS issues. But he has tried a lot in encouraging us to save. This means one is not going to get all the day's wage and spend it on a girl that you're making advances to…. only to be given sex yet from there you can even acquire AIDS from her.

Another participant added:

> The youth chairman has mobilised us to form a SACCO which helps us keep our small amounts of money instead of spending it on girls. In that way am sure that I will get my money, however small it is at the end of the year … I will get something productive out of it, instead of spending it on women.

UYDEL and partners could link up with such forums to explore ways on how HIV and SRH can be integrated in their activities.

Generally, respondents attributed the low and/or even complete lack of participation to absence of opportunities to do so. As noted in one of the FGDs: "I have never participated in any campaign because there has been no chance for us to participate in such arrangements in this community. However, if they come, hopefully we will be able to join them" (FGD with males Lubaga).

4. Conclusions and Recommendations

Addressing young people's sexual and reproductive health remains a huge challenge in Uganda particularly in urban contexts (Dlamini et al., 2019). This study confirms that the prevalence of high-risk behaviours is high among young people in the three divisions of Lubaga, Makindye and Nakawa. Addressing these issues requires urgent investment into comprehensive sexual and reproductive health system that is not only youth friendly but also one that takes into account the socio-cultural contexts of young people in urban areas. Given that young people aged 10-24 comprise a significant 35% of Uganda's total population, projects like EASY-U25 are worthwhile investments that could help the country in securing a productive and AIDS-free workforce.

Similar to Bwambale et al (2021) this study observes that lack of awareness of SRH information, where to seek services, as well as maltreatment by health workers often limit young people's access to HIV and SRH services including STI testing, treatment and condom use. In view of these findings and in consultation with young people, the following recommendations are made to UYDEL on how programming for HIV/AIDS and SRH projects like the EASY-U25 can be improved.

To make HIV and SRH services youth friendly UYDEL and partners need to take a duo approach: one that is targeting providers and another targeting young people themselves. With regards to the former, there is need to build capacities of the providers of HIV and SRH services. The sensitivities that surround these services require that professionals follow sanctified ethical codes which can be upheld through regular training. As aptly captured by one FGD participant "Service providers should undergo regular training to avoid incidences where [they are] unfriendly and rude to their clients. Regular training improves on client relations" (Female FGD Nakawa).

Capacity building should also target equipping providers with knowledge needed to nurture young people's participation – to ensure that young people take part in planning, implementation, monitoring and evaluating programs meant for them. According to young people HIV/AIDS and SRH services should be manned by "people of our kind who

properly understand the ways we live in as youths" (23-year-old male FGD participant 3/5/2021).

On the side of young people, and as suggested by Government of Uganda and United Nations (2017), there is great need to create safe spaces in communities where young people gather, interact with their peers, gain and practice leadership competencies. UYDEL needs to provide information, dissemination and training aimed at building the confidence of young people in Kampala to be able to speak for themselves and actively participate in making decisions that affect them. Given the limited engagement of young people in activities that promote HIV/AIDS and SRH services in their communities, UYDEL should seriously invest in creating and building volunteer networks of young people. Equally important is the provision of information to young people on available HIV and SRH service points in their communities.

Similar to Ssebunya et al (2019), this study shows a higher probability of prior engagement in high-risk sexual behaviours among participants who were unaware of their most recent sexual partners' HIV status. This suggests a need for interventions focused promoting mutual HIV status disclosure between sexual partners.

The study found that young people's knowledge on HIV/AIDS facts is low. This implies urgent need to increase awareness campaigns on HIV/AIDS and SRH. As suggested by a male FGD participants in Lubaga:

> "government should come and clear any distortions that people have on HIV/AIDS and SRH services. For instance, in this locality, there is a thinking that pork reduces the adversities of HIV/AIDS illness, and that family planning technologies in women are cancerous".

To increase access to HIV/AIDS and SRH services, participants suggested the need for implementing policies that mandate provision of services such as condom distribution, same male circumcision and HIV/AIDS testing free in both public and private health facilities especially those in the local communities. UYDEL can partner with private providers such as local pharmacies and clinics to provide HIV/AIDS and SRH services that are free or at least greatly subsidized.

Poverty and lack of employment opportunities was identified as a key driver of high-risk behaviours among young people. Swahn et al. (2018), Bukenya and Mugumya (2018) provide evidence which suggests that engaging in vocational training reduces unemployment, poverty and idleness among young people. Therefore, UYDEL should expand its vocation training programs to empower young people with marketable skills. Such programs must include provision of start-up capital so that young people can create income earning activities for themselves immediately after graduating. Joining vocational training is good because it occupies the youth. It is those who are idle that get the time for engaging in high-risk behaviours. As eloquently captured in FGDs, “an idle mind is a devil’s workshop" (female FGD participant Banda).
Relatedly, UYDEL needs to explore the possibility of providing targeted social assistance to vulnerable young people who resort to transactional sex as a means for acquiring basic needs. As one FGD participant noted “they [government and NGOs] should not only provide medicine but also food stuff…” (Female FGD participant Nakawa). Other study participants observed that social protection services like food assistance helps poor individuals who are on ART to adhere to their treatment.

High rates of sexual relations among partners who are unaware of each other’s’ HIV status calls for urgent need to promote mutual HIV status disclosure between sexual partners. It also calls for interventions for empowering young people to negotiate or demand for HIV status of partners before they engage in sexual relations with them.

Alcohol and substance abuse is both a risk factor and a driver of other risk factors such as early sexual debut, forced sex, and gender-based violence among others. Therefore, greater attention needs to be put on addressing the challenge of substance abuse among young people.

The high rates of attitudes that support gender-based violence among young people suggests the urgent need for gender-sensitive interventions such as DREAMS to address this issue. Bukenya’s (2018) evaluation of the DREAMS project suggests that

young people who participated in this project were equipped with information on how to report and seek support on GBV issues.

While Uganda has a stringent Anti-pornography Act 2014 that could help regulate radio, TV and online content, its enforcement by the authorities is wanting. As discussed earlier this has left young people exposed to adult content. UYDEL and partners should engage the relevant authorities such as the Pornography Control Committee, Uganda Communication Commission, parliament and other relevant stakeholders to devise means of operationalizing this law.

There is need for creating constructive working relations with religious and cultural leaders to ensure that they become facilitators rather than blockers of HIV and SRH services. Since many young people tend to be ardent followers of their faith leaders, turning the latter into SRH campions could provide opportunity for changing the perceptions of young people in a positive direction.

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