Uganda has experienced the largest decline of HIV prevalence of any country in the world, from a peak of 15% in 1991 to 5% today. In cooperation with community-based and faith-based organizations, the Ugandan government has pursued an AIDS prevention strategy centered on urging people to Abstain from sex, Be faithful to one partner, or use Condoms (the so-called ABC model). It is believed that the large drop in AIDS prevalence has been due to behavior change, especially reduction of number of sexual partners among adults and abstinence and delayed sexual debut among youth. The purpose of this study was to conduct a qualitative investigation of Ugandan adolescent’s attitudes and values towards relationships and sexuality, and the ways in which their social environment sends messages and creates perceived norms which shape sexual behavior, especially the behavior of abstinence. Focus groups were conducted with youth between the ages of 13 and 16 years in the districts of Soroti and Masaka. Youth discussed reasons for having relationships, both platonic and sexual; the benefits and risks of relationships; the proper age for boys and girls to initiate sexual relationships; messages they have received regarding sexuality and perceptions of family, peer, and community norms; and values regarding ideal sexual behavior. Youth expressed that the right age to begin having sex is 18 years and above, so that sex does not interfere with education and cause other adverse consequences such as early pregnancy, family strife, and infection with HIV/AIDS.
The Pursuit of Bright Futures: Delayed Sexual Debut, Declining HIV Prevalence, and the Social Construction of Sexual Attitudes, Values, and Norms Among Adolescents in Uganda

by
Allison M. Herling

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Presented May 11, 2004
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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Allison M. Herling, Author
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LIST OF ABBREVIATIONS

ABC  Abstain, Be Faithful, or Use a Condom
AIDS Acquired Immunodeficiency Syndrome
ARV  Anti-Retroviral
CBO  Community-Based Organization
DHS  Demographic Health Survey
GPA  Global Programme on AIDS
HIV  Human Immunodeficiency Virus
P7   Grade Seven, primary school
PEPFAR President’s Emergency Plan for AIDS Relief
S1   Grade One, secondary school
S2   Grade Two, secondary school
STD  Sexually Transmitted Disease
STF  Straight Talk Foundation
STI  Sexually Transmitted Infection
UN   United Nations
UNAIDS Joint United Nations Programme on HIV/AIDS
UNGASS United Nations General Assembly Special Session on HIV/AIDS
VCT  Voluntary Counseling and Testing
WHO  World Health Organization
Dedicated to the children of Uganda,

with admiration for your courage,

with gratitude for what you have taught me,

and with hope that you will have the bright futures you dream of.
TILE
PuRsurr OF BRIGHT FuTuRES: DELAYED SExual DEBut, DECLINING HIV PrevaLence, AND THE Social CONSTRUCTION OF SExUAL ATTITUDES, VALUES, AND Norms AMONG ADOLESCENTS IN UGANDA

INTRODUCTION: THE DECLINE OF HIV/AIDS IN UGANDA

Acquired Immunodeficiency Syndrome (AIDS) has become arguably the most devastating pandemic in human history. Now in its third decade, the pandemic already has claimed an estimated 20 million lives, while an estimated 40 million people currently are infected with the human immunodeficiency virus (HIV) (UNAIDS/WHO, 2003). In 2003 alone, HIV/AIDS killed approximately three million people, while an additional five million were infected (UNAIDS/WHO, 2003). Sub-Saharan Africa has been the region worst-affected, accounting for only 12% of the world’s population, but nearly 70% of those living with HIV/AIDS, or 26.6 million people. In four countries of southern Africa—Botswana, Swaziland, Lesotho, and Zimbabwe—HIV prevalence currently exceeds 30%. AIDS is now responsible for one in five deaths in Africa¹, making it the leading cause of death in the region (UNAIDS/WHO, 2003). The Joint United Nations Programme on HIV/AIDS (UNAIDS) warns that evidence of HIV prevalence “leveling off” in several countries is due to already high HIV incidence rates and high HIV/AIDS mortality, and cannot be taken as a sign that the epidemic has reached a turning point in the region (UNAIDS/WHO, 2003).

In the midst of these sobering realities, Africa does have one success story. Uganda has experienced a decline in HIV prevalence from a peak of 15% in 1991, to 5% today², an achievement that UNAIDS calls a “remarkable feat” and that remains

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¹ In this usage and throughout this document, the term “Africa” will be used to refer to sub-Saharan Africa.
² There is some disagreement over these data; the Ugandan Ministry of Health estimates that national AIDS prevalence peaked at 21% in 1991 and then declined to 6% by 2001, while UNAIDS estimates that prevalence peaked at 15% in 1991 and declined to 5% by 2001. These discrepancies arise from the relative weight given to urban and rural populations. Urban populations were overrepresented in early surveys, raising the estimated prevalence rate of the country as a whole (Green, 2003a, p. 144). In fact, 88% of Uganda’s population is rural, and when the rural population
unique in Africa and the world (UNAIDS/WHO, 2003; Green, 2002). There have been signs of declines in prevalence among other populations in Africa, such as among youth in Zambia and South Africa, and young pregnant women in some locations in Malawi, Rwanda, and Ethiopia (Green, 2004, p. 52; UNAIDS/WHO, 2003). In addition, Senegal, like Uganda, often is considered to have waged a successful campaign against HIV/AIDS at a national level. Senegal has had a national HIV/AIDS prevention and control program since 1987, and has succeeded in keeping HIV prevalence stable at less than 0.5% of the population, one of the lowest rates in Africa. UNAIDS cites Senegal and Uganda as two examples that “HIV/AIDS can be checked with human intervention” (UNAIDS/WHO, 2003), yet to date no other high-incidence country has managed to duplicate Uganda’s success in reversing an AIDS epidemic at a national level.

Uganda is well known for its national-level response to the AIDS epidemic, and evidence suggests that this response resulted in significant behavior change that led to a decline in HIV incidence and prevalence\(^3\) (Green, 2002; Stoneburner & Low-Beer, 2004; Shelton et al., 2004). Both youth and adults reported behavior change such as increased abstinence and decreased number of sexual partners, and later in the epidemic, increased condom use. Youth experienced the greatest decrease in HIV prevalence of any group in the population. For instance, among urban youth aged 15 to 19 years there was a 75% decline in HIV prevalence between 1991 and 1998, and among urban youth aged 20 to 24 years there was a 60% decline in prevalence in the same time period, compared to a 50% decline in prevalence in the population as a whole (Stoneburner & Low-Beer, 2004). Declining HIV prevalence among youth may have been critical to the decline of the epidemic as a whole, and if it was

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is weighted according to its true proportion, the more conservative estimate of a peak of 15% national prevalence results.

\(^3\) Incidence refers to the number of new infections per unit of time, and is thus a rate, while prevalence refers to the proportion of the population currently infected. A decrease in incidence is considered a better measure of the decline of an epidemic than is a decline in prevalence, as prevalence can decline due to AIDS mortality, migration, or other factors, even if the rate of new infections is not decreasing. Yet “AIDS rates” are commonly cited in terms of prevalence, as incidence is more difficult to measure. Prevalence always refers to the proportion of the adult population (aged 15 to 49 years) that is infected.
behavior change among youth that drove this decline in prevalence, then behavior change among youth was also a critical component of the reversal of Uganda’s AIDS epidemic.

Yet what behavior change occurred among youth, and why? This study presents the results of qualitative research conducted with Ugandan youth, in an attempt to answer these questions, and understand the experience of Ugandan youth in relation to the AIDS epidemic. In Africa HIV/AIDS primarily is transferred through heterosexual sex, so the question of what behavior change occurred among youth in response to AIDS is a question of adolescent sexual behavior and sexuality. Youth were questioned about their attitudes and values regarding sexuality, and asked what messages they have received about sexuality and relationships from those in their social environments. The focus of these questions was to understand norms of adolescent sexual behavior in Uganda, and how Ugandan youth are constructing personal attitudes and values and making choices about sexual behavior within the context of their social environments, as well as how so-called contextual factors are impacting the sexual behavior of Ugandan youth. This study also presents an overview of the decline of HIV/AIDS within Uganda and behavior change in the population as a whole, a discussion of Uganda’s model of AIDS prevention, and a review of previous research of adolescent sexuality in Africa and the United States.

**AIDS Prevention in Uganda: an Indigenous Response**

The question of what happened in Uganda to create such a remarkable success against the AIDS pandemic has attracted international attention and considerable debate. Uganda’s campaign against AIDS began in 1986, the year that President Museveni seized power after two decades of war, brutal dictatorships, and extreme social and political upheaval. At that time Uganda had the highest HIV/AIDS prevalence of any country in the world and few resources to combat it. There were no foreign experts, no foreign aid money, and little money for drugs, condoms, voluntary
counseling and testing (VCT), treatment of sexually transmitted infections (STIs), or other biomedical interventions that have been hallmarks of Western approaches to AIDS prevention. Museveni and his advisors relied instead on prevention, and a behavioral approach that to them seemed to be common sense. Museveni’s government, along with a host of community-based organizations, began a campaign to educate Ugandans about AIDS. The message was simple: AIDS was a deadly disease for which there was no cure, and Ugandans must change their sexual behavior to avoid it. Those in marriages or unions were told to be faithful to their partners (often phrased as “love faithfully” or “zero grazing”), and youth and the unmarried were told to abstain from sex entirely until they entered a stable union (Green, 2003b; Shelton et al., 2004; Stoneburner & Low-Beer, 2004).

To Museveni and his advisors this approach was an indigenous response that was consistent with African culture, and especially the concept of “respect,” which was often used to mean sexual fidelity (Green 2003, p. 142.). As Museveni stated in a 1991 speech:

Sex is not a manifestation of a biological drive; it is socially directed... I have been emphasizing a return to our time-tested cultural practices that emphasized faithfulness and condemned premarital and extramarital sex. I believe that the best response to the threat of AIDS and other STDs [sexually transmitted diseases] is to reaffirm publicly and forthrightly the respect and responsibility every person owes to his or her neighbor. (Museveni, 2000, p. 251)

In other ways Museveni emphasized that AIDS was a war that would be won through a community response and responsibility to one’s neighbor. He framed the AIDS epidemic as a crisis that threatened to destroy the nation, and called the whole nation to mobilize to fight it. The image of a lion within a village often was used. Like a lion, AIDS threatened the survival of the entire community, and demanded a response from the whole community if disaster was going to be averted.

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4 In this document the more preferred term STI (sexually transmitted infection) will be used, although quoted statements will sometimes use the term STD (sexually transmitted diseases). The two terms have the same meaning.
AIDS Prevention at the Community Level

From the beginning of the campaign against HIV/AIDS, the government partnered with churches, community leaders, and community- and faith-based organizations to educate Ugandans about AIDS, promote prevention, care for those with AIDS, and destigmatize the disease. The involvement of so many elements of Ugandan society fostered a culture in which AIDS could be openly discussed and those who were infected were not stigmatized. For instance, focus group research conducted in the early 1990s in Rakai District, the epicenter of the epidemic, found that people displayed very positive, sympathetic, and stigma-free attitudes to those with AIDS (Konde-Lule, 1993; cited in Green, 2003a, p. 168). The Ugandan government also prioritized the “advancement” of women and youth, realizing that giving them power over their sexual choices was critical to halting the epidemic. This strategy had a clear impact. For instance, the 2001 Ugandan Demographic Health Survey showed that the proportion of women in Uganda who were able to negotiate safer sex\(^4\) (91%) was higher than in any other country in Africa (Green, 2003a, p. 171).

Demographic Health Surveys\(^5\) (DHS) done throughout Africa have also demonstrated the effect of the destigmatization of AIDS in Uganda. Compared to citizens of other countries in Africa, even countries with higher HIV/AIDS prevalence than Uganda, Ugandans are much more likely to report knowing someone who has AIDS or who has died of AIDS\(^6\) (Stoneburner & Low-Beer, 2004). Note that this does not just mean that a Ugandan knows someone who is HIV-positive, but

\(^4\) Being able to negotiate safer sex is defined in the DHS as a woman being able to refuse to have sex with her husband, or propose condom use, if she suspected that he has a sexually transmitted infection (STI).

\(^5\) Demographic Health Surveys (DHS) are national-level surveys conducted by the United States’ Agency for International Development’s (USAID) MEASURE project. DHS are used by USAID-supported HIV/AIDS programs to monitor and evaluate AIDS programs, and are conducted in dozens of countries around the world. DHS have been conducted in Uganda in 1989, 1995, and 2000/2001. Data from the DHS are available at www.measuredhs.org.

\(^6\) In 1995 91% of Ugandan men and 86% of Ugandan women reported knowing someone with AIDS, while in Zambia, Kenya, and Malawi the proportion was between 68 and 71%, and in Zimbabwe it was below 50% (Stoneburner & Low-Beer 2004).
knows someone who has disclosed the fact that he or she is HIV-positive. When many people in a society are comfortable disclosing their HIV-positive status, this indicates a relatively open social and political climate and that stigma associated with AIDS has been reduced (Green, 2004, p. 149). Ninety-nine percent of Ugandans report having heard about AIDS, and much more so than in other countries, Ugandans report hearing about AIDS through inter-personal communication rather than through mass media or other impersonal networks (DHS). Radios, televisions, and print media are relatively scarce in Uganda, and compared to other countries in Africa, Ugandans are relatively unlikely to report that they heard about AIDS from radio, television, or through a newspaper or magazine (DHS). Ugandans are also relatively unlikely to have heard about AIDS through pamphlets, posters, or health care workers (DHS). Yet Ugandans are more likely than the nationals of any other country in Africa to have heard about AIDS from a friend or relative, or in a mosque or church, and the second most likely to have heard about AIDS in a community meeting (DHS).

The Role of Fear-Based Messages

Fear was an integral part of the Ugandan government’s campaign against HIV/AIDS. The threat of AIDS was not soft-pedaled, and AIDS awareness posters from that time often featured skulls and graves, along with stark reminders that AIDS kills. In a recent BBC interview Museveni remarked, “When I had a chance, I would shout at them. I used to say, ‘You are going to die if you don’t stop this. You are going to die!’” (British Broadcasting Company, 12 August 2002, cited in Green, 2003a, p. 181). Such messages emphasized susceptibility and severity, reminding Ugandans that anyone with risky sexual behavior, such as those with multiple sexual partners, could get AIDS, and that AIDS was fatal. Yet these messages also emphasized efficacy, by telling people that they could change their behavior to avoid the threat of AIDS (Wilson, 2004). Such fear-based messages were felt to be

7 Nationals of the Central African Republic are slightly more likely than Ugandans to have heard about AIDS in a community meeting.
necessary and productive rather than destructive (leading to denial) as long as people were given information about how to protect themselves from HIV/AIDS and told that they had the power to make necessary behavior changes.\(^8\)

Museveni and his advisors have been criticized by Western experts for such a fear-based approach, but they defend the fact that it has been appropriate and effective in Uganda (Green, 2003a, p. 180). In a personal conversation, Dr. Jessie Kagimba, who has been President Museveni's advisor on HIV/AIDS since 1986, defended the role of a healthy fear, saying that although it is no good to talk about the problem unless one also talks about the solution, Uganda has been successful because it has done both. He explained that Uganda's approach was based on the Health Belief Model: perceived susceptibility and severity of the threat lead to behavior change, when combined with a message of efficacy. Dr. Kagimba also noted that it matters \textit{what} behavior changes are promoted, mentioning that although condom use is higher in some African countries than in Uganda, Uganda has been successful against HIV/AIDS because it has advocated other behavior changes, such as abstinence and faithfulness.

Dr. Kagimba asserted that cultural norms have changed in response to HIV/AIDS. For instance, he commented that during his childhood, sex among youth was much more common and accepted, but when AIDS came, people realized they had to change their behavior. In his opinion this response to threat has long been a part of African culture. He remarked that Ugandans had seen sexually transmitted infections before, and had developed protective cultural values in response, such as taboos against premarital sex. He concluded by emphasizing that Uganda's approach to AIDS is simple and that Ugandans do not believe that anti-retrovirals (ARVs), condoms, or other imported technology is the answer. He concluded by saying, "The only solution is for culture to change" (Kagimba, 2003).

\^8\ In surveys conducted by the Uganda Ministry of Health in 2000 and 2001, the most common response given by respondents when questioned why they had changed their sexual behavior, was fear of AIDS (Green, 2004, p. 180). In addition, out of 23 countries surveyed by DHS, Ugandan women ranked third (behind women in Comoros and Senegal) in reporting themselves at "moderate" or "great" risk of contracting AIDS (DHS), in spite of the fact that Uganda is no longer one of the highest prevalence countries in Africa.
The Arrival of Condoms and a Shift in AIDS Prevention Strategy

Uganda’s response to HIV/AIDS did change somewhat with the arrival in the mid-1990s of international non-governmental organizations (NGOs), foreign experts, and foreign money for AIDS prevention. For the first time, condoms, which had not been widely available until 1993, became a significant part of AIDS prevention in Uganda. At first Museveni, as well as many community-based and religious organizations, were resistant to promoting the use of condoms, feeling that condoms were not compatible with traditional African culture. Museveni also felt that given the challenges of distributing condoms to a predominantly rural population, they would not prove to be a sustainable solution. As Museveni stated:

Just as we were offered the “magic bullet” [penicillin] in the early 1940s, we are now being offered the condom for “safe sex.” We are being told that only a thin piece of rubber stands between us and the death of our continent. I feel that condoms have a role to play as a means of protection, especially in couples who are HIV-positive, but they cannot become the main means of stemming the tide of AIDS (Museveni, 2000, p. 252).

Gradually the government as well as various organizations involved in AIDS prevention (including some churches and religious organizations) began to advocate condoms as a secondary strategy for those who chose not to abstain or be faithful. As Dr. Kagimba stated in an October 2003 article in the New Vision, Uganda’s largest daily paper: “The Government position has been: ‘abstain or be faithful but if you can’t, then use a condom’” (Wendo, 2003). Condom use has increased in the last decade and may be partly responsible for the stabilization of Uganda’s AIDS epidemic (Shelton et al., 2004), but condoms, as well as voluntary counseling and testing (VCT) and STI management, were not a part of Uganda’s initial success against HIV/AIDS (Stoneburner & Low-Beer, 2004). In 1991, the year that prevalence in the country peaked, only 5% of Ugandans reported ever having used a condom (Green, 2003a, p. 161), and fewer than 50,000 Ugandans had ever been tested for the AIDS virus (Stoneburner & Low-Beer, 2004).

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9 Incidence is believed to have peaked in 1989.
AIDS Prevention for Youth

The Ugandan government has promoted a clear message to youth regarding AIDS: AIDS is a serious threat, and they must abstain from sex to protect themselves. The government is so intent on promoting abstinence for youth that it has gone so far as to criminalize sex with a minor. Defilement charges carry a sentence of seven years, and there are even reports that boys who are themselves minors have been thrown into jail for impregnating a girl (Watson, 2003). Condom use has also been promoted as protective against AIDS, but it remains a secondary strategy, and Museveni continues to stress that condoms are not an appropriate solution for youth. For instance, in May he criticized the alleged distribution of condoms to primary school students in a certain district (an allegation which later proved to be false), saying,

I will open war on the condom sellers. Instead of saving life [sic] they are promoting promiscuity among young people... When I proposed the use and distribution of condoms, I wanted them to remain in town for the prostitutes to save their lives (Ssejoba, 2004).

In addition to the government’s strong AIDS prevention message, youth also receive information and education about AIDS from a variety of other sources, including schools. Beginning in 1987 the Uganda School Health Education Program (SHEP) has been implemented in primary schools, with the aim of reaching students before they become sexually active. SHEP emphasizes abstinence and delay of sex, but also gives information about condoms. Other sources of information about AIDS and sexuality include media such as radio and newspapers. Perhaps the most important media source for youth are a pair of monthly newspapers called Straight Talk (for youth aged 15 to 19 years) and Young Talk (for youth aged 10 to 14 years) that address AIDS prevention, sexuality and sexual health, relationships, and life skills. Straight Talk also sponsors radio shows and school clubs. Straight Talk and Young Talk have distributed over 22 million copies of the monthly newspaper since 1993 (distributing almost 8 million copies in 2003 alone), and are widely known
among Uganda youth. *Straight Talk* and *Young Talk* promote a strong message of abstinence (especially for *Young Talk* readers), while also maintaining a positive view of condoms. They encourage young people to abstain from sex until the age of 18 years, to get tested before entering a sexual relationship and then only have one partner, and always to use condoms.

**Behavior Change in Uganda**

DHS data show that Ugandan youth as well as adults changed their sexual behavior in response to the AIDS threat. Beginning in the late 1980s, there was a marked trend towards partner reduction and faithfulness among adults, a trend that has not occurred in other African countries to the extent that it did in Uganda. Researchers have argued that this trend may have been pivotal to the decline of the AIDS epidemic within Uganda (Shelton et al., 2004; Bessinger, 2003; Stoneburner & Low-Beer, 2004; Epstein, 2004). According to the 2001 DHS, 97% of married Ugandan women aged 15 to 49 years reported no sexual partners besides their spouse or cohabiting partner in the previous twelve months, and 88% of married men aged 15 to 54 years reported the same. For the unmarried, only 2% of women aged 15 to 49 years reported more than two sexual partners in the previous year, while only 11.2% of men aged 15 to 54 years reported more than two sexual partners in the previous year. It should be noted that the vast majority of Ugandans are married, and that in the 2001 DHS most unmarried Ugandans reported no sexual partners at all in the previous year (72% of women and 65% of men), so that the proportion of Ugandans not practicing faithfulness to one partner was small, especially among those in marriages or unions (Table 1).

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10 In the DHS the term "married" includes those with both spouses and cohabiting partners.

11 According to the 2001 DHS, only 3.2% of Ugandan women and 7.3% of Ugandan men never marry.
Table 1
Number of Sexual Partners: Ugandan Women and Men In Unions and Not In Unions (DHS, 2000/01)

Percent distribution of women and men by number of persons with whom they had sexual intercourse in the past 12 months (excluding spouse or cohabiting partner, for women and men in union)

<table>
<thead>
<tr>
<th></th>
<th>0 partners</th>
<th>1 partner</th>
<th>2+ partners</th>
<th>Percent with 1 partner, or abstaining</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women aged 15-49 years</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In union</td>
<td>97.4%</td>
<td>2.4%</td>
<td>0.1%</td>
<td>97.4%</td>
</tr>
<tr>
<td>Not in union</td>
<td>71.9%</td>
<td>26.0%</td>
<td>2.0%</td>
<td>97.9%</td>
</tr>
<tr>
<td><strong>Men aged 15-54 years</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In union</td>
<td>88.0%</td>
<td>9.7%</td>
<td>2.3%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Not in union</td>
<td>65.4%</td>
<td>23.4%</td>
<td>11.2%</td>
<td>88.8%</td>
</tr>
</tbody>
</table>

Earlier data from Uganda illustrate the magnitude of this behavior change, and the greatest changes in behavior seem to have occurred in the first half of the 1990s (Shelton et al., 2004; Bessinger, 2003; Stoneburner & Low-Beer, 2004). According to the World Health Organization (WHO)/Global Program on AIDS (GPA) surveys conducted in 1989 and 1995, the proportion of males in all age groups having more than one sex partner in the past year declined from 39% to 21%, while for females the decline was from 18% to 9%. The 1989 WHO/GPA survey asked an open-ended question regarding whether or not respondents had changed their sexual behavior because of HIV/AIDS, and 69% of respondents reported that they had, with abstinence and faithfulness being the most commonly cited behavior changes. While there are no national data to show what behavior change occurred previous to 1989, it is likely that there had already been significant behavior changes by 1989,

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12 Some researchers argue that abstinence and faithfulness behaviors decreased in Uganda in the late 1990s, possibly because of increased condom promotion and resulting “disinhibition” (Bessinger, 2003). There is sobering evidence that AIDS prevalence in Uganda may now be rising slightly. Prevalence rates among antenatal women in Kampala have shown a slight increase in the last two years.

13 Fewer than 1% of respondents stated that they had adopted condom use in response to this question, in spite of the fact that condom use was the only behavior change specified by the survey (Green, 2003a, p. 158).
given that this was the year in which national HIV incidence is believed to have peaked (Green, 2003a, p. 160).

**Condom Use**

Condom use has also increased in Uganda, although as previously noted, condom use was very low until the mid-1990s, when HIV incidence and prevalence had already peaked. According to the 2001 DHS, condom use among those having sex with non-regular partners is relatively high, with 38% of women and 59% of men reporting using a condom during last sex with a non-regular partner. As in other countries, condom use in Uganda has tended to be very low with marital or cohabiting partners, remaining at less than 5% since the mid-1990s (Bessinger, 2003). Also consistent with data from other countries, condom use has tended to be higher among men and younger, urban and more educated populations. Reported condom use with regular partners was slightly over 5% among urban women, urban men, and young men in the 2001 DHS (Tables 2 and 3).

| Table 2 | Use of Condoms Among Ugandan Women by Type of Partner and Background Characteristics (DHS, 2000/01) |

| Percent of respondents who had sex in the past year who used a condom at last sex |
|---------------------------------|---------------------------------|-----------------|
|                                  | With marital/ cohabiting partner | With non-marital/ non-cohabiting partner | Total |
| 15-24 years                      | 3                               | 44               | 11    |
| 25+ years                        | 3                               | 29               | 5     |
| Urban                            | 7                               | 59               | 19    |
| Rural                            | 2                               | 30               | 5     |
| Total                            | 3                               | 38               | 7     |
Table 3
Use of Condoms Among Ugandan Men by Type of Partner and Background Characteristics (DHS, 2000/01)

**Percent of respondents who had sex in the past year who used a condom at last sex**

<table>
<thead>
<tr>
<th></th>
<th>With marital/cohabiting partner</th>
<th>With non-marital/non-cohabiting partner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24 years</td>
<td>6</td>
<td>62</td>
<td>35</td>
</tr>
<tr>
<td>25+ years</td>
<td>4</td>
<td>59</td>
<td>9</td>
</tr>
<tr>
<td>Urban</td>
<td>8</td>
<td>81</td>
<td>37</td>
</tr>
<tr>
<td>Rural</td>
<td>3</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>59</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

**Behavior Change among Youth**

Youth also reported significant behavior change beginning in the late 1980s. Median age of first sex or sexual debut has been steadily increasing, fewer youth have been reporting premarital sex, and the median number of years between first sex and first marriage has been decreasing. The median age of first sex increased by almost a year for all women and almost a year and a half for all men, regardless of background characteristics, between the 1988 and 2000/01 DHS for women and between the 1995 and 2000/01 DHS for men\(^{14}\) (Figures 1 and 2). For women ages 20 to 24 years median age of first marriage has been constant, but an increase in median age of sexual debut has led to a decreased number of years between first sex and first marriage (Figure 3). For men aged 25-29 years median age of sexual debut has increased almost two years, and median age of first marriage has been decreasing, causing a decreased number of years between first sex and first marriage (Figure 3).

\(^{14}\) The 1988 DHS did not gather data on age of first sex for men.
Figure 1
Median Age at First Sex and First Marriage Among Ugandan Women Aged 20-49 Years by Background Characteristics

19.0
18.0
17.0
16.0
15.0
14.0
13.0
12.0
urban rural no education primary education secondary education

1988 DHS 1995 DHS 2000/01 DHS

Figure 2
Median Age at First Sex and First Marriage Among Ugandan Men Aged 20-54 Years by Background Characteristics

20.0
19.0
18.0
17.0
16.0
15.0
14.0
13.0
12.0
urban rural no education primary education secondary education

1995 DHS 2000/01 DHS
Premarital sex also decreased, especially during the early 1990s. According to the 1989 and 1995 WHO/GPA surveys, the percentage of never-married women aged 15 to 24 years who reported having had sex in the past year decreased from 53% to 16%, while for never-married men aged 15 to 24 years the decrease was from 60% to 23% (Figure 4). Data from the 1988, 1995, and 2001 DHS report a similar decrease in premarital sex, although for women there was a small increase in premarital sex between 1995 and 2000/01 (Figure 5).

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15 Twenty to 24 years is the youngest age range for which the DHS gives data on first sex and marriage, but for men there are sufficient missing data in this age range that the age range of 25 to 29 years was used.

16 The 1989 and 1995 WHO/GPA surveys reported a larger decrease in premarital sex than did the 1988 and 1995 DHS. USAID’s report on Phase I of the ABC study addresses this discrepancy, noting that the 1989 and 1995 WHO/GPA surveys were not true national surveys (covering eight and four districts, respectively), and that they over-represented Kampala. This may have led to the WHO/GPA surveys overstating the drop in adolescent premarital sex (Bessinger 2003).
Figure 4
Premarital Sex: Percent of Never-Married Ugandan Women and Men Aged 15-24 Years Who Had Sex in the Past 12 Months (WHO/GPA Data)

![Chart showing premarital sex percentages for never-married Ugandan women and men aged 15-24 years, comparing 1989 and 1995 surveys.]

Figure 5
Premarital sex: percent of never-married Ugandan women and men aged 15 to 24 years who had sex in the past 12 months (DHS Data)

![Chart showing premarital sex percentages for never-married Ugandan women and men aged 15 to 24 years, comparing 1988, 1995, and 2000/01 DHS surveys.]

Trends among Ugandan youth towards later sexual debut, less time between first sex and first marriage, and decreased premarital sex are particularly significant when compared to trends among other African youth. USAID, in an ongoing study of trends in five African countries (Uganda, Zambia, Cameroon, Kenya, and Zimbabwe), concludes that only in Uganda and Zambia was there a “clear trend towards delayed age of sexual debut among youth,” as well as a trend towards decreased premarital sex (Bessinger, 2003). Zambia saw significant declines in HIV prevalence among young women aged 15 to 19 years in the mid-1990s, although not in any other part of the population (Bessinger, 2003). Although median age of sexual debut for Ugandan women is relatively low, compared to that of other women in Africa, age of first marriage is also relatively low, leading to a relatively short period of time between first sex and first marriage (Figure 6). Ugandan men have a somewhat high median age of sexual debut when compared to other African men, but they also have one of the lowest median ages of first marriage, also leading to a relatively short period of time between first sex and first marriage (Figure 7). Uganda is also the only country in Africa in which age at first marriage among men is decreasing (DHS).
Figure 6
Median Age at First Sex and First Marriage for Women Aged 20-24 Years in Various African Countries

22
21
20
19
18
17
16
15
14
13
12

Cameroon 1998
Ghana 1998
Kenya 1998
Mal 2001
Senegal 1997
Tanzania 1999
Uganda 2000/01
Zambia 2001/02
Zimbabwe 1999

- first sex  - first marriage
As previously noted, condom use has tended to be higher among Ugandan youth than among the general population, and condom use among younger age cohorts has increased significantly since the mid-1990s, especially for sex with non-regular partners. According to data from the 1995 and 2001 DHS, condom use with last non-regular partner increased from 25% to 44% for Ugandan women aged 15 to 24 years, and from 42% to 62% for men aged 15 to 24 years (Figure 8). Condom use with regular partners has remained low, at 3% for women 15 to 24 years, and 6% for women aged 15 to 24 years (Table 2).
Figure 8
Condom Use Among Youth: Percent of Ugandan Women and Men Aged 15-24 Years Who Had Sex in the Past Year with a Non-Regular Partner Who Used a Condom at Last Sex with That Partner

![Graph showing condom use among youth.](image)

- **Women:**
  - 1995 DHS: 25%
  - 2000/01 DHS: 44%

- **Men:**
  - 1995 DHS: 42%
  - 2000/01 DHS: 62%

1995 DHS & 2000/01 DHS
The ABC Approach and the Global AIDS Pandemic

Uganda’s approach of promoting abstinence, partner reduction, and faithfulness as primary behavior change strategies, with condom use as a secondary strategy for those who cannot or choose not to adopt those primary behavior changes, has become known as the ABC approach, for Abstain, Be faithful, or use Condoms. As a recent USAID Technical Meeting on the ABC approach explained:

...balanced ABC approaches might be implemented in the form of “A” interventions promoting sexual deferrals to younger, sexually inexperienced youth; “B” interventions promoting partner reduction to sexually experienced youth and the general adult population; and “C” interventions promoting condoms, with enhanced STI services, to highly sexually active youth and adults, especially sex workers (USAID, 2002).

Evidence for the ABC Approach

The ABC approach often is seen as having a greater emphasis on abstinence and delayed sexual debut for youth, and faithfulness for adults, than do standard AIDS prevention approaches that rely more on condom promotion, STI management, and voluntary counseling and testing (VCT). Although condoms are an important part of the ABC approach, as the USAID statement notes, condoms are not promoted as a primary strategy to the general population, but are rather promoted to high-risk populations such as commercial sex workers and people with multiple sexual partners.

One reason for this strategy is that condoms have never been shown to bring about a decline in HIV incidence in a general population. As a recent report for UNAIDS on condom effectiveness concluded, “There are no definite examples yet of generalized epidemics that have been turned back by prevention programs based primarily on condom promotion” (Hearst & Chen, 2004). Data from a prospective randomized community trial in Rakai, Uganda showed that while consistent

\[^{17}\text{In the British Medical Journal Shelton et al. stated that partner reduction, arguably the most important part of the ABC model, “is still given little attention in most HIV prevention programmes” (Shelton et al., 2004).}\]
condom use significantly reduced HIV incidence (rate ratio= 0.37), inconsistent condom use had no effect on HIV incidence even after socio-demographic and behavioral characteristics were accounted for (rate ratio= 0.96).\textsuperscript{18} Despite “high HIV prevalence” in the region, 16.5% of the sample reported inconsistent condom use in the previous year, while only 4.4% reported consistent condom use (Ahmed et al., 2001). This is the first prospective community trial of condom effectiveness in Africa. Such data suggest that while condoms have proven effective for HIV prevention in high-risk populations, they may not prove effective in generalized epidemics.

A comparison of Uganda with other countries also provides evidence for the efficacy of the ABC approach. While condom use has been no greater in Uganda than in other African countries in which severe AIDS epidemics have not abated (Figure 9), behavior change such as partner reduction has taken place in Uganda to a greater degree than in other African countries (Figures 10 and 11). As a senior monitoring and evaluation specialist for the World Bank’s Global HIV/AIDS program stated at the 2003 International Conference on AIDS in Africa, “We were a bit over-optimistic and naïve about the level to which universal condom promotion would reduce HIV infection rates in Africa. We are now more pessimistic [about condoms] than we were ten years ago” (David Wilson, quoted in Wendo, 2003).

\textsuperscript{18} As inconsistent condom users tend to have riskier sexual practices than do non-users, inconsistent condom users actually had a higher HIV incidence rate than did non-users in this study.
Figure 9

Figure 10
USAID currently is in the process of investigating the efficacy of the ABC approach in an ongoing study of six countries (three which have seen decreases in HIV prevalence, and three which have not\(^\text{19}\)), known as the ABC Study. Although the study is not yet complete, Phase One results have been sufficiently compelling to lead USAID to adopt the ABC approach as its official strategy for AIDS prevention (Hayman, 2003). In practical terms, this means more resources will be invested in promoting abstinence and faithfulness, whereas in the past condoms have been the only component of the ABC approach that have been seen as a viable prevention strategy or received significant funding. The ABC approach and Uganda’s success in implementing it have also received the attention of the Bush Administration. When President Bush pledged $15 billion to fight global AIDS in January 2003, he referred

\(^{19}\) Declines in HIV prevalence have occurred in Zambia, Uganda, and Thailand, while declines in HIV prevalence have not occurred in Cameroon, Kenya, and Zimbabwe.
to Uganda as a model, and the President’s Emergency Plan For AIDS Relief (PEPFAR) is funding prevention according to an ABC approach.20

Controversy over the ABC Approach

The ABC approach is controversial. It has been criticized for being overly simplistic, for ignoring underlying social problems such as women’s frequent lack of control over their own sexual lives, and for being judgmental, moralistic and repressive of human sexuality. For instance, a November 2003 article in the Global Health Council’s publication AIDSlink, called “The ABCs of HIV: It's Not That Simple,” argued,

"Behind the relative simplicity of the ABCs lies a mistaken notion that ignores the power and gender inequalities that have seriously impacted the best-planned interventions. Moreover, emphasizing the ABCs might be inculcating those most vulnerable to infection into self-stigmatization and viewing infection as a mark of personal failure (Osborne, 2003)."

Another critic of the ABC approach has denounced USAID’s decision to change “the current approach of aggressively social marketing male and female condoms in Africa, to instead refocus prevention efforts on abstinence and marital fidelity using what has become known as the Uganda model.” He calls Uganda’s approach to AIDS prevention “sex-negative,” and adds that “regressive” religious institutions have already “cast a pall over sexual freedom and expression on the African continent.” He warns that the ABC approach will only have the negative effect of reducing “sexual diversity” within African cultures (Feldman, 2003). In addition, critics have conflated the ABC approach with abstinence-only or faith-based approaches to AIDS prevention, or charged that U.S. funding of the ABC approach in the developing world is being fueled by right-wing religious ideology (Center for Health and Gender Equity, 2004; Osborne, 2003; Feldman, 2003; Burkhalter, 2004).

20 It should be noted, however, that prevention is not the main focus of PEPFAR. Only 20% of the PEPFAR budget is being allocated for prevention (including mother-to-child transmission programs and other non-behavior change initiatives), compared to 55% for treatment, 15% for palliative care, and 10% for care of AIDS orphans.
One of the main proponents of the ABC approach and foremost experts on ABC in Uganda is medical anthropologist Edward C. Green, a Senior Research Scientist at Harvard’s School of Public Health and a member of the President’s Advisory Committee on HIV/AIDS. In a USAID-sponsored report entitled “Faith-Based Organizations: Contributions to AIDS Prevention” (2003), Green argues that religiously-based organizations are the major providers of care and support services to people living with HIV/AIDS in the developing world, and should therefore be embraced as partners in AIDS prevention. Furthermore, the values of such organizations are much more in agreement with local cultures than are the ideologies of most Western organizations (Green, 2003b). Although the ABC approach is not religiously based, Green argues that religiously based organizations have a natural advantage in promoting behaviors such as abstinence and partner reduction and have already proven their effectiveness in promoting behavior change in countries such as Uganda, Senegal, Jamaica, and the Dominican Republic (Green, 2003b).

Proponents of the ABC approach also argue that while power and gender inequalities exist, the reality of oppression and injustice does not preclude the need to urge individuals to change risky sexual behaviors when such behaviors are under their control. Although the ABC approach is often called simplistic, some experts argue a condom-only strategy is itself simplistic, and “vastly oversimplifies the problem of HIV control” (Mosley, 2004). Finally, proponents of the ABC approach argue that it has succeeded in reversing AIDS epidemics, notably in Uganda, where other approaches have failed (Mosley, 2004; Green, 2004).

The ABC approach probably will continue to be controversial. Yet it is undeniable that on a global scale, most AIDS prevention efforts have not proven effective. With tens if not hundreds of millions of lives at stake, the possibility that the approach to prevention that was successful in curbing Uganda’s AIDS epidemic might also prove effective elsewhere, is too tantalizing and monumental a possibility to dismiss. 21 Green argues such a point in his recent book, Rethinking AIDS

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21 Thailand is another country that has reversed its AIDS epidemic, although in Thailand AIDS was mainly concentrated among commercial sex workers, IV drug users, and other high-risk groups, and
Prevention (2003). He asserts that many Western organizations and experts involved in AIDS prevention in Africa and other resource-poor areas of the world have been blind to the fact that much of what they have promoted has been dangerously incompatible with local cultures and values. The attitudes of such Western organizations and experts have amounted to ethnocentrism and technological arrogance. Furthermore, Western interventions have yet to prove successful on a national scale anywhere in Africa, as Uganda remains the only “success story” on the continent. Green argues that there is obviously something wrong with our Western models of AIDS prevention, and that Uganda provides an example of an indigenous, low-tech, and low-cost approach that may be a more viable alternative (Green, 2003a).

Other Approaches to AIDS Prevention and Treatment

While in the past condom-based AIDS prevention has been the main focus of Western-funded AIDS programs in the developing world, in recent years the international community has been increasingly turning its attention to biomedical measures such as voluntary counseling and testing (VCT), anti-retroviral (ARV) treatment, microbicides, prevention of mother-to-child transmission, and an HIV/AIDS vaccine. Many seem to hope that these interventions will succeed in curbing the global AIDS pandemic, where behavioral-based programs and prevention have failed.22 Certainly such efforts can only benefit those at risk of HIV/AIDS, and ARV treatment is a critical need for those already infected. Yet it seems unlikely that

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22 Consider that President Bush’s Emergency Plan for AIDS Relief (PEPFAR) has allocated only 20% of its $15 billion budget to prevention, compared to 70% for ARV treatment and palliative care for those with HIV/AIDS. Kevin de Cock, of the U.S. Center for Disease Control (CDC), has stated that such an emphasis reflects prevention’s “problem of credibility”: prevention has not been seen to work. He has further stated that “traditional prevention” has failed (de Cock, 2003).
such expensive medical interventions will prove to be a “magic bullet” for the AIDS epidemic.

Despite years of research, the hope for an effective vaccine remains, at best, distant.\(^{23}\) While VCT services are expanding in Africa, most Africans still do not have access. Although VCT serves the critical function of informing individuals about their HIV status, counseling them, and enrolling them in care (whether palliative or ARV treatment), these are all individual benefits. Recent studies have cast doubt on the assumption that VCT has the ability to impact an AIDS epidemic at a population-wide level. A study of VCT in 27 countries, conducted by USAID, concluded that VCT did not reduce HIV prevalence (Hayman, 2003), while a recent prospective cohort study conducted in rural Rakai, Uganda showed that an increase in VCT services did not decrease HIV incidence in this population (Wawer et al., 1999). One reason for this failure of VCT to reduce HIV transmission may be that an estimated 60% of HIV transmission occurs in the first 12 weeks of infection (Chataway, 2004), when the viral load of the recently infected person is very high. Yet in these first 12 weeks few people know they are infected, and HIV cannot yet be reliably detected by standard tests (Chataway, 2004).

Even when those infected with HIV/AIDS are aware of their sero-status, they do not necessarily change their behavior to reduce transmission of the virus to others. A study in rural Uganda found that those who were tested and knew their HIV status showed no difference in their practice of risky sexual behavior compared with those who had not been tested (Kipp, Kabagambe, & Konde-Lule, 2001). Further data from the prospective cohort study in Rakai show that among sero-discordant couples with access to condoms, 6.3% of couples reported inconsistent condom use, while an additional 1.2% of couples reported consistent condom use, even though all couples were aware of the high risk of HIV transmission (Gray, 2001). These data call into question the wisdom of promoting VCT as a primary means to control AIDS in a

\(^{23}\) Of the 18 vaccines that have undergone Phase I testing, only one has made it to Phase III (the last and most critical stage of testing), where it failed. Another vaccine is not expected to undergo Phase III testing until 2008 (Chataway, 2004).
population, even though VCT is clearly a matter of individual well-being and even human rights.

Six million people worldwide currently are in need of ARV therapy, and without ARV treatment three million people die each year from HIV/AIDS. Although 400,000 people worldwide have access to ARVs, the vast majority of them are in industrialized countries, and only 50,000 (or 2.5%) of the approximately 2 million people in need of ARV therapy in Africa currently have access. The price of generic ARVs has dropped precipitously in recent years, now hovering at around $300 per year, but ARVs remain out of reach for most Africans, both because $300 is a major proportion of (or even equivalent to) many African’s yearly income, and because the health infrastructure of Africa presently is not equipped to handle the demands of ARV treatment for millions. WHO/UNAIDS has prioritized universal access to ARVs, designating it core policy and setting an ambitious goal of having three million people on ARV treatment by 2005 (the so-called Three-by-Five initiative). Yet this initiative, even if fully funded (funding currently stands at about half of the $5.7 billion needed) will reach only half of those currently in need of ARV treatment, and is only an intermediate goal towards treatment of the tens of millions who will be in need in coming years (Mason, 2004).

Perhaps most sobering is the fact that barriers to access extend beyond lack of money, to the acute lack of doctors and health infrastructures in Africa, to far more subtle realities such as denial and stigma. The experience of Botswana, the only country in Africa to offer free ARVs to all citizens who need them, illustrates the challenges of providing universal access to ARV treatment. Botswana has natural advantages in being a relatively small country, and in having a stable government. Botswana is also the second-wealthiest country in sub-Saharan Africa, with arguably the second-best health care system, after South Africa. Botswana has the added

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24 This has been made possible through a five-year trial funded by the Bill and Melinda Gates Foundation and Merck pharmaceutical company, which will run from 2002 to 2007.
25 The population of Botswana is approximately 1.7 million.
26 Botswana (per capita GPD $9,500), like South Africa (per capita GDP $10,000) is considered a middle-income country (CIA World Factbook, 2002 estimate).
urgency of having the highest HIV prevalence (38%) of any country in the
world. Yet to date Botswana has succeeded in enrolling in ARV programs only
17,500 of the 110,000 people in need of treatment, in spite of the fact that cost is not a
barrier. Much of the low uptake of ARVs in Botswana can be attributed to the stigma
associated with HIV/AIDS, and widespread reluctance to undergo HIV testing. In
fact, in response to low testing rates, in January 2004 President Mogae took the bold
and unprecedented step of instituting routine HIV testing of everyone who entered a
hospital or clinic, with the hope that this would dramatically increase testing and
uptake of ARV treatment (LaFraniere, 2004).

Yet the sheer logistics of implementing a national treatment plan are
overwhelming. Ndwapi Ndwapi, the director of the largest ARV program in the
country, is “skeptical” that Botswana will succeed in enrolling the target of 55,000
persons that has been set for 2005. He comments,

Many think that accessing the funds to put the plan into action is the
biggest challenge. But once you have the money, you suddenly find there
are seemingly insurmountable challenges. The gross inefficiencies in the
system, that have been a problem for some time, become so apparent when
you try to ask the system to do something this big... (Ndwapi, 2004)

The challenge of implementing such programs may be even greater in countries
like Uganda (with a population of 26 million, a per capita GDP of only $1200, and a
much more limited health care system), as well as in the many other African countries
which have similarly large populations and scarce resources. Even as ARVs become
available to more of the world’s poor, the hope associated with ARV treatment may
at times mask the fact that AIDS has no cure, and that it remains unknown to what
extent ARVs, especially the lower-cost fixed-dose pills that are being marketed to
developing countries, can extend a life. ARVs are not a panacea, but rather a “late
step,” and prevention efforts must continue so that people do not reach the stage of
needing ARV treatment (Moore, 2003). With commitment to the mandate of AIDS
prevention flagging within the international community, a paradigm shift to the ABC

27 Data were released in May 2004 that Swaziland may have a slightly higher HIV prevalence.
28 This program is at the Princess Marina Hospital in Gaborone.
approach may be what is needed to revitalize prevention efforts and renew the belief that prevention can work.
ADOLESCENT SEXUALITY

In Africa, the predominant mode of HIV transmission is heterosexual sex, and half of those who become infected are between the ages of 15 and 24 years (UNAIDS/WHO, 2003). Adolescent sexuality has long been a subject of concern to public health practitioners, policy makers, parents, and others, and perhaps never more so than in an era of HIV/AIDS. In fact, youth are often seen as being at the center of AIDS epidemics, and may lack the knowledge, skills, and power to protect themselves from HIV/AIDS. Understanding adolescent sexuality, including both the social context of sexuality and how youth individually construct beliefs and make decisions, is crucial to designing effective AIDS prevention programs and to keeping youth safe from HIV/AIDS.

Sexual Behavior and HIV Risk Among Youth in Africa

At the height of the AIDS epidemic in Uganda youth aged 15 to 24 years had the highest HIV incidence rate of any age group, and as AIDS began to decline they also experienced the greatest decline in HIV prevalence (Green, 2003a, p. 141). For urban youth, prevalence declined 75% between 1991 and 1998 for youth aged 15 to 19 years (from 20.9% to 5.2%), and 59% for youth aged 20 to 24 (from 24.9% to 10.2%) (Stoneburner & Low-Beer, 2004), compared to a 50% decline for all age groups (Green, 2003a, p. 185). Similarly, a study of prevalence over a 10-year period (1989 to 1999) in a rural population in south-west Uganda found that the greatest declines in prevalence were among men aged 20 to 29 years and women aged 13 to 24 years (Mbulaiteye et al., 2002). As previously noted, there was significant behavior change among youth during and before this time period, namely delayed sexual debut and decreased premarital sex, and a decreased period of time between first sex and first marriage. This behavior change among youth was likely responsible

29 Note that the majority of youth appear to have been infected before the age of 19!
for the decline in HIV prevalence among youth. A team of UNAIDS researchers has stated that, "A delay of a few years in first sexual activity has been associated with a reduction of HIV prevalence among young people in Uganda" (Laga, Schwartlander, Pisani, Sow, Carael, 2001; cited in Green, 2003a, p. 185).

Furthermore, these trends among youth appear to be critical to the progression of the AIDS epidemic in Uganda as a whole. Studies from the late 1980s showed that the highest infection rates were found among youth aged 15 to 19 years, suggesting that infection rates in this group were driving the national epidemic (Konde-Lule, 1995; cited in Green, 2003a, p. 141). It therefore seems plausible that a decline in HIV prevalence within this group also drove the decline of HIV prevalence nationally. Peter Piot, executive director of UNAIDS, has been quoted as saying that, "In every single country where AIDS has been brought under control it has begun with young people" (Reuters, May 10, 2002; cited in Green, 2003a, p. 49).

An increase in age of sexual debut is important not only because it delays the age at which a young person becomes at risk of HIV/AIDS, but also because later sexual debut is associated with decreased number of premarital sexual partners and lifetime sexual partners, and is predictive of "lower levels of future high-risk sexual behaviors and increased protective factors," including condom use (Bessinger, 2003). Lifetime number of sexual partners is positively associated with a higher risk of HIV/AIDS. Therefore delaying sexual debut, and decreasing the period of time between sexual debut and marriage, can decrease number of lifetime sexual partners, and risk of HIV/AIDS, for an individual. The UNAIDS Multicentre study, which compares trends in four African cities,\(^{30}\) found that young age at first marriage, young age of women at sexual debut, lifetime number of sexual partners, and large age differences between spouses were related to high HIV prevalence in the population as a whole, while other risky sexual behaviors (including contact with sex workers and lack of condom use) were not (Carael & Holmes, 2001).

There is evidence that increases in age of sexual debut have occurred among youth in South Africa and Zambia, and youth in these countries have also experienced

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\(^{30}\) Cotonou, Benin; Yaounde, Cameroon; Kisumu, Kenya; and Ndola, Zambia
In spite of these successes, abstinence and delayed sexual debut remain seriously understudied. Although the DHS has been collecting data about age of sexual debut for women since the late 1980s in connection with fertility trends, data about age of sexual debut for men was not collected until the mid 1990s. In the DHS module on HIV/AIDS there has been only one question about age of sexual debut, compared to twenty-nine questions related to condom use. In 2000, USAID finally adopted age of sexual debut as an AIDS-related indicator (Green, 2003a, p. 68). The United Nations General Assembly Special Session on HIV/AIDS (UNGASS), which focuses its global AIDS prevention efforts on youth, currently has just one indicator: condom use by youth. UNGASS has announced its intention, however, to expand the methodology used to measure this one indicator to also “provide information for measuring levels of and trends in abstinence and faithfulness/partner reduction behaviors” (USAID, 2002).

In addition to the lack of quantitative data, to date there have been no qualitative studies of abstinence among youth in Uganda or elsewhere in Africa, published in peer-reviewed journals. Previous studies have addressed other facets of adolescent sexuality in Uganda, including knowledge of HIV/AIDS and attitudes and intentions towards condom use (Abraham, Rubaale, Kipp, 1995; Kinsman, Nakiyingi, Kamali, Whitworth, 2001), but have devoted very little attention to delayed sexual debut and abstinence. For instance, a group of researchers has published several detailed qualitative studies of youth in Masaka, Uganda, addressing attitudes towards sexuality, the negotiation of sexual relationships, and condom use, but has barely addressed the topic of abstinence, in spite of the fact that in certain studies approximately half of the participants were not sexually experienced (Nyanzi, Pool, Kinsman, 2001; Kinsman, Nyanzi, Pool, 2000; Kinsman et al., 2001). Using

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31 UNAIDS found that HIV prevalence among South African women aged 15 to 19 years decreased from 21% to 15% between 1998 and 2001, even as prevalence among older women increased, and concluded that “the decline in HIV prevalence was very likely due to an increase in age of first sex among teenagers” (UNAIDS/MAP 2000 and UNAIDS/WHO 2002, cited in Green, 2003a, p. 52). Among Zambian youth in the 1990s, there were an increase in age of sexual debut, a decrease in premarital sex, and a decrease in AIDS prevalence. As in South Africa, these declines in AIDS prevalence occurred only among younger cohorts and not in the general population (Bessinger, 2003).
qualitative methods, the current study will investigate attitudes and values of Ugandan youth regarding sexuality and especially abstinence, as well as factors in the social environment, including social and peer norms, which shape individual attitudes, values, and behavior.

Literature Review: the Social Construction of Adolescent Sexuality in Africa and the United States

Research has shown that adolescent sex behavior are influenced by a spectrum of factors, ranging from individual-level factors such as knowledge, attitudes and values, to peer-level, family-level, and society-level factors. While most research has explored individual-level factors, less research has explored the “contextual factors” which shape individual beliefs and behavior (MacPhail & Campbell, 2001; Blum & Mmari, 2004). Such contextual factors include government policy, the economic climate, family functioning, school climate, and relationships with peers and within communities (Blum & Mmari, 2004). There is a particular lack of research examining such factors in the developing world (MacPhail & Campbell, 2001). A 2004 World Health Organization analysis of studies of adolescent sexual and reproductive health in developing countries, 1990 to 2004, notes this paucity of data (Blum & Mmari, 2004). Only 158 studies met modest criteria for inclusion in the report, and very few of these addressed peer-level, family-level, or society-level contextual factors. As the report concluded, “most research focuses on adolescent knowledge, attitudes, and beliefs with little attention to how these are derived” (Blum & Mmari, 2004) The report urges more research into such factors as adolescent connectedness to school, perceived versus actual peer behavior, connectedness to parents, and community and cultural norms, values, and expectations (Blum & Mmari, 2004).

32 An adolescent is a person between the ages of 13 and 18 years of age, while “youth” typically refers to a person up to the age of 24 years (WHO). Both terms will be used to refer to young people in this study, with the more specific term “adolescent” being used particularly in this section, which addresses research of adolescents.
Most research of African adolescents has explored individual-level factors, especially knowledge, yet knowledge itself is not always a good predictor of preventive behavior (Abraham et al., 1995). A disjuncture between knowledge and behavior has been evident in the spread of HIV/AIDS within Africa, and researchers have noted the coexistence of high levels of knowledge regarding HIV/AIDS and high levels of risky sexual behavior in certain populations (Agyei, Mukiza-Gapere, Epema, 1994; Lema & Hassan, 1994; Campbell & MacPhail, 2001). Many AIDS prevention efforts have aimed to increase knowledge regarding AIDS prevention and sexual health, but have not documented whether or not increased knowledge has actually led to change in behavior or reduced risk of HIV/AIDS (Klepp et al., 1994; Mbizvo et al., 1997; Taffa, Klepp, Sundby, Bjune, 2002; Rahlenbeck & Uhagaze, 2004). One reason knowledge may not lead to healthy behaviors is that information may not always be usable in situations of economic and social disadvantage, especially for women (Hallman, 2004).

Some researchers have emphasized the importance of contextual factors, asserting that to a great degree adolescent sexuality is socially constructed (MacPhail & Campbell 2001; Kinsman et al., 2000). In their qualitative studies of adolescent sexuality in South Africa, Campbell and MacPhail (MacPhail & Campbell, 2001; Campbell & MacPhail, 2002) argue for a conception of sexuality as being defined not only by sexual practices, but by what people "know and believe about sex, particularly what they think is natural, proper, and desirable" (Holland, Ramazanoglu, Sharpe, Thomson, 1990; cited in MacPhail & Campbell, 2001). MacPhail and Campbell continue,

Much of previous research, particularly in developing countries, has concentrated on the phenomenon of sexuality at the level of the individual, while neglecting societal, normative, and cultural contexts. Focusing on the individual-level assumes that sexual behavior is the result of rational decision-making based on knowledge. In reality, the complex nature of sexuality means that adolescents conduct their sexual lives through experiences and beliefs that have been generated through their
membership of particular societies and communities (MacPhail & Campbell, 2001).

One of the ways such membership in societies and communities shapes individual sexual behavior is through the messages that adolescents receive, either verbally or non-verbally, from their social environments. The strongest messages may come from people in immediate social environment: parents and families, peers, teachers, religious leaders, and other members of the community. These figures may have a particularly strong role in Uganda, where a relatively open social and political environment has developed in which AIDS and sexuality are discussed more openly than in other African countries. As previously noted, DHS data have shown that Ugandans are much more likely to receive information and education about AIDS through interpersonal networks than through media or other impersonal sources.

Twa-Twa (1997), in his study of Ugandan adolescents, presents a theoretical framework within which to examine the role of the social environment in shaping sexual activity. He lists four “environmental” factors that shape sexual activity: parental care, peer influence, economic factors, and AIDS education. Of these four, parental care, peer influence, and AIDS education clearly involve the transmission of messages. Twa-Twa writes, “The social environment plays an important role in adolescent sexuality through socialization, verbal and sign communication, modeling, sanctioning, and the internalization of norms and values” (Twa-Twa, 1997).

Data confirm the importance of contextual factors in shaping adolescent sexual behavior in Africa. In Twa-Twa’s study, youth who had more friends and who had friends who consumed alcohol were more likely to be sexually experienced, which suggests peer influence in the decision to have sex (Twa-Twa, 1997). Youth who lived with both parents were less likely to have engaged in sexual activity than adolescents whose parents were separated, who lived with only one parent, or who had been orphaned (Twa-Twa, 1997). Students who boarded at school were more likely to have had multiple sexual partners than students who lived at home (Twa-Twa, 1997).
A survey done in Soroti, Uganda, also noted the importance of peer and family relationships in determining sexual behavior. This survey found that more than a third (37%) of sexually active adolescents cited “friends did it” as a reason for engaging in sexual activity, and 14% cited “copied adults” as a reason. This study also noted the role of other types of messages, such as those transmitted through mass media. A school-based AIDS education program aimed at increasing abstinence among primary school students resulted in a decrease in sexual activity of almost 75%. The study concluded that one reason for this success might be the fact that Soroti is very rural and has few “competing messages” from such sources as advertising, cinemas, and popular music (Shuey, Babishangire, Omiat, Bagarukayo, 1999).

Kinsman et al. (2000) discuss socializing influences and the construction of sexual values for adolescent girls in Masaka, Uganda. Children commonly mimic the sexual behavior of their parents from a very young age, and as they get older begin to form opinions of their parents, and especially mothers, as either good role models or bad role models in the area of sexuality. The study reported that conversations between parents and children about sex were rare, however. Peer pressure emerged as an important source of influence, with girls who were sexually active forming an informal “club” to which only other sexually active girls were admitted. Other girls had decided they valued their virginity and did not want to be sexually active, and these two groups had developed a very strong sense of “us” versus “them,” with the non-virgins sharply criticizing the virgins for not being “good people.” The girls also discussed the messages they had received at school and from their teachers, and their exposure to pornography and other sexually explicit media, which they felt might “negatively influence the development of their views and values concerning sex” (Kinsman et al., 2000).

Research conducted elsewhere in Africa has had similar findings. In a study of Kenyan female secondary school students, “lack of parental guidance,” parents

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33 Ugandan children typically have a much greater familiarity with the sexual practices of their parents, as homes are typically small and lacking in privacy.
exposing their children to their own sexual activity or having affairs, and “over stimulation by the mass media” such as television and films, were identified as being reasons that girls chose to have sex while still in school (Lema, 1990). Other predictors of adolescent sexual behavior include amount of education and living in an urban versus a rural environment. Ugandan DHS data show that girls living in an urban environment have a later sexual debut than do girls living in a rural environment, and that girls with secondary education start sex almost two years later than do girls with only primary education or with no education (Figure 1). (Among Ugandan boys, all groups of boys appear to have very similar ages of sexual debut (Figure 2).) Lack of education is often a result of economic disadvantage, and early sexual debut among girls with less education may be an outcome of poverty as well as lack of education. Data from South Africa show that relative economic disadvantage is found to significantly increase the likelihood transactional sexual relationships and coerced sex for girls, multiple sexual partners for girls and boys, and early sexual debut for girls and boys, and to decrease the likelihood of sexual abstinence, condom use, and communication with sexual partners (Hallman, 2004).

**Contextual Determinants of Adolescent Sexuality in the United States**

The role of contextual factors in shaping adolescent sexual behavior has been studied more extensively in the United States than in Africa and the developing world. One researcher, in a review of studies of the onset of sexual activity among American females, notes that “most published correlates of sexual intercourse among adolescents are environmental,” rather than individual (Goodson, Evans, Edmundson, 1997), and another researcher asserts that the transition to sexual activity is “socially timed” (Upchurch, Aneshensel, Sucoff, Levy-Storms, 1999). In studies of American adolescents, parents consistently emerge as one of the strongest influencers of adolescent sexual values and behavior. Family structure and parental education level consistently have been shown to influence adolescent sexual behavior, with adolescents with separated parents or an absent father tending to have an earlier onset
of sexual activity, and children of more highly educated parents tending to have a later onset of sexual activity (Goodson et al., 1997). Children of mothers who believe premarital sex to be wrong are significantly less likely to engage in premarital sex (Donovan, 1995), while children of parents who are perceived as either being too strict and over-controlling or extremely permissive are likely to engage in sexual activity at younger ages than children of more moderate parents (Upchurch, et al., 1999). Children of mothers who work outside the home and adolescents with “poor parental monitoring” tend to have an earlier onset of sexual activity (Klitsch, 1994; Goodson et al., 1997).

Peer beliefs and norms also emerge as a strong predictor of adolescent sexual behavior, with adolescents with greater numbers of sexually active friends being more likely to be sexually active themselves (East, Felice, Morgan, 1993; Murry, 1994). Adolescents who perceive their friends to be sexually active are also more likely to be sexually active, whether or not this perception is accurate (Goodson et al., 1997). Media, especially television and movies, have well-recognized socialization effects. According to social learning theory, behavior is modeled by others, observed, and then reproduced. Adolescents are more likely to reproduce the sexual relationships they see modeled in the media than are adults, as they are more likely to see them as being realistic (Chapin, 2000). For religious adolescents, religious communities, including religious leaders and peers within that community, are an important source of messages regarding sexuality and sexual norms, and religious adolescents are more likely to postpone sexual involvement (Thornton & Camburn, 1989; Goodson et al., 1997; O’Connor, 1998, Lammers, Ireland, Resnick, Blum, 2000).

**Individual-Level Determinants of Adolescent Sexuality**

In addition to these peer-, family-, and community-level influences, individual attitudes and behaviors have been determined to be associated with sexual behavior, both in Africa and the United States. Alcohol use is strongly associated with sexual activity for both African adolescents (Taffa et al., 2002; Twa-Twa, 1997; Lugoe,
Klepp, Rise, Skutle, Biswalo, 1995) and their American counterparts (Klitsch, 1994). Substance abusers are more likely to engage in high-risk sexual behaviors such as having multiple partners and no, or minimal, condom use in Africa (Taffa et al., 2002; Blum & Mmari, 2004) and the United States (Krantz, Lynch, Russell, 2002). Adolescents on both continents who have more permissive attitudes towards premarital sex are likely to have an earlier sexual debut (Blum & Mmari, 2004; Goodson et al., 1997). One study of Tanzanian adolescents has shown attendance at a church or mosque to be associated with sexual abstinence (Lugoe et al. 1995), as have studies of American adolescents (Thornton & Camburn, 1989; Murry, 1994; Beck & Cole, 1991).

In Africa girls with "low future aspirations" are more likely to have an early pregnancy (Blum & Mmari, 2004), and girls who are not in school are at a greater risk for a variety of negative outcomes, including early pregnancy and HIV/AIDS (DHS). Similarly, in the United States, adolescents who have positive attitudes towards school and adolescents who plan on going to college tend to have a later onset of sexual intercourse (Goodson et al., 1997). Poor school performance and a "feeling of limited future economic opportunities" are associated with an earlier initiation of sexual activity (Klitsch, 1994), while higher school performance is associated with a delayed onset of sexual activity (Lammers et al., 2000).

**Theory: Attitudes, Values and Perceived Norms**

Although all of the factors discussed above impact adolescent sexuality and certainly warrant further research, this study will focus on the three constructs of attitudes, values, and perceived norms regarding sexuality. Attitudes and norms are central components of models of individual health behavior, such as the Health Belief Model and Theory of Reasoned Action. According to the Health Belief Model, individuals hold attitudes regarding the perceived severity of a disease or condition, their own susceptibility to it, and the benefits of behavior change. These attitudes,
along with self-efficacy (an individual’s confidence in his or her ability to act),
define the likelihood of behavior change (Bandura, 1986). According to the related
Theory of Reasoned Action, attitudes about the risks and benefits of a certain
behavior, combined with perceived social norms, together define one’s behavioral
intention, which is the most important determinant of behavior (Fishbein & Azjen,
1975). Attitudes can be defined as beliefs about the outcomes or attributes of
performing a certain behavior, weighted by evaluations of those outcomes or
attributes (Montano, Kasprzyk, Taplin, 1997, p. 87). Perceived norms can be defined
as personal beliefs about whether or not those in one’s reference group—whether
peers, family, community, or society—approve of a certain behavior (Montano et al.,
1997, p. 87).

The construct of values is less clearly defined within behavior change theory,
yet sexual behavior is often constructed as a moral behavior. Individuals form
normative values about what behavior should be that may not be logical or rational,
and values can therefore be defined as normative and possibly moral beliefs that stand
apart from more rational attitudes about outcomes of behavior. Attitudes and values
are to some degree interrelated, however. For instance, an individual’s attitudes about
the risks and benefits of early sex can define his or her values regarding whether early
sex is morally right or wrong. Conversely, an individual’s values regarding sex—
whether shaped by religion, culture, or some other external set of beliefs—can affect
how he or she perceives the risks and benefits of a certain sexual behavior, and his or
her attitudes about the relative weight of these risks and benefits.

This study will investigate attitudes, values, and perceived norms in an attempt
to explain how knowledge of the risk of HIV/AIDS has been translated into healthy
behavior and reduced HIV risk among youth in Uganda. While many AIDS
prevention programs have succeeded in increasing knowledge among youth but failed
to produce changed behavior and reduced risk of HIV/AIDS, Uganda has succeeded
in changing behavior and reducing risk of HIV/AIDS among youth at a national level.
This raises the question, then, of how knowledge about HIV/AIDS is constructed and
interpreted by Ugandan adolescents, and how this results in behavior change.
Attitudes and values can be understood as subjective interpretations of knowledge, that influence intentions and ultimately behavior. Perceived norms are also powerful determinants of behavior, as they are beliefs about what is acceptable and sanctioned within a specific social context.

Attitudes, values, and perceived norms can be considered individual-level factors, as they all relate to individual beliefs, and for that reason they cannot capture the full range of factors that influence adolescent sexuality and sexual behavior. Although research has shown that individual-level factors, including attitudes and values, are determinants of adolescent sexuality, research has also shown that contextual factors perhaps play a greater role than do individual factors. Attitudes, values, and perceived norms can provide indirect evidence of contextual determinants of adolescent sexuality, however. As will be seen, inquiring about attitudes towards sexual behavior with questions such as “Why do boys and girls have sexual relationships?” and “What good and bad things can there be in relationships?” elicits information not only about personal attitudes towards sex, but also about external factors that influence sexual behavior. Similarly, inquiring about normative values regarding sexuality fosters discussion about the social context within which those values are formed and maintained.

Perceived norms are perhaps most directly related to peer-, family-, community-, and society-level determinants of adolescent sexuality. While perceived norms are personal (and subjective) opinions, norms themselves operate on a social level, whether that of peers, family, community, or society. Questioning youth about the messages they receive from these social groups and the norms they perceive is therefore a means to investigate the beliefs and dynamics of these groups as well as the influence they exert on individual adolescent behavior. Many of the contextual factors discussed in the literature, such as family functioning, lack of education, gender inequalities, poverty, and peer group behavior, can thus be explored through an investigation of individual attitudes, values, and perceived norms. Data gathered through such a process have the added advantage of coming from the point of view of
youth themselves. Such data address not only what contextual factors influence adolescent sexual behavior, but how youth perceive these factors and their impact.

As this study will adopt not only an individual-level but also a social-level model of adolescent sexuality and sexual behavior, community and societal models of human behavior also provide useful paradigms. According to social learning theory, people form attitudes and values within a social context, and behavior is shaped by perceived peer norms, social pressure to perform or not perform a certain behavior, and what people see modeled by those around them (Kebaabetswe & Norr, 2002, p. 516). The diffusion of innovation theory is even more specific about how behavior is modeled: “innovations” in behavior spread gradually from “innovators,” who are usually influential and persuasive people, to the rest of the community (Kebaabetswe & Norr, 2002, p. 516). The role of these individuals goes beyond simply disseminating knowledge. As diffusion of innovation theorists Rogers and Shoemaker (1971) suggest, while mass media channels are important in spreading knowledge, the “persuasion function” of persuading people to change their behavior in response to knowledge is more readily accomplished through interpersonal channels (Rogers & Shoemaker, 1971; cited in Green, 2003a, p. 175). This is consistent with data from Uganda which show that most communication about HIV/AIDS and behavior change has taken place through interpersonal channels.
MATERIALS AND METHODS

Setting

Research for the current study was conducted in September through November of 2003 in two sites: the town of Soroti, in the eastern region of the country, and rural Masaka District, in the central region of the country, in a location approximately 30 kilometers southwest of Masaka Town34 (Figure 9).

Figure 12
Map of Uganda

34 Soroti and Masaka are the names of both districts and towns, with Soroti Town and Masaka Town being the largest towns in their respective districts.
Soroti Town under normal circumstances has approximately 20,000 residents, but during the period of the research as many as 100,000 internally displaced people (IDPs), fleeing the civil war in the north, had settled in the town for safety. Masaka District is mostly quite rural, and in the small town where the research was conducted there were not more than a few hundred people, with most people in the area (such as the participants in this study) living in small farms outside the “town” center.

Soroti is an area of relatively low HIV prevalence. Ministry of Health data show that prevalence declined from 9.1% to 5.0% between 1993 and 2000 (Green, 2003a, p. 144). These figures can be compared to national HIV prevalence, which declined from 15% to 5% between 1991 and 2001 (UNAIDS). In addition, Soroti District is the site of a highly successful school-based program targeted at reducing adolescent sexual activity. The African Medical Research and Education Foundation (AMREF), which evaluated the program, found that sexual activity among students in the last year of primary school (P7) decreased 90% over the period of the study. In 1994 23.6% of P7 girls and 61.2% of P7 boys reported having had sexual intercourse, but by 2001 that proportion had dropped to 1.9% of girls and 5.2% of boys (Green, 2003a, p. 186). The predominant ethnic group in Soroti District is the Iteso, with several other smaller ethnic groups such as the Kumam also present. Most people are peasant farmers.

Masaka is an area of historically high HIV/AIDS prevalence. The first AIDS cases in Uganda were identified in Rakai, Masaka’s neighboring district to the south, in 1982, and Masaka and Rakai were the epicenter of the Ugandan AIDS epidemic in the late 1980s and early 1990s (Okware, Opio, Musinguzi, Waibale, 2001). Since then these two districts have also been the target of massive IEC campaigns, and were the sites of the largest longitudinal cohort study of HIV transmission in Africa to date, which followed over 10,000 people from 1990 to 2001 (Nunn & Mulder, 1997). Knowledge of HIV/AIDS has been shown to be high among the adolescent population in Masaka district (Kinsman et al., 2001), and HIV prevalence has been declining since the early 1990s, with the prevalence among young women aged 13 to
19 years less than 2% and the prevalence for young men aged 13 to 19 years less than 1% in 1999 (Mbulaiteye et al., 2002). The population in Masaka district is almost exclusively of the Baganda ethnic group, and most are peasant farmers.

Methods and Population

Design of Focus Group Discussion Methodology

This study employed qualitative methods, as it was felt that sufficient quantitative data had already documented the reality of behavior change among Ugandan youth, and that the remaining question of why this behavior change has occurred was better addressed through qualitative rather than quantitative methods. While quantitative data focuses on verifiable facts and measurable quantities, qualitative data seeks a “deeper understanding of the circumstances that help to explain why and how people make the decisions they do” (Ulin, Robinson, Tolley, McNeill, 2002, p. 22). This approach is inherently subjective rather than objective, recognizing that the world is “constructed, interpreted, and experienced by people in their interactions with each other and with wider social systems,” and that the subjective meanings people attach to facts are as important as the facts themselves (Ulin et al., 2002, p. 22).

Qualitative data were gathered through focus group discussions conducted with 8 to 10 adolescents of the same gender and between the ages of 13 and 16 years. Eight to 10 participants per focus group was felt to be a large enough number to produce good discussion and a diversity of opinions, without being so large that the group was unmanageable or that some participants did not have an opportunity to express themselves. Two trial focus groups (which were not included in the final

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35 The exception to this is the focus group discussion conducted with out-of-school youth, which involved groups of 4 to 6 youth and in some cases, youth over the age of 18. The majority of this paper will focus on in-school youth, with out-of-school youth being analyzed in a separate section.
results of the study) confirmed this as a good size. Girls and boys were separated to facilitate discussion of potentially sensitive topics, and also to ensure that both genders had a chance to be heard.

Focus group discussions were felt to be particularly appropriate for this study as they allow for interaction and even debate among participants, and create a focus on peer norms rather than individual values and beliefs. As MacPhail and Campbell argue, focus group discussions are consistent with a movement away from a "conceptualization of 'sexual behavior' as the product of individual decisions" and towards a concept of "sexuality as a socially negotiated phenomenon, strongly influenced by peer norms." Focus group discussions also "reveal the way in which particular individuals' opinions are accommodated or assimilated within an evolving group process" (MacPhail & Campbell, 2001). It is these very peer norms and the construction of personal values within a context of socially-mediated messages that this study hoped to examine. Focus group discussions can also facilitate the discussion of somewhat "taboo" topics such as sexuality, in that less inhibited members of the group can "break the ice" for more reticent participants (MacPhail & Campbell, 2001).

The age range of 13 to 16 years was selected as youth in this range are in the period of early adolescence in which they are going through puberty\(^{36}\), and are starting to think about and form opinions about sexuality, although for the most part they are not yet sexually active. Other researchers have identified the period of 13 to 16 years as a critical period for interventions aimed at delaying the onset of sexual activity. In a study of South African adolescents, MacPhail & Campbell (2001) note that "it is increasingly being argued that preventive interventions... may be most effective if directed at young people below the age of 16 years." In a review of studies of adolescent sexuality in Africa, Kaaya et al. (2002) assert, "The age of 13 to 14 years is an important transition point for interventions that aim to delay the onset of sexual activity."

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\(^{36}\) The median age for first menstruation in Uganda is 14 years, with 75% of girls experiencing their first menstruation by the age of 15 years (DHS, 2001). Boys can be assumed to enter puberty at approximately this age, or slightly later.
of sexual activity in younger population, and to increase the adoption of risk
reduction strategies in older populations."

Primary school students, secondary school students, and out-of-school youth
were included in this study. Students from both types of schools were included as
students between the ages of 13 and 16 years can be in either primary or secondary
school, given the fact that Ugandan students often progress through school at very
different rates. It was felt to be particularly important to include primary school
students, as approximately 75% of Ugandan youth do not progress to secondary
school. All secondary schools in Uganda are privately owned and require students to
pay significant fees to attend, with the result that students who manage to attend
secondary school are not only in the minority but tend to be of a higher socio-
economic class than other Ugandan youth. They may therefore have significantly
different experiences than do other Ugandan youth, and may experience poverty, lack
of education, orphanhood, and other risk factors for HIV/AIDS to a lesser degree than
do other youth. In contrast, most primary schools are government-run and charge
much smaller fees to attend, so primary students are not a socio-economically "elite"
group as are secondary school students. Out-of-school youth have been even more understudied than have primary
school students, and so including them in this study was felt to be critical. A 2002
review of articles on sexual behavior of African youth published between 1987 and
1999 identified 47 such articles, but only 4 articles included out-of-school youth in
the sample. Research with out-of-school youth presents some special challenges that
research with in-school youth does not, such as locating adequately-sized populations
of out-of-school youth. Yet out-of-school youth make up a significant proportion of
all youth, and should not be ignored. According to the 2001 Ugandan DHS, 56% of
girls between the ages of 15 and 19 years, and 31% of boys between the ages of 15

37 Under Uganda's Universal Primary Education law, primary schooling should be free for all
Ugandan children. In reality, fees are still assessed for uniforms, books, exams, and other necessities,
so that cost is still a barrier to primary education for some Ugandan youth.
and 19 years, were no longer in school. Furthermore, out-of-school youth may be at additional risk of becoming infected with HIV/AIDS. Out-of-school youth do not benefit from in-school AIDS education programs such as those offered in Ugandan primary and secondary schools, and they may be illiterate and unable to benefit from other sources of AIDS prevention information, such as print media. They may also be more likely to be poor, and more likely to be orphans. Out-of-school girls may be particularly at risk of becoming infected with HIV/AIDS, as they have a much earlier sexual debut than do girls with some education (Figure 1). Out-of-school girls are also more likely to experience an early pregnancy (DHS).

The questions used to guide focus groups discussions addressed attitudes, values, and perceived norms (Appendix 1). The first set of questions addressed attitudes, asking “Why do boys and girls have relationships?” and “What bad and good things can there be in relationships?” This was followed by “Why do people have sexual relationships?” and “What bad and good things can there be in sexual relationships?” The second set of questions addressed values. Youth were asked, “At what age should boys and girls start having relationships and why?” and “At what age should boys and girls start having a sexual relationship or playing sex and why?” The third set of questions addressed perceived peer, family, community, and societal norms. Youth were asked about the advice they had received from friends, parents and family members, teachers, religious leaders, community elders, the government, and media such as newspapers and radio. A final set of questions again addressed attitudes and values by asking youth what they thought of the messages they had received (values), if they thought it was possible to follow that advice (attitudes), and what they advice they would give to their peers as the best things for young people to do (values).

Population

Participants included equal numbers of girls and boys: 35 in-school girls and 33 in-school boys for a total of 68 in-school youth, and 9 out-of-school girls and 11 out-
of-school boys, for a total of 20 out-of-school youth. Eighty-eight youth participated in total: 44 girls and 44 boys. The average age of the in-school youth was 14.6 years, with a range of 13 to 16 years, and the average age of out-of-school youth was 16.5 years, with a range of 13 to 18 years for girls and 13 to 21 years for boys. Boys were slightly older than girls, with an average age of 15.4 years for boys and 14.5 years for girls. Participants were representative in terms of ethnic group, with most participants in Soroti Town being from the Teso ethnic group (and a minority being from the closely related Kumam ethnic group), and most participants in Masaka district being from the Baganda ethnic group. The participants from the boarding (secondary) school from which participants were recruited in Masaka District did include some students who were originally from other parts of the country and other ethnic groups, so 9 of the 20 participants from that school were in fact non-Baganda. Participants were also diverse in terms of religious group, including Catholics, Protestants, Pentecostals, and Muslims. Muslims were somewhat under-represented, with only 5.7% of participants being Muslims, compared to 16% nationally. However, Muslims tend to be concentrated in certain areas of the country, and the two regions in which research was conducted are not among the heavily Muslim parts of the country.

Implementation of Focus Group Discussions

In each site, six focus group discussions were conducted, for a total of twelve focus group discussions. In each site one focus group discussion was conducted with girls and one with boys for each of three populations: primary school students, secondary school students, and out-of-school youth. Focus group discussions with in-school youth were held in English, with some participants translating at times for other participants who were not able to fully express themselves in English. According to national law, all education in Uganda is conducted in English, and so all students spoke English, although some were not as conversant in English as were others.
Focus groups with in-school youth in Soroti were held with the help of a research assistant, a young man who had experience supervising AIDS prevention clubs in schools, but did not work at any of the schools used in this study and so was not known by the participants in this study. The researcher discussed with the research assistant the goals of the projects and the principles of qualitative research, especially the need to not express personal opinions or ask leading questions, and the research assistant demonstrated an excellent grasp of these concepts during the focus group discussions. During the focus group discussion the research assistant helped to translate the researcher’s questions into more colloquial English when necessary, and similarly helped the researcher to understand the participants’ English, when necessary. The researcher did not use a research assistant with in-school focus groups in Masaka, as she was by this time more familiar with the colloquial English spoken in Uganda, and no longer had trouble communicating with participants in English.

Focus group discussions with out-of-school youth were held in local languages with the help of a translator. In Soroti the research assistant served as a translator. In Masaka one girl and one boy who had participated in the focus groups with in-school youth were recruited to serve as a translator for out-of-school youth. This decision was made as the only adults or young adults in the area who were fluent in English were also well-known by the study participants, and it was felt that the presence of such an adult in the focus group would constrain or bias the discussion. It was felt that a younger child who was not well-known to the participants, would be a more neutral presence as translator. The students who served as translators already had a good understanding of the goals of the research, and the researcher discussed with them their role as translators before the focus groups with out-of-school youth were conducted.

In each location students between the ages of 13 and 16 years were recruited from one primary school and one secondary school. An effort was made to select schools that seemed more or less typical of the schools in that location, but it is

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38 Research in Masaka was conducted in a quite rural area, in which the members of the small community were well known to each other.
unknown to what degree the students in these schools were representative of all students in that area. The schools used included a community-based primary school in the town center of Soroti Town, a private secondary school in the outskirts of Soroti Town, a free private Christian primary school in which approximately half of the students were AIDS orphans in a rural area of Masaka District, and a private boarding secondary school also in a rural area of Masaka District. Students were also recruited from one additional secondary school in the first location, Soroti, in order to conduct two trial focus groups.

The researcher first met with the principal or a head teacher at each school in order to introduce herself and explain the goals of the study and the student participation that would be required. The researcher showed the principal or head teacher the questions to be used in the focus group discussion, and answered any questions the principal or head teacher had. After permission was granted to conduct the research and to speak with the students, the researcher visited the P7 classes (in the primary schools) or S1 and S2 classes (in the secondary schools) with a teacher. In schools in which there was more than one class per grade level, the researcher visited all classes of that grade level and attempted to include an equal number of students from each class.

The researcher then addressed each class, informing the students that she was conducting a research project and needed the participation of several students between the ages of 13 and 16 years. In some cases the teacher told the class that the researcher was studying HIV/AIDS, and the researcher then gave a brief explanation of the goals of the study, as described on the informed consent document (Appendix 2). In other cases, in the interests of time and when the teachers seemed to be in a hurry, the student researcher gave less information. The researcher then asked for a specific number of girls and a specific number of boys between the ages of 13 and 16 years to volunteer by raising their hands. Students were usually somewhat shy to volunteer at first (perhaps because some of them were having trouble understanding the researcher and did not fully grasp what she was asking), but sufficient students always volunteered without further prompting.
Two trial focus groups discussions were conducted (one with girls, one with boys) with secondary school students in Soroti, and minor changes were made to the focus group discussion questionnaire, before the researcher proceeded with the other focus group discussions. For the remaining four focus group discussions in Soroti, recruitment proceeded as described above. In the primary school in Masaka, all P7 students between the ages of 13 and 16 years participated, as it was a small school. In the secondary school in Masaka, the principal did not allow the researcher to address the classes because the students were taking exams, and instead compiled a list of students to be included in the study. The researcher suspected that the teachers might have selected the “best” students, and explained that it was important to have a representative sample, and not just the “best” students. As the list contained students who were not in S1 or S2, the researcher used this as an excuse to request a new list. The principal also requested that the focus group discussions be held on a Saturday, which meant that only students who were boarding at the school could participate. The school then drew up a list of S1 boarders (10 girls and 10 boys), which seemed to include most of the S1 boarders between the ages of 13 and 16 years.

After participants were selected, the researcher met with the entire group (girls and boys together) to explain what participation in the study would involve. The researcher gave the students a chance to read the informed consent document (Appendix 2), which explained the goals of the study in general terms, and then discussed the contents of the informed consent document to make sure that all of the students understood. The researched welcomed questions about the study, and then asked the students if they wanted to participate. If they did not, they were excused from the meeting. With one or two exceptions, the students were enthusiastic about the opportunity to participate in the study. The researcher then asked each student to write his or her name, age, number of siblings, father’s occupation, and religion on the informed consent document, and to sign it if he or she wished to participate in the study. This basic demographic data was gathered in order to give the researcher information about the demographics of the study population, and especially if the population was representative in terms of age, family size and father’s occupation.
(both possible indicators of socio-economic status), and religion. The students were then given an informed consent document to take home and have signed by their parent or guardian. In cases in which secondary school students were boarding at school and could not obtain the signature of a parent or guardian, a teacher at the school agreed to sign the informed consent document, as guardian. This introductory meeting was held during school hours and took twenty to thirty minutes.

The researcher scheduled times to hold the focus group discussions with the principal and teachers. In both secondary schools focus groups were held outside school hours (in the late afternoon or on a weekend), while in both primary schools focus group discussions were held during school hours at a day and time that the teachers had given permission for the participants to miss class. This second arrangement was necessary because these younger students would not have been able to participate outside of school hours, as they either had family responsibilities or had to walk home before dark. In the case of the primary school in Soroti, the teachers released the participating students during a recess and a time when no classroom instruction was planned. In the case of the primary school in Masaka, the P7 teacher was absent, and so the school was glad to have the P7 students occupied by the research project.

All focus group discussions with in-school youth were held in classrooms. Before beginning the focus group discussion, the researcher collected the informed consent documents that had been signed by parents or guardians and made sure that all participants had turned in both informed consent documents. If a participant did not have the informed consent document signed by their parent or guardian, he or she was asked not to participate, although this happened a surprisingly few number of times. The researcher again asked the youth if they had any questions, and then began the discussion.

Out-of-school youth were recruited through community-based organizations (CBOs) that provided vocational training to out-of-school youth. This recruitment method was used because of the difficulty of locating populations of out-of-school youth, although the researcher realized that this would mean that the out-of-school
youth included in this study were not necessarily typical of all out-of-school youth in Uganda. As these youth were receiving vocational training, their experience may have been more similar to that of in-school youth, than to some other out-of-school youth.

The researcher met with the director of the CBO, and explained the goals of the study and the participation that would be required by the out-of-school youth. As both CBOs were small and there were not sufficient youth between the ages of 13 and 16 years, all youth up to age of 18 years for girls and 21 years for boys who were available and willing to participate were included in the study. Youth who were married or had children were excluded, as the focus of this study was adolescents who had not yet married or had children. In both Soroti and Masaka the youth were unable to meet with the researcher before the day of the focus group discussion, and so the director of the CBO gave them a copy of the informed consent document and discussed the goals of the research with them in lieu of the researcher. The youth were asked to read and sign the informed consent document, and those who still lived with a parent or guardian were asked to have that parent or guardian sign an informed consent document.

Focus group discussions with out-of-school youth were held at the office of the CBO in Soroti, and in a classroom in Masaka. Before beginning the focus group discussion, the researcher discussed the goals of the research and the informed consent document with the youth, answered any questions they had, and asked them if they wished to participate. All youth were enthusiastic about participating in the study. As noted above, these focus group discussions all took place in local languages, with the help of a translator.

The researcher asked questions to focus the discussion (Appendix 1), but also gave youth considerable freedom to guide the discussion themselves. The researcher tried to give each person in the group a chance to speak and to keep any one person from monopolizing too much of the discussion, although in each focus group there were several youth who did much of the talking and one or two youth who said very little or nothing. The researcher tried to let conversation between the youth proceed as
naturally as possible, and not to interrupt with a new question until conversation around the previous question had naturally concluded. This meant that at times the youth got somewhat "off topic" in their conversation, and that the group did not necessarily discuss every topic on the focus group questionnaire before running out of time. Although the researcher did not set a time limit for the focus group discussion, it became obvious that the longest most groups could sustain focus was an hour to an hour and fifteen minutes, so focus groups tended to last between 45 minutes and an hour and 15 minutes. The researcher asked the questions in the order given on the questionnaire, so if time was running out in a focus group discussion, the group would not necessarily discuss all of the points of the third question (sources from which they received messages about sex and relationships). The researcher always made time to ask the last question, regarding what youth thought was the best thing to do, if they thought this was possible, and what advice they would give to other youth.

One of the strengths of a focus group methodology is that participants engage each other rather than simply responding to the focus group facilitator. Discussions were often quite animated as participants reacted to and at times challenged each other’s statements, in a group process of trying to answer complex questions and come to consensus on complex issues. Among boys, discussions would often develop into something of a debate, with boys striving to convince each other and establish who was "right" and who was "wrong" on various points. Often these debates would be waged not over questions directly related to the focus group questionnaire, but rather over questions such as when girls and boys first want to start to have sex, when girls can first get pregnant, and whether or not HIV/AIDS can be cured. The end result would usually be a fair amount of consensus, although in the process the debates often got quite passionate. In the process all participants were forced to examine and defend their opinions and beliefs. Focus groups also created a dynamic of accountability, in which participants were at times challenged on the validity of their statements, such as regarding the groups of friends they chose to associate with.

Youth reported enjoying the experience, at times asking when they would have another opportunity to speak with the researcher. Youth were very interested in how
the results would be used, and especially in the fact that their opinions and voices would be “heard” by people in America. The participants also had many questions they wanted to ask the student researcher, which the researcher encouraged them to ask these questions after the focus group discussion was concluded. Many youth wanted to know more about the research project, and what in particular the researcher was trying to find out from Ugandan youth. Youth often asked the researcher what she thought was the “best” thing for them to do, after the researcher had asked them this same question at the end of the focus group discussion, and asked her what advice she would give to them. Youth often were curious if the researcher supported abstinence among young people personally, and what her religion was. Youth were also very interested in whether or not HIV/AIDS was a problem in the United States, and asked various questions about the United States, from how many children women had to how young people behaved there. Youth also took the opportunity to ask questions about HIV/AIDS, such as what the symptoms were and if it was treatable. The sessions often ended with expressions of gratitude from the youth, for the opportunity to participate in the study.

Focus group discussions were recorded on audio tapes. The researcher also took notes during the focus group discussion, and recorded the order of speakers. These tapes were later transcribed by the researcher, and each comment was identified by speaker. For the focus group discussions conducted with out-of-school youth, only the English (translated) part of the discussion was transcribed. The researcher then coded the data by theme, and also by tracing the opinions and comments of each individual participant through the discussion.
RESULTS: IN-SCHOOL YOUTH

The themes that emerged from focus groups with in-school youth followed the structure of the questionnaire: reasons for having relationships, both platonic and sexual, as well as benefits and risks to those relationships; values regarding the proper age for girls and boys to initiate friendships and sexual relationships, and reasons for these values; the messages that youth have received regarding sex and relationships and their perceptions of peer, family, and community norms; and values regarding ideal behavior for youth in the area of sex and relationships. Other major themes that emerged included the importance of education for future well-being and “bright futures”; the risk of early pregnancy and the potential for early pregnancy to destroy chances for education and bright futures; the link between sex, fertility, and long-term commitment; the consistency of messages which youth are receiving regarding sex and relationships; and the importance of abstinence as a strategy to avoid risk and achieve goals.

Relationships: Risks and Benefits

Relationships with members of the opposite sex can be either platonic or sexual. Girls and boys cited the same reasons for platonic relationships with members of the opposite sex as they did for friendships with members of their own sex: companionship (especially if they are orphaned), encouragement to work hard, the exchange of advice and someone to talk to about “important decisions,” help in the midst of illness, problems or even danger, help with schoolwork, and a way to “enjoy life.” Girls particularly seek help from boys with the subject of math, because they believe that girls are bad in math and that boys are much better.

In some sexual relationships between girls and boys, money or gifts are given to the girl in exchange for sex. This pattern has been discussed extensively by Nyanzi et al.’s 2001 study of secondary school students in rural Masaka. Participants in the
current study were frank in discussing the reality of such relationships, usually framing them in terms of "need." Girls often are in need of school fees, underwear or other clothing, or money for food or various small luxuries, and choose to have sex with boys who can provide for these needs. Orphaned girls were believed to be particularly likely to enter into these relationships, as they often were without anyone to provide for them, but even girls who had parents often found their parents unable to provide for their needs, as families are large and resources limited. Mothers and fathers could attempt to transfer responsibility for providing for the child to the other parent, thus refusing to help daughters themselves, or even suggest that their daughter find a boyfriend who could provide for needs that they as parents could not.

_Girl_: Other [girls] want to play sex to get money. When the boy tells her, "After I will give you money for shoes." And the parents accepted things, and she plays.

Conversely, boys were often described by both girls and boys as having a "need" for sex, which they could satisfy by entering into sexual relationships with girls, relationships that often demanded that the boy give the girl gifts or money. Boys also employed language of being "forced" by their sexual desires to enter into sexual relationships and even commit rape.

_Boy_: Because when you are there without work, and then you see a girl who is beautiful, you can be forced to play sex with her.

_Boy_: Boys have sex due to sexual desire. Because there are some boys who cannot control their sexual desires. When a sexual desire comes, it needs just to do the thing at that time. That's why, that's why some boys or some men are forced to rape these younger girls, because of, they can't control their sexual desires.

At times, boys also blamed girls for causing them to play sex, such as when they wore mini or tight skirts.

Opinions regarding these transactional relationships varied. Some girls and boys saw them as a fact of life that some girls were forced into by their circumstances,

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39 The mean number of children per household in this study was over 7, which is consistent with national total fertility rates (DHS 2001).
40 "Play sex" is a common expression meaning to have sex.
while other girls and boys saw them as being dangerous, exploitative, and to be avoided at all costs. These relationships often were discussed in ambiguous terms, without specifically stating their sexual nature, such as a girl who stated that “you can relate to the boy in order for the boy to buy [things] for you.” In one particularly interesting comment, a girl discussed how such transactional relationships could turn into love and friendship.

_Girl:_ Certain girls are related to boys in the extent that some girls may be lacking certain things, like maybe a panty [underwear]... So the girl will be related to the boy so that the boy can buy for her. And when the boy has bought for her those things there the girl will continue being related. So the boy will be loving that girl and the girl will be loving that boy. And when they continue with their studies they will become friends.

In contrast, many relationships between girls and boys seemed to be platonic, and girls spoke of the fact that platonic relationships with boys could actually protect them from exploitative sexual relationships with other boys.

_Girl:_ There are some boys who used to advise girls [with] good ideas so that they not go to what? go with other boys. Like if you get a good boy he can tell you all characters concerning boys... he can advise you the way you can avoid such boys [boys with bad character] into your life.

Another girl commented that platonic relationship with boys could also help girls to avoid sexual desires.

_Girl:_ If you become used to a boy or if you relate to a boy it’s like your brother, he can advise you so you avoid sexual desires.

Girls also spoke of other girls “needing” to play sex, and even “suffering” without it, while at other times sex was talked about as something that they merely “wanted.” Most girls did not approve of such “wants” or “needs,” and seemed instead to prize non-sexual relationships with boys. However, they were wary that friendship with boys could lead into sex and skeptical of boys’ motives in these friendships, expressing the fear that boys could pressure them to have sex or even rape them. One group of girls offered the following comments:

_Girl 1:_ Some boys want just to have a relationship to make you pregnant.
Girl 2: Some boys want to have relationships with girls because they want to spoil your future.

Girl 3: Some infected boys want to spread AIDS somehow.

Girl 4: Some boys want just to play sex so that they may leave.

Girl 2: Some boys want to have sex and after having sex with you they expose your name that you’re cheap.

Girl 4: Some boys want to play sex in order to destroy your body... by having sex.

In constrast, boys tended to think of relationships with girls in much more sexual terms. When asked why young people formed “relationships” (a term that was left intentionally ambiguous in the questionnaire), boys usually began to talk immediately of sexual relationships with girls. The impetus for these relationships was the desire for “sexual enjoyment” and to “enjoy life,” or even the “need” for sex. Boys also spoke of wanting to have female friends in order to share advice and help each other with endeavors such as schoolwork, but these reasons were often mentioned secondarily. At times boys recognized that often their primary motivation for relationships with girls was sexual, and if they believed that sexual relationships at their age were bad, they also decided that at their age all relationships between girls and boys were bad.

Boy: Relationship is bad when a boy is with a girl. Because for us as we are, we know that boys, all mens, are the ones which are fond of asking women for sex. You cannot find a boy working with a girl somewhere, he must have asked her for sex, talking about the sex...

When asked if it was possible for girls and boys to be friends without having sex, this boy responded that it was possible, that there were some boys who were able to work with girls without asking them for sex, but he seemed to think this was rare. Other boys disagreed, expressing that non-sexual friendships with girls were possible.

While recognizing things such as sexual enjoyment that made sexual relationships desirable, girls and boys also were acutely aware of the possible dangers of sexual relationships during adolescent years. In fact, they spent much more time
talking about the risks and dangers of such relationships than they did talking about the enjoyment or benefit that could come from such relationships. The most frequently cited risks to adolescent sex were early pregnancy, dropping out of school, and contracting HIV/AIDS.

Surprisingly, youth seemed to see early pregnancy as a bigger danger than contracting HIV/AIDS. For girls, a pregnancy during the school years would almost certainly mean that she would have to drop out of school permanently, and could also lead to complications during birth, an illegal and dangerous abortion, future barrenness, or even death. In addition, the girl’s family would likely react with shame and anger that the money they had spent educating their daughter had been “wasted,” and could even deny education to other girls in the family as a result.

*Girl:* You are two girls in the family... when you are in S4 [secondary school, grade four] and another one who is in S1 [secondary school, grade one], when you get pregnant, you can cause that one who is in S1 to stop studying, because then [your parents] are annoyed, saying “Even this one will also become pregnant.”

Many girls were afraid that they would be kicked out of their homes or that their parents would refuse to give them any help if they got pregnant. Even if a girl’s parents agreed to help her and the baby, girls realized that this would be a heavy burden for her parents and the resources of the family, especially if the parents already had sacrificed heavily to send their daughter to school.

Girls were also afraid that their boyfriends would abandon them if they got pregnant, and refuse to take responsibility for them and the baby. Girls often told “worst case scenarios” of what might happen.

*Girl:* You can be in school and you have a boyfriend and at the same time he can force you to get out of school [even if] your parents have money that they can pay for your school fees and... you can run away from your home. They don’t know where you have gone. You can get pregnant and

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41 Abortion is illegal in Uganda.
42 Although in 1996 the government committed itself to universal primary education (UPE), in reality there are still costs associated with primary school, and secondary school is so expensive that only a quarter of Ugandan youth are able to attend. Any family that has managed to educate its children, especially to the level of secondary school, has therefore committed large amounts of money to the endeavor.
the boy cannot get money that he can feed you and at the same time you cannot feed yourself, the baby is there, you don’t have enough shelter, the boy can run away, at the same time you can suffer. You can imagine that you had stayed at your home but you can’t go there again.

At times boys also described similar scenarios.

Boy: I think now early pregnancies is very bad. When we start playing sex with a girl at school for very young as some of us are... that will lead you to drop out of school and eventually your girlfriend may fall a victim of pregnancy which may lead you to start running away from school... When that girl produce our child some may not be able to produce... Some may lead to abortion which may lead to death.

Alternatively, a boy might agree to marry a girl, but she might become an abused member of her husband’s household, forced to work hard for her mother-in-law and the rest of the family. In either scenario, dire poverty and “suffering” would become an additional potential outcome of early sex.

The thought of an early pregnancy was no less terrifying to boys than to girls. Although they likely would not get thrown out of school as girls would, they would face what was in their minds a very real possibility of going to prison for impregnating a girl under the age of 18 years. Under Uganda’s defilement law a person can go to jail for up to seven years for having sex with someone under the age of 18 years. In reality, this law is mainly enforced among men and boys, and boys can be sent to jail for this offence, even if they themselves are under the age of 18 years. How often boys are actually imprisoned on defilement charges is unclear, but it was clear that the boys in this study saw imprisonment as a real threat. In addition, if boys impregnate a girl, they also face the possibility of their families reacting with shame and anger, and disowning them or kicking them out of the house. One boy expressed that his father, an “army man,” might even beat him or kill him.

The threat of HIV/AIDS was also a serious concern. Although the consequences of contracting HIV/AIDS were seen as being more delayed and long-term (as opposed to pregnancy, which could radically alter one’s life in the next year), the youth believed that AIDS was a “very bad disease” that could ruin your life. All
youth undoubtedly had known someone with AIDS, and many youth, especially in Masaka, had been orphaned by AIDS. As one boy who had lost his father to AIDS remarked:

*Boy:* I can’t supporting to people to play sex because sex lead a person to get AIDS and die... AIDS has killed people here in Uganda and we have lost our parents, brothers, because of AIDS... But I’m just giving the advice to those who are playing sex to abstain on it because it can lead you to die.

Youth were also aware that AIDS could cause death at a young age.

*Boy:* For us in this world we are just like passengers. Any time you can pass away... when you are still 20 years you die of AIDS, they say AIDS casts [determines] your future.

*Girl:* Some people now-days they have died of AIDS when they are still young. Therefore they tell us that to wait [to get married] until you are mature enough.

**Age of First Sex**

Girls and boys had very strong ideas about the appropriate age at which to begin sexual relationships. As previously discussed, early sex can have dire consequences, and youth spoke repeatedly about early sex being dangerous.

*Girl:* Sex is so dangerous and it’s true, when you start sex at any early age there are so many problems.

*Boy:* That [early sex] is not okay, not okay. Early sex can lead to many troubles.

When asked about the right age to start having sexual relationships, the consensus of each focus group was *always* that the proper age to start sexual relationships was 18 years and above. Answers for the appropriate age ranged as high as 25 or 30 years, depending on the circumstances of the person, and especially whether or not they were still in school. Although in some cases youth argued that it was okay to start having sex at a younger age than 18 years, in every case these
individuals changed their minds during the course of the focus group and later came to agree with the majority opinion of no “early sex” before the age of 18 years. This happened through a process of debate, in which the risks of early sex were thoroughly discussed, and in which social pressure may have been exerted against those who did not agree with the majority. This process seemed to sway the opinions of those who had initially defended early sex.

The clearest example of a young person going through such a change of opinion was a boy named James (not his real name). In the beginning of the focus group he talked extensively about boys’ need to have sex, asserting that playing sex at a young age was natural because that was the age at which a boy was going through the biological changes of puberty, and therefore needed sex. He believed that early sex was beneficial because a boy gained sexual experience, and learned to be “strong” and not intimidated by girls. Other boys argued with this view, and in the process of debate James started to speak at length about the dangers of early sex, especially the possibility of a boy fathering a child that he would not be able to care for. James concluded his remark with the following statement:

My advice to the young generation, because the young generation is the one that is going to lead this world in the future. My advice is, let them abstain. Not using condoms. Because condoms are not one hundred percent good... So my advice would be to youth that they should abstain from sex and get advices from parents and guardians.

The reasons given for not initiating sex until the age of 18 years were very consistent among girls and boys. The most commonly cited reason was that girls and boys were not “mature enough” for sexual relationships before the age of 18 years, either physically or emotionally.

Boy: For me, I say [the right age to have sex] is 18 years, because at 18 years that’s when a girl and a boy are regarded as mature people, because they can care for themselves.

Girls were afraid that if they conceived before the age of 18 years their bodies would not be developed enough to carry a baby safely, and that they could have complications which would endanger their lives and also the lives of their babies.
Girls were also concerned that they would not be emotionally ready to care for a child. They felt that at the age of 18 years they would be ready to face the responsibility of being a parent and the demands of a family, including the demands of their mother-in-laws, whom they would have to care for as part of their husband's family.

*Girl:* It’s good to start a relationship at around, at above 18 years, because if you get any problems like pregnancy... you are mature enough... to even help yourself, if that boy refuses you. That’s the age, at around 18 years.

*Girl:* It is good to relate to a boy when you are above 18 years because if you start to relate to a boy when you are still young there are some problems. At least when you are 18 years you can, in fact your reasoning capacity is then okay, you can care for your kid in case you conceive and to deliver is not a problem. So at least above 18 years.

Girls felt that at the age of 18 years they would be emotionally and mentally ready for a relationship, and would have the power they needed in relationships to avoid exploitation by boys.

*Girl:* For me I think 18 years and above [to start a sexual relationship]. My reason is that that is the age where you can be older enough to... you can think about good things and bad things that can be needed at your age. That is when if someone can tell you bad things and you can say that “Those are bad.” You can choose bad and good. And you say that, “This is the right thing that I must do,” and “This one is the wrong thing that I must not follow.”

In another focus group three girls had the following exchange:

*Girl:* I think it’s 18 because [at] that age the boy cannot force you to play sex.

*Girl:* It’s above 18 because at that age the boy cannot force you to play sex.

*Girl:* I think it’s 18 because, it’s like, when you have a boy lover, and you tell, by then you’ll be mature and you also have that trait of telling him “No” when he tells you something, you say, “I don’t want to do that.” Because you know what the bad things are going to, how it’s going to affect your relationship.
Boys similarly were concerned that they be mature enough to negotiate a successful relationship and protect themselves from risks like sexually transmitted infections.

*Boy:* It must be 25 years [to start a sexual relationship], because there at 25 years they can be adults, they know what good things, which things are good, and which things they should use. If you are below that age, you might not know how to use these condoms. But above 25, you know how to use condoms in order to avoid the sexual diseases.

Additionally, boys were concerned about being able to provide for their families without having to depend on their parents, and about being good fathers to their children.

*Boy:* For me I think the age of having sex is 28 years because even then [you can] produce children. Produce children, and you can manage to control those children. You have the skills of having them.

Another important consideration for girls and boys was that they not begin sexual relationships while they were still in school. Often they would state that the right time to begin a sexual relationship was either when they were 18 years old, or when they were finished with their studies, even if this meant that they waited to initiate sex until after university, by which time they would be in their twenties. Girls knew that if they were to get pregnant it would mean the end of their schooling. Boys knew that getting a girl pregnant could cause problems in their studies. Additionally, girls and boys felt that having sex while they were still in school would be distracting, and that they would no longer be able to concentrate on their studies.

*Girl:* Because if you are into sex you cannot really perform well in class. Because if you serve two masters at a go, you will not manage. And if you start sex at that early age of yours you will not even manage to study because in that time you are thinking of having sex or you are thinking of that boy.

*Boy:* I advise them [peers] that better finish your education and then you start such things [sex] after... you cannot serve two masters at a go. Education plus playing sex, it can’t, it’s not good.
Another often-cited reason to not start sex before the age of 18 years was that this was the law of the land. As previously noted, having sex with a person under the age of 18 years is considered a crime, and boys are sometimes imprisoned under the defilement law, but youth seemed to be compelled by more than the threat of punishment. The fact that they were not supposed to start sex before 18 years, according to the law of their country, was something that they respected and that seemed to carry considerable weight.

*Boy:* The right time is above 18 years. As the law also allowed. The law of Uganda allows boys and girls to marry above 18 years.

At other times girls and especially boys based arguments about the "proper age" to begin sex on biological factors, such as the age that girls and boys begin puberty. Some youth discussed physical benefits that could be derived from sex that might constitute "need," such as reducing erections for men, or developing breasts, hips, and fatness for girls (all of which are considered desirable). James, quoted above, initially argued that boys could start having sex at the age of 13 or 15 years because that was when they went through puberty, but girls should not have sex until the age of 18 years because that was the age at which they were "pubically mature." He later argued that both girls and boys should not have sex before the age of 18 years, basing his opinion on the risks of early sex, rather than biological factors. In another focus group, a boy initially expressed the opinion that boys could start having sexual relationships at 12 years of age and girls at 15 years, based on the fact that this was when girls started their periods. He later changed his mind and argued that both girls and boys should start sex when they are 18 years. He again based his argument on biological factors, this time a loosely defined idea of changes in sexual drive that occur at 18 years. Both girls and boys expressed that 18 years was a good age because that was when girls were able to become pregnant, and in one focus group an argument broke out among boys over whether or not girls could or could not get pregnant at ages younger than 18 years.
In other groups youth discussed the need to wait until the age of 18 years to have sex, even if puberty and the beginning of sexual desire occurred much earlier. In one group a boy spoke of girls "needing" to have sex when they began to have their periods, at the age of 17 or 18 years. However, another boy challenged him, saying that even though adolescence started below the age of 18 years it wasn’t acceptable to have sex yet. The first boy subsequently changed his mind to say that sex was not allowed before the age of 18 years because that was the law of Uganda. In another group a girl expressed that having sex at 20 years and above was right, because that was the age when girls became interested in sex. Other girls in the group challenged her, saying that girls became interested in sex much earlier, but that they should control their desire and not have sex until the age of 18 years. Some girls and boys seemed to be somewhat confused as to which criteria—biological, social, legal, or otherwise—they should use in determining when girls and boys were old enough to start having sex.

Many youth defended 18 years as the proper age to start any relationship at all between girls and boys, although other youth believed that girls and boys could start a friendship at an earlier age, but should wait until the age of 18 years to start a sexual relationship.

*Boy:* Relationship is good but relationship somehow is bad when you are doing nonsense things like sex.

Some girls and boys argued that having a friendship with a member of the opposite sex in the early teenage years was a good thing in that it taught a girl or boy how to act with members of the opposite sex.

*Girl:* It is even good to relate when you are still young [below 18 years] because when you are still young, actually, you don’t have that feeling. Even if you are still with a boy and you become used to a boy, she has nothing to do with him because he is still young, he has nothing like sexual desires. But if she relates to a boy who is above, in fact who is mature, he can actually force you into sex. But at least when you are still young that is not a big problem.
A boy said that it was good to start a relationship with a girl at the age of 13 years, for the following reason:

*Boy:* Let us say that you started studying with her when you were in Primary 7, now you will be developing her character, knowing her character. By the time you reach to marry her, it will be simple.

In contrast to these statements, girls and boys often commented that a platonic relationship could easily turn into a sexual relationship, and therefore many were wary of any kind of relationship before the age of 18 years.

*Girl:* It's good to have a relationship to a boy at above 18 years, because when you are related to that boy it may be a relationship to the extent of that boy impregnating you.

Two young people expressed opinions that were outside the dominant view that one should wait until one was at least 18 years old and had completed school to initiate sex. One girl commented that it was okay to have sex while you were still studying (although above the age of 18 years), as long as you used condoms. One boy expressed that it was okay to have sex if you were below 18 years, as long as you were married.

For both girls and boys sex was inevitably linked to fertility and long-term relationships. For some this was an explicit connection, with some girls and boys arguing that youth should not have sex before marriage because it was a sin before God. For most youth, the connection between sex and marriage or a long-term partnership was more implicit, with their comments about starting a sexual relationship inevitably slipping into comments about raising a family. If a boy and a girl started a relationship, it was the beginning of a potentially long-term partnership or marriage, and it was felt that both the boy and girl should be ready for the commitment of having children. The possibility of this commitment seemed to raise the stakes, and when youth spoke of not starting sexual relationships until they were mature it was because they knew the potential outcomes of those relationships would require maturity.
Condoms

Youth seemed to have a high level of knowledge regarding condoms, with most if not all knowing that condoms are protective against pregnancy and STIs, including HIV/AIDS. Two misconceptions about condoms were stated. One girl said that they were not protective against AIDS, and another girl expressed a belief that a condom could slip off and "drop inside," leading to death. Besides these two comments, the youth expressed an accurate and matter-of-fact knowledge about condoms. However, condoms were discussed relatively little, with an average of four or five references to condoms in each focus group, as compared with the several dozen comments in each focus group about abstinence or delaying sex. Youth knew that if they were going to have sex, they should use condoms, but condoms were usually discussed as a secondary strategy, if one was not able to avoid having sex, or was over the age of 18 years and chose to have sex.

Some youth were wary of condoms, arguing that they were not a hundred percent effective and that abstinence was a better strategy.

*Girl:* Abstinence is the best protection because even condoms are not one hundred percent safe. If you use condoms and you don’t know how to use them properly you’ll end up getting pregnant or HIV positive.

Other youth with similar concerns strongly felt that the government and parents should not promote their use, and that by doing so they were encouraging youth to play sex.

*Boy:* The government cannot say that, "Don’t play sex." They put their condoms.

*Boy:* The government also always advise the youth to use condoms, even the doctors, even the elder brothers, but the one only way for us to stop easy spread of these STD diseases should be to abstain from sex because even the condom cannot satisfy the needs of the man because even the

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43 This boy seems to be combining the common African belief that condoms reduce sexual pleasure ("even the condom cannot satisfy the needs of the man"), with his belief that condoms are not one hundred percent effective.
condom is not even one hundred percent. So there are some condoms which are even expired.

_Boy_: The government of Uganda is giving condoms to help for AIDS when they’re playing sex, but condoms is not good, is not a hundred percent, not a hundred percent… But me, I not like it, I not like it.

Other youth discussed information about condoms that they had received from sources such as the radio and other media, parents, and even churches in a straightforward way. They recognized that condoms could protect one from HIV/AIDS and other STIs, and believed that being told to wear condoms was good advice. However, condoms often were felt to be a second-best strategy, for use only if abstinence became impossible or sexual feelings became “uncontrollable,” as in the following exchange between two girls.

_Girl 1_: The government says if you want to have sex, use a condom.

_Girl 2_: And you should be above 18 years.

_Girl 1_: The government says that abstinence is safer.

At other times condoms and abstinence were discussed as being co-existing AIDS prevention strategies, with no acknowledgment that there was any tension between the two approaches. One boy, when asked what the best thing for young people to do, responded: “Say no to sex and use condoms.” As most, if not all, young people felt that sex was only appropriate after the age of 18 years, they saw condom use as being something that would be appropriate in the future, at the age of sexual involvement. For example, one girl, while arguing that youth should only have sex after the age of 18 years, realized that using condoms gave girls power.

_Girl_: Even by now we have condoms, eh? Female condoms, and the male condoms are available. So if you want to play sex, and you don’t want to [get] pregnant, you can tell your boy lover that, “Go and get condoms,” and you yourself you might also be having one [condom]. So by then, you can feel protected and you can control your pregnancy, by playing protected sex.
While this girl later said that she advised her friends to “be patient” and not have sex at that time because they were not ready, she added if they did decide to have sex they “might also use this protected sex, to avoid some bad circumstances, like pregnancy.”

Messages

Young people in Uganda live in family, peer, and social environments in which AIDS and sexuality are frequently discussed. Uganda has done more than perhaps any other country in Africa to reduce the stigma of AIDS and make AIDS and sexual behavior subjects that can and should be talked about. The commitment of the government and a host of community-based and non-governmental organizations has resulted in a high level of knowledge regarding HIV/AIDS, and AIDS and sexuality are topics that are discussed not only by health workers but within churches, communities, families, and friendships. Although some of the girls involved in this study were somewhat shy about discussing sexuality—or at least in public, in English, with a foreign researcher—most young people were very eager to talk about what they knew and thought about sexuality. The subjects of AIDS and sexuality were obviously critically pertinent to their lives, subjects which they spent significant amounts of time discussing themselves, and subjects about which they frequently had strong advice and opinions that they wanted to pass on to others.

Parents and Families

When youth were asked about messages they had received regarding sex and relationships, families emerged as one of the primary contexts within which advice and messages were transmitted. Parents and other family members had a wealth of personal experience, as well as a vested interest in their son’s or daughter’s welfare and future, that prompted them to speak to their child about sex and relationships. No
one reported that his or her parents did not talk to him or her about sex and relationships, and some youth related that their parents or families talked to them often, such as the boy who said, “My mother... every day, every day is giving me advice to abstain from sex, every day and every day.” Even those youth who lived away from their families at boarding school for most of the year reported their parents being active participants in their lives, and giving frequent advice about completing their educations and avoiding AIDS, pregnancy, and other risks of early sex.

Parents’ primary concern was that their children not do anything that would harm them or cause them not to complete their education. Parents warned about the risk of HIV/AIDS as well as the health risks of early pregnancy, but most of all counseled their children to avoid sex so that they could stay in school. They advised their children to wait until they had reached 18 years or had completed school, and then choose one partner with whom to have sex. Parents and families advised their children against early sex not only because they were concerned about the consequences for their children, but because they realized that their children’s actions could affect the whole family.

_Boy:_ I always have my father, brothers, and sisters. So they always advise me that, “Well, sex is not bad, but you first concentrate on your studies, and if you complete your education, you will get a woman.”... They always advise me that if you hurry in sex there are very many problems... They always say that, “Okay you see our father’s properties. Those are not yours. You also first concentrate on your studies, and you first of all get your properties, of for which those properties you be using for your wife and actually the family.”

_Boy:_ So our parents, they advise us to, “Don’t do those things, they are very bad.” So when you do those things, you get a lot of problems, and your father, and even all of your family a lot of problems.

Parents warned their sons and daughters that they could not afford to care for a child that their son or daughter produced, and even threatened to disown their son or daughter or chase him or her out of the house in the event of a pregnancy. Many girls and boys reported receiving quite harsh advice. One boy reported that his father told him the following:
Boy: For you, anyone who gets a girl and impregnates, you just go. Don’t even come to my place again... The properties you see here are not yours. I’m the one who struggled for it. So you have to, you have also to study and get yours. You buy your land. You get your house or your room. Then you marry. But don’t go and start playing sex and get pregnant when you’re still depending on me and everything.

Parents often framed their advice to delay sex in terms of waiting for something “good” that would come later, stressing that sex was to be enjoyed, but at the proper time. One girl said that her parents told her “wait until you have finished your studies and then get one partner and enjoy sex.” Parents told their children that for the time being they should either limit themselves to friends of the same gender, or pursue non-sexual relationships with members of the opposite sex, and spend their time with “good” peer groups that did not pressure them to have sex. As one girl reported, her parents told her to “take boys as your brothers, they’re your brothers, so that prevent those feelings,” while another girl said that her parents told her to get a “boyfriend” who could help her in classes but not a “boy lover” who would lead her into having sex.

Girls and boys reported that they welcomed their parents’ advice, knowing that their families were “planning for their future” and wanted the best for them. They also realized that the dangers of which their parents warned them were very real. For some girls and boys, the threat of harsh punishment if they became pregnant or impregnated someone was also very real, and a harsh deterrent to disobedience. When asked if they agreed with their parents’ advice, girls and boys said such things as: “For me I agree with them because they are preventing me from desperate situations.”

Several focus groups also discussed other young people who chose to disobey their parents’ advice, and instead “abused” their parents for it. A few girls and boys said that their parents were shy in discussing sex with them, but one girl stated that her mother managed to overcome her shyness.

Girl: My mom is a bit shy to tell me about sex, but at least she gets some time to talk about all that when I’m in free time. She tells me, “My daughter, it’s bad to do like this... when you get boy lovers, don’t tend to love him so much, ever to show him, giving all your body to him...”
Other youth talked about ways in which parents were not giving good advice, identifying this as a reason that young people engage in early sex. One boy said, “Some children may get sex because their parents don’t mind about their life,” while another boy commented, “Young people have sex due to lack of parental care or parental guidance.” One girl stated that there were even parents who encouraged their daughters to get “sugar daddies” to take care of their needs. Other youth discussed ways that parents were bad examples, such as buying condoms for their children, going “clubbing” (going to clubs and discos), working as prostitutes, not having “stable homes,” and watching “blue movies” (pornographic movies) that they also permitted their children to see.

Boy: They tell us not to play sex, but on the other hand they give us bad advice… When they play these tapes, okay, blue movies, in the house, there, as if they are telling us that “You go and play sex.”

Boy: Some parents give us bad advices by giving us condoms, and because of ignorance you see that they have advised us to play sex.

Youth also discussed the situation of parents having sex in circumstances in which their children could see or hear. A previous study conducted in rural Masaka has identified this situation as common (Kinsman et al., 2000). In one discussion boys recognized this situation as being a difficult one; many family homes were not large enough for the parents to have privacy when having sex, but the boys still felt that such a situation was not good for the children in that it would encourage them to imitate their parents at a young age.

Teachers

Girls and boys also reported that teachers gave them information and advice about AIDS and sexuality. All primary schools are required by law to teach AIDS prevention information under the SHEP curriculum, but rather than discussing specific AIDS prevention education they had received, youth were more likely to
discuss the personal advice they had received from teachers. Like parents, teachers urged youth to stay in school, avoid sugar daddies, and abstain from sex.

_Girl:_ Our teachers normally advise us here in school to say no to boys who normally tell you to, “Let’s have sex.”

_Girl:_ Yes, at school they do advise us that avoid free gifts because they can cause anything bad. When you get a gift sometimes the boy may turn and say, what, “Me also, I want something, because you also, I gave you my sweets or pen.”

_Boy:_ Okay, here at school, teachers always do advise us that for you students, first concentrate on your studies. Getting involved in sex when you are still young is a problem, because first of all, some of you, you are orphans, some came from poor families, so you better get involved in studies.

Teachers had the advantage of being present to see many of the social interactions that took place between girls and boys at school, and so could warn girls and boys in specific situations, such as when they felt girls or boys were being pressured to have sex.

_Girl:_ The headmaster tried to tell us you can have relationship with a boy, but the boy can be demanding you to have sex, and the headmaster told us that... only love is not sex. You can have love when it is not sex... And that headmaster always told us not to have sex when we are still young. We have to wait until we are mature.

Several girls and boys mentioned that their teacher advised them not to become romantically involved with the students around them, but to wait for the “more beautiful ones” that would come later.

_Boy:_ For me, my teachers used to tell me that you just concentrate on your books. In the future, you [are] going to get a beautiful wife, [more than] that one you are looking [at] in class. Because this teacher tell me that in primary here, you just, the girls are just kids. If you reach secondary level you just reach, just, ladies, beautiful ladies. If you reach university level just what, girls as mirrors. So I also feel the interest, that me I also reach university level so that I will also come to know how those girls, looking like mirrors that my teacher used to tell me.
Youth felt that parents, teachers, and other adults were all giving them a consistent message. As one boy stated,

*Boy*: There is no any people in Uganda who is, eh, who is full grown, [who] is encouraging people to play sex, these people who are still young to play sex, [they] just advise them to abstain from sex and mostly those who are still in school to abstain from sex.

**Churches and Mosques**

Some girls and boys mentioned churches and mosques as places they had received messages about sexuality and AIDS, while others reported that they did not hear about sexuality or AIDS at their places of worship.

*Girl*: For me, I've never had priests talk about sex because in the church we just go to praise God. They don't talk about sex. They just talk about abstinence, explain like that, outside. Outside the church.

Those churches and mosques which did address sexuality emphasized abstinence and delaying sex, choosing one partner, and especially marriage.

*Girl*: They tell us [at the mosque] to delay sex until the age of 18.

*Girl*: They tell us [at the church] to wait until you are mature enough and have only one faithful partner.

*Girl*: They tell us [at the church] wait [to have sex] until you wed with your partner.

*Boy*: On the side of the churches they also advise students... early to marriage and sex is a crime to God. So you better complete your education. If you want to marry, let her go and get saved, and you marry in church.

In most focus groups there were at least one or two youth (in this case, always Christians) for whom religious faith was obviously deeply important, and these youth oriented their decisions about sexuality around their religious faith, often referring to what the Bible instructs about sex.
Boy: I say that when you know God you can avoid from getting diseases like AIDS... there are two social problems among teenagers like peer pressure and early pregnancies but you can avoid them by not having sex.

Boy: For me I follow the Bible and I can’t, I can’t play sex.

Girl: You can read the Bible to help you and it acts, it can act as a guidance.

These youth felt that religious faith gave them not only direction about what was right and wrong, but also gave them the means to do what was right, by giving them patience, courage, and trust. Religious faith helped them to sustain commitments to delaying sex, and to resist the temptations of “the world.”

Girl: My pastor used to teach us in the church that, at least seek first the Kingdom of God, and everything will be added onto you... They used to advise us not to follow this world... it has disadvantages in it. So seek first the Kingdom of God. There is nothing impossible with God. Trust in the Lord.

Girl: In the church they told us that nowadays there are many diseases, many diseases like AIDS and other STDs..... When you want to avoid those STDs you must use condoms... if you want to overcome those AIDS or those problems you must [have] patience. The pastor said that also God said that patience is a gift of the Holy Spirit.

Boy: But for me I say that if you pray every day and call the Holy Spirit to help you, I think that he will be able to help you and you will not be able to do the things [sex].

Media

Information about sex could also come through impersonal sources, such as media. These messages could be a negative influence, as in the case of pornography, or they could be a positive influence, as in the case of radio messages or publications like Straight Talk and Young Talk.

Boy: Some people gets information from just, from watching blue [pornographic] movies. You’ll find that younger boys goes to the video hall, start watching blue movies, you find that the boy or girl will start development, developing the period of playing sex. Even getting some of
the red [sexually explicit] papers, looking at such pictures, you will find that the boy or girl will start developing that, starting to feel like to have sex. In the film you will find that you will see how people kissing, such things, which are not allowed in the level of the, as you are, a student. Is not allowed to you to watch such films.

Radio messages and newspapers such as *Straight Talk* and *Young Talk* reinforced the messages of delayed sex and abstinence that youth were receiving through interpersonal communication, and also included an emphasis on condom use and VCT.

*Girl:* [The radio] tells us that if you want to have sex, sexual intercourse with a boy, use a condom.

*Girl:* In the radio we hear that sex is dangerous. HIV infection is now common in Uganda, so many people are dying. So you should abstain from sex.

*Boy:* But more so this *Straight Talk* is advising us, it says that “If you abstain from sex, you feel happy and healthy. Thus, you’ll become able to read your books.”

As noted earlier, some youth felt that they were receiving message to use condoms, with which they disagreed; the radio was identified as one of the main ways such messages were disseminated.

**Peer Pressure**

Youth also had significant discussions and received significant advice from friends and peers, and peer pressure emerged as a strong influence on their values and behavior. Youth were very aware of this influence, and often spoke of wanting to “be related” to other youth who had “good manners.” They realized that peer pressure could either be negative, pressuring them to do things that they saw as dangerous or bad, or positive, making it easier for them to do things that they deemed valuable or good and avoid that which was dangerous and bad.
Girls spoke of other girls pressuring them to get sugar daddies, either by flaunting the gifts they had received from sugar daddies, or by directly pressuring them to enter such a relationship.

*Girl:* Other friends can make you problems, other friends [who] have bad manners, they can teach you bad manners, they can tell you, “Now you go and find a friend, a boyfriend [who] can get for you money”... and [you] finally go, and you get pregnant, so finally you don’t want to get pregnant, but other friends can teach you how to go to boys.

Sometimes girls even served as “mediators,” arranging a transactional sexual relationship between another (often younger) girl and a boy, and receiving a gift or money themselves from the boy in exchange for their role in setting up the relationship. Often pressure to have sex or get a sugar daddy could exist within a peer group, and girls identified such groups as dangerous. Kinsman et al.’s study of youth in rural Masaka district also identified such peer pressure, with only sexually active girls being allowed into certain “clubs” (Kinsman et al., 2000). One girl explained that even if you did not want to get involved in the things other girls in the peer group were doing, you inevitably would, and that such a peer group was “dangerous to your life.”

Boys also could face negative pressure from their peers, such as pressure to prove their manhood by having sexual relationships. Boys could pressure other boys to have sex by saying it was a sign of maturity, by telling them that they had to have sex when they were still young because “practice makes perfect,” and by embarrassing them by publicly asking how many girls they had “enjoyed.” Sexually experienced boys could taunt the non-experienced by talking about how enjoyable sex was, and telling them that they were missing out. This peer pressure could be strong; one boy commented that a boy could find himself having sex simply because his friends were having sex. Another boy spoke of a group in his home village that made having sex a prerequisite to membership, and had therefore pressured him to have sex, a pressure that he claimed to have resisted.

*Boy:* You can find a group, and you go in that, they can tell you, “Don’t walk with us if you have refused to play sex.”... For me, I will just walk
away looking for another friends and I will just make excuse to these ones who are telling me about sex and I will just… walk away and find another friends which are not involved with sex.

Although peer pressure usually seemed to operate within one’s own gender group, girls also faced social pressure of various kinds from boys. Boys could “tell them about bad things” (like sex), pressure them for sex within the context of a relationship, and refuse to listen to a girl when she said “no.”

Girl: Here in our school it’s like a slogan to the guys. Whenever you say “No,” they say, “Ah, that girl has said, ‘Yes.’” When you’re meaning “No!” and say “No!” but they say, “The girl has said yes, she loves me.”

Boys could also publicly humiliate girls. Ironically, girls identified this as being a possibility whether or not a girl gave in to a boy’s demands for sex. If she refused him, the boy might “humiliate her publicly,” but if she did have sex with him, he might publicly brag that he had taken her virginity and “ruined her,” thus ruining her reputation. Girls spoke of wanting to be related to “good” or “good-mannered” boys because those boys would not force them to do “bad” things, and of good-mannered boys encouraging them to be good mannered themselves and to not behave in bad ways. Girls similarly wanted to be related to “good-mannered” girls.

Girl: You can see a girl, you can just look at her appearance like this and start thinking, “That girl is not good mannered.” Most of the boys and girls get related because of being good mannered. If you are good mannered most of the people like you in the community.

Peer pressure could also be positive. Many youth spoke of their friends encouraging them to abstain, and reminding them that early sex was dangerous and could jeopardize their health and futures. Young people seemed to seek friends who reinforced their beliefs and values, although they could also have friends with whom they disagreed over matters of sexual behavior. Such disagreements could lead to arguments among friends. One group of girls discussed the way such an argument could occur, when they tried to warn their friends of the risks of early sex.
Girl 1: When you try to talk to your friends, and they feel like as if, they call you a “saved-ee.” They tell you that, “I can’t abstain from sex, because it’s my game, and I should have it every day.”

Girl 2: But if you advise a friend, a friend will just say, “You leave me alone, I am mature enough.”

Girl 3: Or when you tell a friend she will just tell you, “I was born alone so leave me alone.”

Girl 4: Some girls say that they have read in the Red Pepper [a sexually explicit newspaper] that girls you have to “meet [have sex] before you die.” Now they have to “meet” before they die.

Girl 5: If you advise a friend, she will tell you to leave her alone!

Girl 1: If you advise a friend of yours to abstain from sex, she will tell you that “It’s not your body which they are using, they are using my body.”

Girl 6: If you advise a friend the risks of HIV/AIDS the friend will just tell you, “It’s not my first time hearing about AIDS and I’m not the first person or the last person to die.”

Girl 4: Some say that AIDS has not come to kill rocks or trees, it has come to kill human beings like you and me.

Girl 3: If you advise a friend she will tell you, “Even before AIDS came people used to die. Now let us die with AIDS.”

Girl 6: If you advise a friend not to have sex she will try to tell you, “How did you come into the world? Was it not through sex?”

Boys also commented that other boys could be “stubborn” and refuse to listen to advice.

Boy: You may find stubborn boys in school... who is 13 years and he likes to play sex more than the men. He dislike some people who advise him that, “Stop, stop playing sex, stop that habit, it is bad.” He might ask you, “Why is it bad?” And you answer him, “You may get AIDS.” [He answers] “Can it die immediately, can it make a person die immediately?”

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A term that refers to someone who is thought to be very religious, though not necessarily Christian. The girl who used this term was a Muslim.
Ideal Sexual Behavior and Advice to Other Youth

When asked what they considered to be the best advice, or what advice they would give to other young people, girls and boys spoke of avoiding sugar daddies and bad peer groups, continuing with their education in order to obtain bright futures, and practicing abstinence, patience, and self-control. Comments included:

*Girl:* That’s why I advise my fellow students to, “Let’s say no to sex. It is dangerous for our lives.”

*Girl:* I appeal to my fellow students that avoid sugar daddies because they will deceive us with the money they give us but we shall end up getting HIV...

*Girl:* Avoid peer groups… they are dangerous to your life.

*Boy:* The advice [that I give to] my fellow students is that playing sex you will gain nothing. Because as you are playing sex there are very many problems which I cannot risk.

*Boy:* For me I think that it is not good because when you play sex at this age I think that you cannot achieve your goals.

*Girl:* The best thing that I can tell my friends or my sisters is that abstain from sex. Abstain from sex is one of the best things in the world.

*Girl:* Let’s trust in the Lord, because God knows you better. He knows even the right time to give you a husband. Don’t rush before your time. And don’t die before your time.

*Girl:* It needs our minds, our hearts, it needs our hearts to be courageous… When we are told a certain piece of advice, it needs us to get that word and put it in mind that if I do bad what will it be, and what situation will I be ending with?
RESULTS: OUT-OF-SCHOOL YOUTH

Research of African adolescents has predominantly focused on in-school youth, although a large proportion of adolescents in Africa are not in school. Yet there is a need for research with out-of-school youth, as their experience in regards to sexuality and HIV/AIDS is often quite different from that of in-school youth. For instance, data in Uganda have shown that never-educated girls are more likely to become mothers while still teenagers than are girls with primary or secondary school education. In fact, while rates of teenage pregnancy decreased for primary and secondary school educated girls between 1995 and 2001, the 2001 DHS showed that rates of teen pregnancy for never-educated girls had actually increased, with 50% of never-educated girls becoming mothers while under the age of 19 (Figure 13).

Figure 13
Additionally, out-of-school girls may be more likely to become infected with HIV/AIDS than are their in-school counterparts. Data collected from women at antenatal clinics in the town of Fort Portal have shown that while HIV prevalence among educated women decreased from 1991 to 1997, HIV prevalence among illiterate women remained high, although prevalence among women with secondary education had initially been higher than that for illiterate women (Kilian et al., 1999).

The current study encountered predictable problems in carrying out research with out-of-school youth: it was difficult to find a population of out-of-school youth (especially as out-of-school youth do not tend to live in town centers), and there were language difficulties as these youth were not conversant in English as were in-school youth. The decision was made to recruit out-of-school youth through community-based organizations providing vocational training to out-of-school youth. Therefore the out-of-school youth included in this study are not typical of out-of-school youth: they have received vocational training, and both community-based organizations also gave them AIDS prevention and life skills training. The out-of-school youth in this study were also outside the target age range of 13 to 16 years, with a range in age of 13 to 21 years. Sample sizes were small, with focus groups among out-of-school youth having between 4 and 6 participants, and only 20 out-of-school youth in total. Finally, the language barriers and need to use a translator created some difficulties in carrying out the focus group discussions, and prevented the youth from being heard “in their own words” as in-school youth had been, so that out-of-school youth will not be directly quoted as were in-school youth. For these reasons the data presented from out-of-school youth should be interpreted with caution.

In three focus groups, the statements and opinions of the out-of-school youth were strikingly similar to those of the in-school youth. In the remaining focus group, conducted with out-of-school girls, the girls had a much different perspective and set of values than any other youth in this study. This focus group will be discussed separately.
Out-of-school youth gave the same reasons as did in-school youth for pursuing relationships with members of the same or the opposite sex. A friend was someone to share things with such as food, to get advice from (especially if one was an orphan), to share ideas with, to get help from, and to work on schoolwork with. One girl also mentioned that relationships made you part of a community. If you had a relationship with a boy you could become acquainted with his family, and he with yours, tying you into the same community. One boy said that relationships could build foundations for marriage. Girls discussed the motivation to seek relationships with boys in order to get money for clothes and school fees. One 14-year-old girl said that her sisters showed off the dresses they received from their boyfriends and told her that they could be a go-between and obtain a boyfriend for her. She claimed to refuse this suggestion, but admitted that the pressure from her sisters was considerable.

Interestingly, out-of-school youth frequently mentioned the value of education and the importance of not allowing sex to interfere with education. One 14-year-old girl said that friendships between girls could be valuable because the friends could encourage each other to continue with the “struggle” of education. This same girl said that a bad thing that could happen in a relationship would be if a girl and a boy had sex and the girl got pregnant, causing her to drop out of school. The boy would likely continue with his studies, and could refuse to help the girl. The girl’s parents could also refuse to help her, telling her that they had told her to continue her education and warned her not to have sex. The girl who narrated this scenario stressed that in such a case the major consequences would fall on the girl, and not on the boy. Another girl mentioned an additional way in which romantic relationships could interfere with studies, saying that if a girl and a boy were in a relationship and also in the same classroom, they would be unable to concentrate on the lesson. Besides the fact that sex could interfere with education, out-of-school girls and boys mentioned that sex could lead to AIDS, and early pregnancy and health risks for a girl, including an unsafe abortion. One boy, who had previously said that relationships could unite
people, said that an early pregnancy could cause conflict and separate families from one another.

**Delaying Sex and Age of First Sex**

When asked about the proper age to initiate sex, out-of-school gave the same reply as in-school youth, saying that the proper age for sex was 18 years and above. Out-of-school youth also gave the same reasons as in-school youth: at 18 years, girls and boys were mature enough to make good decisions and be responsible, and girls were old enough to safely deliver a child. One boy expressed the opinion that if girls and boys got married when they were too young, the marriage could end in divorce as the partners were not mature enough to handle their family affairs, while another boy emphasized that it was important for the boy to be old enough to earn money before entering a relationship. These boys said that although boys and girls could think they were old enough for a relationship when they were younger, such as at the age of 14 years, they really were not ready for a relationship. A third boy agreed, noting that if a boy impregnated a girl he might be forced to marry her, even if he was not ready to get married, and that he therefore thought it was good to abstain. Out-of-school girls and boys also were very aware of the possibility of boys being imprisoned for defiling a girl, and one boy said that the law against defilement helped boys to abstain.

Out-of-school youth felt that delaying sex was the best strategy for youth to avoid these negative consequences. Girls discussed their intentions to abstain from sex until the time came to get married, and then to get a blood test and marry one faithful partner. These girls said that they would advise other youth also to abstain, and to stay away from places like discos that might tempt them to have sex. Girls also warned against desiring material things, which might lead girls to have sex for money, putting them at risk of HIV/AIDS. The 18-year-old girl cited above, who obviously prized her economic independence, said that she would advise younger girls to “endure” and to work for their own money rather than being dependent on any
man's money. One boy also discussed the importance of being economically independent before entering a relationship, saying that he had made a decision to work hard and become employed before he initiated a relationship and sex.

Boys discussed abstinence and condom use as strategies to avoid STIs, HIV/AIDS, and early pregnancies, and one boy said that abstinence was good because it gave you "more years." However, in one group of boys, some boys expressed that although they felt abstinence was desirable, it was not always possible above the age of 18 years. The boys in this group debated this question, with one boy saying that abstinence was possible above the age of 18 years and defending his position from the Bible, and other boys saying that a boy who was still abstinent at that age would be taunted as a "bachelor," and that such pressure made continued abstinence impossible. One boy said that the younger ones in the community were already not waiting until the age of 18 years to have sex, and another boy said that for those younger boys the pressure of puberty and sexual feelings had become too great. Other boys countered that if one was in school, it was possible to wait to have sex because education was the priority. The debate ended with most boys agreeing that abstinence was possible, but that it was difficult and required courage, self-control, and advice from other people such as elder and parents. Reading Young Talk, listening to the radio, and worship and prayer could also help them to abstain.

Messages and Peer Pressure

The parents of out-of-school youth were concerned for their children's well-being, and therefore advised them about relationships and sexuality. Boys and girls reported that their parents told them to delay sex and continue with education, and one girl said that her parents asked her who would bury them if she died, saying it was not for the old to bury the young. Several boys and girls said that their parents told them to get a medical check-up or blood test before they entered marriages or sexual relationships. One girl said that some parents told their children that if the
child did have a sexual relationship with a girlfriend or boyfriend, the child should introduce that girlfriend or boyfriend to the parents, rather than hiding the relationship. Boys reported that their parents warned them against getting involved with girls, and one boy said that his parents warned him that they were unable to pay a dowry if he became involved with a girl. Another boy said that his mother was trying to make the choice of his partner for him.

When asked what advice they had received in their churches and mosques, out-of-school youth said that they had received the message that they should abstain from sex until marriage. One girl said that her church leaders urged the youth to avoid bad peer groups which could “mislead” them. These church leaders also told the youth that if they decided to get married, they should bring their future spouses to the church leaders and the church leaders would give them counsel, including advising them to go for a blood test. One boy reported a similar thing, saying that his church leader told his congregation that the church leaders knew sex was there, but that sex could have consequences. The church leader therefore advised the congregation that if a man was interested in a woman, they should get tested for HIV/AIDS. Another boy said that his pastor spoke against polygamous marriages, and this boy said that the advice he received at church was good, because God had clearly spoken to Christians in the Bible about sexuality.

Out-of-school youth also mentioned hearing radio messages that advised them to abstain from sex until the age of 18 years, or to have sex using a condom if abstinence became too difficult. Two girls argued against such advice, saying that condoms were not one hundred percent perfect, because a person could fail to use them correctly and then get infected with HIV/AIDS. Boys also mentioned hearing about condoms through newspapers and the radio, but felt that abstinence was a better strategy. One group of boys discussed that the government was very aware of the AIDS epidemic, and had therefore encouraged young people to abstain and be “friends without sex.”

One girl, who was already 18 years old (and one of only two 18-year-old girls in this study), described the harassment she had faced from her friends for continuing to
delay sex. They told her that she was wasting her time, and that girls younger than she were already married. These friends were not urging her to have casual sex, but rather to find a boyfriend who could become a husband. This girl told her friends that she would get a husband in the future, but that it was not yet time, and she seemed quite confident in her decision. One 17-year-old girl had a similar account. She said that her friends had urged her to have sex, and also told her that she was “getting wasted” when she refused. She also seemed confident in her ability to resist pressure from her friends. Boys also discussed peer pressure, saying that most of their friends encouraged them to initiate relationships and sex after the age of 18 years, and warned them of the consequences of early sex. One boy reported that his friends warned him to stay away from certain girls whom they suspected of being infected with HIV/AIDS.

Out-of-School Girls: a Different Response and Norm

The above comments were expressed in three focus groups. In the remaining focus group, conducted with out-of-school girls, quite different opinions were expressed. The girls in this final focus group stated their opinion that although early sex did have some risks, it was enjoyable and should not be delayed until the age of 18 years. These girls were not shy about admitting that they were sexually active themselves, and seemed to think that the subject of sex was a source of much hilarity. They laughed and joked throughout the focus group, which was in marked contrast to the serious and even somber mood that often prevailed in other focus groups as youth discussed the risks of early sex.

When asked what good things could come from relationships, the girls in this focus group said that girls could have babies, and when asked what bad things could come from relationships, they said that girls could get diseases. When asked at what age young people should start having sex, each of the five girls offered a different answer. Three girls answered 12 years, 15 years, and 16 years. When asked why they
thought these were good ages to initiate sex, they offered no reason other than this was the age at which girls did start sex, and even got married. Two girls answered 17 and 18 years, saying that these were good ages to get married. One girl said that if a girl played sex below the age of 18 years her parents would refuse to let her get married, and the other girl said that this was the age at which a girl could have a wedding in the church. It was not clear that these two girls were sexually active, and throughout the rest of the discussion they were relatively quiet as the other three girls boisterously defended their sexual activity.

These three girls, who were between the ages of 15 and 17 years old, stated that they had sex because they “loved” it, in spite of advice they received to the contrary. These girls admitted that their parents advised them not to have sex, to avoid discos, and to avoid getting pregnant, but the girls said that they did not agree with their parents’ advice. Two of the girls said that they had friends advise them not to have sex without a condom as they could get diseases, but it was not clear that the girls were following this advice. One girl stated her belief that a condom could slip off inside a girl during sex, causing immediate death.45

All of the girls in the group realized that there could be serious consequences to sex, and said that their friends or parents warned them that boys could deceive them, by telling the girls that they would marry them but then abandoning them. One girl said that a boy could force a girl to play sex, and lie to her and tell her he would give her gifts, but when she got pregnant he would abandon her and her parents would chase her out of the house. Another girl described a similar scenario, saying that even if a girl used a condom a boy might have poked a hole in it, and she still might get pregnant and be abandoned by her boyfriend and her parents. A third girl said that her parents told her not to play sex because even if a boy had promised to marry her he might later refuse, and she might get pregnant and suffer.

These girls did not seem to have high expectations of their relationships with men, and they seemed to believe that sexual relationships would more likely than not

45 This is not an uncommon belief among youth in Uganda. It was mentioned by an in-school girl in another focus group, and reader letters published in Straight Talk have addressed this concern.
cause them to suffer. Yet the only benefit to sex, expressed by the three girls in
the group who professed to be sexually active, was that it was pleasurable and they
“loved” it. When all the girls were asked at the end of the discussion what things they
got from relationships, and specifically if they got any gifts from boys, the girls all
answered at once, saying that they did not get any gifts, but that they only suffered.

Discussion of Out-of-School Youth

Compared to the attitudes and values expressed by the other out-of-school youth
and the in-school youth, the response from this group of out-of-school girls is
significant. Results from this group of girls should be interpreted with particular
cautions, in that the group was small (5 girls) and the researcher had particular
language difficulties in this focus group. The translator for this focus group was
somewhat limited in her ability to translate, which did not allow the researcher to
probe certain questions to the extent she would have liked, and the researcher was not
able to follow up with this group. Although these data on out-of-school girls are far
from complete, they are important in that they present a very different picture than
that portrayed by the other groups in this study, and suggest that there are minority
groups among Ugandan youth with very different perspectives and experiences than
that of the majority group. In some ways the experience of these minority and
majority groups is similar: all of the youth agree that there are possible negative
consequences to early sex, and all of the youth are receiving advice to abstain from
sex from influential people in their social environment, such as parents. Yet the risks
of early sex and the advice given by parents did not persuade this group of out-of-
school girls to abstain from sex, or even to decide that abstaining from sex was
desirable.
One possible explanation for the very different response of these out-of-school girls is that in some very important ways, their experience is not similar to that of in-school youth, nor to that of the other out-of-school youth in this study. A primary reason, if not the primary reason, that in-school youth gave for remaining abstinent was that they wanted to stay in school. Education was a clear and tangible goal which early sexual involvement and especially pregnancy would jeopardize. The other groups of out-of-school youth in this study also had clear and tangible goals, as they were receiving vocational training and hoped to be able to support themselves with these skills. They also knew that sexual involvement could jeopardize their life chances and “bright futures.” One group of out-of-school boys and one group of out-of-school girls were receiving training in various occupations such as carpentry and sewing, and although they were not in an academic course of study they were receiving regular instruction, as well as life skills training and AIDS prevention information. The out-of-school youth in these groups had a high regard for education, and were obviously motivated to complete their own courses of training. As previously noted, the fact that they are receiving such training means that they are not typical of out-of-school youth.

The second group of out-of-school boys was also receiving vocational training, although the community-based organization of which they were a part did not provide nearly the same degree of support and instruction as did the first community-based organization. However, this second group of out-of-school boys was also very motivated, and had clear goals of income generation and financial independence. Although the second group of out-of-school girls was also part of this second community-based organization, the girls did not seem to be involved to the same degree, or have the same kind of goals as did the boys. In addition, the boys in this second group were involved in AIDS education outreach to surrounding communities, something the researcher did not discover until the end of the focus
group. In contrast, the girls in the same community-based organization were not involved in this AIDS education, and therefore had a much different attitude towards AIDS prevention and sexuality.

In short, it seems that although this second group of out-of-school girls saw the risks of early sex, they did not see any clear benefits to abstaining, and so the risks did not become enough to outweigh the benefit of pleasure from sex. While in-school youth and other out-of-school youth were working toward clear goals and looked forward to future rewards such as financial independence and educational achievement, the second group of out-of-school girls seemed to anticipate only marriage and child-bearing. While these girls seemed to look forward to having children, defining having a baby as a positive outcome of a sexual relationship, they seemed to have very low expectations of potential partners and did not have the same hope of waiting for the "best" partner that several in-school girls and boys expressed. With such limited life expectations, delaying sex added little value to their lives. These girls therefore chose to enjoy the temporary benefits of sexual activity, even knowing that they were bringing suffering on themselves, and perhaps even gambling with their lives.

46 The boys traveled to surrounding communities and held community gatherings to educate people about AIDS and AIDS prevention. These boys were unusually well-informed about AIDS and AIDS prevention.
Results: Analysis of Straight Talk and Young Talk

The monthly newspapers Straight Talk and Young Talk are distributed free of charge to Uganda’s 15,000 primary and secondary schools, as well as inserted into the daily newspaper the New Vision and distributed through 600 community-based organizations and churches countrywide. They have a combined monthly print run of over 300,000, and are seen by a majority of Ugandan youth (Valerio & Bundy, 2003). The Straight Talk Foundation was recognized in a 2003 World Bank report entitled Education and HIV/AIDS: a sourcebook of HIV/AIDS prevention programs, as one of 13 successful youth-targeted AIDS prevention programs in Africa (Valerio & Bundy, 2003). The Straight Talk Foundation publishes Straight Talk and Young Talk in several local languages besides English, and also sponsors school clubs and radio shows in English and four local languages. Straight Talk and Young Talk are widely read not only by youth but by adults, and are arguably the most important mass-media type of communication for youth regarding issues of AIDS prevention, sexual health, and sexuality in Uganda. Besides having a major role in shaping the discourse of such issues among youth in Uganda, Straight Talk and Young Talk are also an important source of information about adolescent’s attitudes and values regarding sexuality, as the monthly newspapers center their content around the thousands of reader letters they receive each year.

Cathy Watson, a journalist, founded Straight Talk in 1993 to provide AIDS prevention and sexual health information to Ugandan youth. At that time HIV prevalence among youth and among the general population was still among the highest in the world, and the fact that HIV prevalence had peaked and was already on the decline was not yet known. Straight Talk received funding from UNICEF under the Safeguard Youth from AIDS (SYFA) program. Straight Talk had no affiliation with the Ugandan government, but was given the freedom to operate. This is indicative of the government’s policy of partnering with civil society in AIDS prevention, and allowing political space for such initiatives.
In one of its first editions, *Straight Talk* stated that its goal was to “empower and encourage youth to postpone sex” (December 2003), but in early years abstinence and delayed sex were promoted more or less as an equal strategy to condom use. In more recent years *Straight Talk* has promoted a stronger message of abstinence being the best behavior for young people. This shift occurred as reader letters provided evidence that early sex created many problems for young people, and that young people could in fact abstain from sex (Watson, 2003). Condoms are discussed frequently and in a positive manner in *Straight Talk*’s pages, but *Straight Talk*’s main message has become that young people should abstain from sex until the age of 18 years, get tested before entering a sexual relationship and then be faithful to one partner, and always use condoms. *Straight Talk* targets youth between the ages of 15 and 19 years. *Young Talk* was started in 1998 for youth between the ages of 10 and 14 years. *Young Talk* has promoted abstinence even more heavily than *Straight Talk*, and there is little mention of condoms in *Youth Talk*’s pages, as the Straight Talk Foundation feels that such a message is not appropriate for children in that age group. Although *Straight Talk* and *Young Talk* heavily promote abstinence, they also provide frank information on sex and sexual health. As Watson comments, “to promote abstinence, you have to talk about sex” (Watson, 2003).

**Content Analysis of *Straight Talk***

A content analysis of ten years of *Straight Talk* (October 1993 to October 2003) revealed how reader concerns, attitudes, and values have changed during the course of a decade, and also how *Straight Talk*’s message to youth has evolved. Of course, the reader comments published in *Straight Talk* cannot be assumed to be representative of youth in the country as a whole. *Straight Talk* readers tend to be secondary school students (although *Straight Talk* has made a concerted effort to also reach out-of-school and illiterate youth), and it is likely that the youth who write in to *Straight Talk* are the Ugandan youth who most agree with *Straight Talk*’s viewpoint.
and message. The adolescent opinions expressed in *Straight Talk* can therefore be seen as being representative of one group of Ugandan youth, if not all Ugandan youth. Yet *Straight Talk* is valuable in that it is a wealth of qualitative data, and the only such source of data about adolescent attitudes and values regarding sexuality over a ten-year period in Uganda.

Much of *Straight Talk*'s content has stayed consistent over the years. One of *Straight Talk*'s major objectives is to provide information about HIV/AIDS and AIDS prevention, as well as addressing sexual health and “knowing your body” (including clear drawings and photographs of male and female genitalia), HIV testing and family planning, and negotiating safer sex and resisting pressure to have sex. *Straight Talk* has also focused on more general topics such as relationships with parents and friendships with members of the opposite sex, self esteem, respect, gender roles, and life skills. *Straight Talk* also addresses other critical issues for youth, including “sugar daddies,” rape, and other violence against women. Other features include stories about people living with HIV/AIDS, people abstaining from sex, and other types of role models, and articles on education, staying in school, and generating income. *Straight Talk* also offers a regular column answering reader questions about sexual health and relationships, and more general reader letters and pictures of readers make up much of every edition.

Yet in spite of these common themes, *Straight Talk*'s focus and content have changed somewhat over the years, with the clearest change being a shift towards a stronger message of delaying sex until the age of 18 years. While early editions of *Straight Talk* often discussed delaying sex until a young person was “ready” or “mature,” *Straight Talk* is now much more unequivocal about telling young people that they are not ready to have sex. For instance, the May 2003 edition of *Straight Talk* featured the headline “Yes to Sexuality, No to Sex at Present.” The article continued,

> For those adolescents who have started sex, we’d like you to think about stopping. You can, you know! It would definitely be best for you. If you do not stop sex, make it safe. Test with your partner for HIV, and never
have sex without a condom. That is our message in 2003 (*Straight Talk*, May 2003).

*Straight Talk* has communicated a consistent message over the years that while sexuality is good and healthy, sexual urges are not uncontrollable, and the safest sex for adolescents is no sex. *Straight Talk* has also repeatedly emphasized that love is not sex, encouraging young people to pursue relationships with members of the opposite sex that do not include sex, and reminding readers that sex at the wrong time is not pleasurable or fun, as in the following statement:

There is a wrong belief among youth that sex is enjoyable and fun. It is not fun or enjoyable if it is done at the wrong time, with the wrong person, and in the wrong place. It is actually wrong timing to have sex as a teenager because there are so many things you may not be able to deal with: pregnancy, STDs, and HIV infection. You can only enjoy sex when you are ready for it (*Straight Talk*, July 1995).

Reader letters have also demonstrated a change in reader experiences, attitudes, and values over the past decade. In early years readers often wrote about being harassed for being virgins, but the number of reader letters reporting such harassment steadily decreased over the years, and more readers started to report that they were proud of being virgins and that virginity was treated with respect by other young people. In February 2001 one 16-year-old boy wrote, “Virgins are highly respected by people of the opposite sex and I like that.” In the same edition *Straight Talk* published several letters from readers about virginity under the heading “Virgin Power.” Readers also started to write about specific reasons for staying a virgin, such as staying in school and having successful futures. Statements such as the following became common:

*Boy:* We either engage in sex and suffer or abstain and have a wonderful future (*Straight Talk*, June 2001).

*Girl:* Abstinence is the answer to a successful life. Stay virgins like me, until you are ready (*Straight Talk*, August 2001).

*Girl:* Sex leads to many problems which young people cannot handle. Brothers and sisters, enjoy friendship but not sex (*Straight Talk*, November/December 2001).
Girl: After your advice, I have decided to remain single and abstain until I have finished my studies. I am still single and a virgin (November/December, 2002)

Virginity is freedom to develop a healthy friendship, understand sex, concentrate on your studies, and plan your future. It is freedom from pregnancy, abortion, STDs, HIV/AIDS, cancer of the cervix, and ruining your future (November/December, 2003).

Other readers (although a minority) relay in their letters that they are following Straight Talk's advice that if a young person is going to have sex, he or she should get tested, be faithful to one partner, and use condoms consistently.

Boy: My girlfriend and I had great love. We were both members of the Straight Talk club and we were faithful to each other. We used condoms because we knew the disadvantages of unprotected sex. We had tested for HIV (Straight Talk, June 2003).

Straight Talk emphasizes that even if young people have begun to have sex, they can again choose to abstain. Some readers write about their experiences with “secondary abstinence,” as the boy who wrote,

I stopped abstaining from sex after failing to control my emotions. When I started having sex, it was protected with a condom. After one year of condom use, with good communication between my partner and I, we decided to go for an HIV test. We were both negative. As a result I made a decision to abstain again (Straight Talk, August 2003).

Reader statements and opinions and Straight Talk’s message are clearly interrelated. Straight Talk allows reader letters to drive its content, and Straight Talk’s content in turn shapes reader values and attitudes, and to some degree defines the discourse of adolescent sexuality within Uganda. An example of this can be seen in the development of the discourse of “bad” and “good” peer groups. There had been no mention in Straight Talk’s pages of peer groups until a front-page article in May 2000 with the headline “Positive Peer Pressure.” This article featured three testimonials about bad peer groups, and urged readers to turn negative peer pressure into positive peer pressure, or if they encountered only negative peer pressure, to “go solo.” The May 2000 edition also featured a reader letter which stated, “In my
Straight Talk club, members are discouraged from joining bad peer groups.” In the June 2000 Straight Talk there was a similar reader letter, advising other young people to “Avoid bad peer groups because they can lead you into trouble, like dropping out of school.” From that point peer groups became a consistent theme in reader letters, with youth often appealing to other youth to avoid bad peer groups with such statements as:

Make friends with people who will help you have a bright future (Straight Talk, October 2001).

Avoid bad peer groups because they can lead to unwanted pregnancies, STDs, school drop outs, and spoil your future (Straight Talk, December 2001).

I avoid bad groups whose priority is sex talk. I go for games and sports (Straight Talk, June 2002).

The theme of avoiding sex and staying in school became another such trend within Straight Talk content and reader letters. An eloquent poem by 16-year-old Aguma Jacinta, titled “A Girl Says ‘No,’” was published in the September 1995 edition of Straight Talk. It began:

No, and nothing you say will make me change my mind.  
No, I don’t want to get pregnant and lose my education.  
No, I want to concentrate on my studies.

In this same edition a reader letter was published in which a girl wrote about sex interfering with her academic performance, but for several years there was little mention in reader letters or Straight Talk articles of the importance of education or of sex interfering with education. Then in November 1997, Straight Talk featured a front-page article with the headline “Reaching Your Dreams,” and from July to December of 1998 there was a monthly feature called “Working Student” which profiled youth who were working in various odd jobs, often to earn money for school fees. The November/December edition of Straight Talk celebrated Straight Talk’s fifth anniversary, and stated, “We’ve asked you to cherish your bodies, respect your family, stay in school, and value hard work.” In 1998 a flood of reader letters about
education began, with almost every edition of *Straight Talk* featuring statements from reader letters such as the following:


*Boy:* We should respect ourselves and avoid risky behavior so that we study hard. Education is the only answer to a bright future (*Straight Talk*, November/December 1998).

*Girl:* Education is my priority. Sex is at the bottom (*Straight Talk*, May 2000).

*Boy:* Work hard because education is the key to success (*Straight Talk*, October 2000).

*Boy:* Avoid sugar daddies and mummies. Invest in education and brighten your future. Suffer now and enjoy the future (*Straight Talk*, April 2002).

**Straight Talk Reports: "Sexual Feelings" and "Good Sex"**

*Straight Talk* has begun to solicit reader responses to specific questions, and in 2003 the Straight Talk Foundation (STF) authored two reports analyzing reader responses to the following two queries (published in *Straight Talk* at various times in 2002):

Sexual feelings are normal. How do you handle yours?

For years we have talked about safer sex. We know what safer sex is. But what is good sex? Can you define it for us?

STF received 202 reader letters in response to the first question, and 843 reader letters in response to the second question. Approximately two-thirds of the respondents to both queries were male, and more than 90% were enrolled students (Namubiru, Walugembe, Wamai, Wamai, Barton, 2003a).

The "sexual feelings" study found that the majority (86%) of young people who wrote in to discuss sexual feelings were abstaining from sex. Respondents rarely described sexual feelings as "lust, animal drive, or a biological need that must be
satisfied to ensure health and the normal development of the body.” The study notes that this discourse had been the “norm” in the first decade of the HIV epidemic in Uganda, but that abstinence has become more socially acceptable since then. Instead youth described sexual feelings as natural feelings that are under the control of humans and do not have to lead to sex, and discussed various strategies they used to control sexual feelings. One strategy was to seek advice or information from sources such as elders and friends, Straight Talk newspapers and radio shows, and from films, books, and the Bible. Another strategy was to engage in activities that “divert the mind and/or tire the body,” such as playing sports, doing physical work like digging, and attending church or praying. Youth also discussed the importance of avoiding bad peer groups and being alone with members of the opposite sex, stimulators such as alcohol or pornography, and other situations that could encourage sexual feelings. Knowing the risks of sex and the benefits of delaying sex was also felt to be important. A minority of respondents discussed sexual behavior such as masturbating, hugging and touching, or protected sexual intercourse as a “last option” for handling sexual feelings (Namubiru et al., 2003a).

In response to the query about “good sex,” Straight Talk readers responded that good sex was sex at the right time and with the right partner. The right time was overwhelmingly felt to be above the age of 18 years,47 and when both partners had completed their education, were economically independent and stable, were able to handle the consequences of sex, and were married. Good sex was defined as sex that happened within committed, respected, and mutual beneficial relationships, and not within casual relationships. Nearly 90% of respondents who addressed this topic said that the right kind of relationship was a marriage. The “right person” was defined as someone who was faithful, trusted, healthy, and of the opposite sex.48 Some respondents also said that good sex was sex when both partners were healthy and had

47 Of the 270 respondents who referred to a specific age as the “right age” for good sex, only 3 respondents stated an age less than 18 years; these 3 stated the age of 17 years (Namubiru et al., 2003b).
48 All respondents who mentioned the gender of a sexual partner as an issue expressed negative views towards homosexuality.
tested negative for HIV/AIDS, when sex was protected, when sex was consensual and not forced, and when sex had no negative consequences (Namubiru, Walugembe, Wamai, Wamai, Watson, 2003b).

The sample for these two studies was rather narrow, as it self-selected and confined to *Straight Talk* readers who chose to write a letter in response to *Straight Talk*’s questions. These readers cannot be assumed to be representative of all Ugandan youth. Yet the consistency of certain themes within reader responses to these questions suggests that the opinions expressed by the youth in these studies are strongly representative for at least one group of Ugandan youth. These studies may provide the best qualitative description to date of the behavior changes that have occurred among Ugandan youth, and the motivations for these changes. Furthermore, the attitudes and values expressed by youth in these studies are strikingly similar to the attitudes and values expressed by youth in the current study. Data collected by the Straight Talk Foundation thus provide important triangulation for the results of the current study.
DISCUSSION

This study has investigated the attitudes, values, and perceived norms of Ugandan youth regarding sexuality and sexual behavior, in an attempt to explain why AIDS prevention efforts among Ugandan youth have been so successful not only in transmitting knowledge, but also in changing social norms, producing behavior change, and contributing to decreased HIV/AIDS prevalence among Ugandan youth. While attitudes and values can be individual-level determinants of sexual behavior, contextual factors also strongly influence adolescent sexuality and may be even more important predictors of behavior than are individual-level factors. Adolescents define their sexuality and make decisions about sexual behavior within the context of membership in communities comprised of peers, families, community leaders, religious leaders, and other members of their societies. These communities transmit messages about norms of adolescent sexuality, and these perceived norms can be powerful influencers of individual beliefs and behaviors. At a broader level, adolescent sexuality is also influenced by realities such as poverty, gender inequalities, lack of education, and youth’s and women’s lack of power. Investigating individual attitudes and values can shed light on the way individuals perceive and experience these societal realities.

This study found that Ugandan youth expressed a highly consistent set of attitudes and values towards sexual behavior, with the notable exception of one group of out-of-school girls. Youth held attitudes about the benefits of relationships, including companionship and help in time of need, but also about the possible negative outcomes of sexual relationships with members of the opposite sex. These possible negative outcomes included HIV/AIDS and other STIs, early pregnancy and health risks for girls, a premature end to education, family strife, possible prison sentences for boys, and poverty and suffering. Youth also held values about sexuality and sexual behavior, expressing that young people should not start having sex before the age of 18 years. For some youth these normative beliefs were tied to religious beliefs that pre-marital sex was wrong, while most youth simply espoused the value
that early sex was bad or wrong, because of the negative outcomes that could entail. The most important reason that youth expressed for not engaging in early sex was the attitude that delaying sex would allow them to complete their educations and obtain “bright futures.”

**Attitudes, Values, Norms, and Behavior**

These attitudes and values, while individual, had been formed in response to strong messages from peers, parents and families, teachers, religious leaders, and impersonal sources such as the government and media. In fact, youth’s attitudes and values were very consistent with the norms of sexuality and sexual behavior they perceived within their peer groups, families, communities, and society. Youth had been urged by multiple members of their social environment to abstain from sex, pursue education, and remain safe from HIV/AIDS. These messages seemed to be powerful because they were consistent, and because they emphasized issues which seemed to resonate with youth, such as the dangers and rewards of choosing to have or not have sex. Furthermore, these messages often emphasized a young person’s responsibility to his or her community, such as parents warning their children they had invested in their educations and could not afford to have the investment wasted, or to care for their son’s or daughter’s child.

As social learning theory suggests, behavior is modeled and then reproduced, and individual behavior is influenced by the behavior of those in one’s social environment. Youth seemed to inherently understand this dynamic, in that they discussed the desire to have friends who were “good mannered” and who would encourage towards healthy behaviors such as abstinence. Youth discussed “bad peer groups” as being “dangerous,” realizing that if they were members of a social group which was engaging in early sex or other risky behaviors, the social pressure to conform could be intense. Some youth expressed that they had friends who did not share their attitudes and values regarding sexuality and sexual behavior, but these
other attitudes did not seem to change the prevailing norm of what adolescent sexual behavior should be. Although there was doubtless a range of actual sexual behavior among these youth, no youth defended early sexual activity, and delaying sex until the age of 18 years emerged as a clear and powerful norm. As researchers such as Goodson et al. (1997) have noted, perceptions of peer behavior may be as powerful as actual peer behavior in shaping individual behavior. The definition of early sex as non-normative has doubtless had an impact on the behavior of individual Ugandan youth.

A process of diffusion of innovation is also evident within the construction of adolescent sexuality in Uganda. As was seen in the content analysis of Straight Talk, new discourses and norms of behavior, such as delaying sex in order to get an education, and avoiding bad peer groups, develop and are then “diffused” through the pages of Straight Talk and through peer networks. The youth whose letters and pictures are featured in Straight Talk may be seen as the innovators, as they are held up as examples to other Ugandan youth and are influential because of the many Straight Talk readers who are exposed to their opinions and beliefs. Innovators may also include youth who are influential in their immediate peer networks, including youth who read Straight Talk or are members of Straight Talk clubs. The obvious similarity of comments made by participants in this study, to comments made in reader letters published by Straight Talk, suggest that to a large degree the ideas and norms expressed in the pages of Straight Talk are being diffused to the most local level, and are shaping the norms and discourse of adolescent sexuality in Uganda.

The experience of youth in Uganda therefore suggests ways in which community and societal norms are transmitted to adolescents and shape individual attitudes and values, which may in turn impact behavior. Discussions with youth also suggested that attitudes and values are not always clear determinants of behavior, however, and the relationship between attitudes, values, and behavior may be complex. The youth betrayed something of a contradiction, in that they spoke of other young people who were having sex, and the reasons those young people chose to have sex, but almost unanimously expressed that sex at their age was a dangerous and
bad thing, giving the impression that they were not themselves having sex. The researcher brought this contradiction to the attention of one focus group, and asked why none of the sexually active young people they talked about seemed to be in the group. That group answered that it was the older grades that tended to be sexually active, and not their grade. In another focus group, some participants revealed another explanation for the discrepancy between their comments about “others,” and the attitudes and values they themselves expressed.

*Girl 1:* For me I think [abstinence is] possible, it is possible to some and impossible to some. Because us we are talking now, some are, some can be just pretending because we are just here in conversation. When we go out of here, for them they have different ideas. What we talk from there, they leave it here, when they go out they do what they feel like.

*Girl 2:* But now I think all of us we have got the right ideas from some friends. I think we shall what? We shall get, we shall make it into action, we shall ever be saying no to ourselves.

*Girl 3:* Not all.

*Girl 4:* What we talk, some of us leave it here. All of us don’t have the same ideas.

This exchange indicates that not all participants in the focus group were being completely honest about their real attitudes and values, but were rather, as one of the participants said, “pretending.” This is also a possibility in other focus groups. Yet there was a certain amount of accountability in the focus groups, since the youth were already acquainted with each other and knew each other’s reputations and actions to some degree, and this may have mediated the tendency among youth to “pretend.” For instance, in one focus group a boy asserted that his mother told him to abstain from sex and that he followed her advice, and another boy expressed doubt that he was really following his mother’s advice. The first boy protested that in the past he had had bad friends but now he was truly following his mother’s advice, implying that although he may have made bad decisions in the past he now was practicing abstinence.
Another possibility is that those with dissenting views were excluded from the focus groups through the recruitment process, or that they were present in the focus groups and simply chose not to speak up. In every group one or two individuals had very little to say, meaning that their true opinions and feelings were unknown. In one focus group a girl spoke just once to say that she thought the right age for a relationship was 13 (not specifying whether she meant a sexual or platonic relationship) and then never spoke again, even after probing by the researcher. Her reticence could have been because she held a different opinion on the age at which youth should start sex, or simply because she was shy. Boys and to a lesser extent girls felt free to argue and disagree with each other, however, which seemed to indicate that there was a safe space in the focus group discussions for dissent.

Poverty, Lack of Education, and Risky Sexual Behavior

As the attitudes and values expressed by youth in this study made clear, adolescent sexuality is also influenced by societal-level, or even structural, factors such as poverty, gender inequalities, lack of access to education, and youth’s and women’s lack of power. The transactional sexual relationships described by participants, although not necessarily the main pattern of sexual relationships among youth, are a cause for deep concern as they reveal girls’ (and sometimes boys’) lack of power to determine their own sexual lives, and their vulnerability to sexual exploitation and abuse. This vulnerability to sexual exploitation is inherently tied to economic vulnerability. Poverty has far-ranging consequences, from limiting access to education to increasing likelihood of transactional and coerced sexual relationships, early sexual debut, multiple sexual partners, and other risky sexual behavior (Hallman, 2004). Lack of education is also a risk factor for unsafe sexual behavior and vulnerability to HIV/AIDS, meaning that poverty, lack of education, and risky sexual behavior are all inherently connected.
For the youth in this study, the most important reason to delay sexual debut was that they wanted to complete their educations and obtain “bright futures.” The desire to pursue education and obtain “bright futures” was often discussed as a desire to escape poverty and achieve economic self-sufficiency. With education, boys hoped they would be economically self-sufficient and able to provide for their families so that their own children would not be economically disadvantaged, while girls hoped they would not be vulnerable to sugar daddies and other exploitative sexual relationships. As poverty, lack of education, and risky sexual behavior are intertwined, providing education can be a way of breaking patterns of risky sexual behavior and eventually, poverty. As a recent Global Campaign for Education report (in cooperation with Oxfam International) concluded, education is such a strong predictor of increased knowledge about HIV/AIDS, safer sexual behavior, and reduced infection with HIV, that it can be considered a “social vaccine” against HIV/AIDS (Global Campaign for Education, 2004). UN and World Bank experts suggest that education may be “the single most effective preventive weapon against HIV/AIDS, and the Global Campaign for Education estimates that if all African children were given access to primary education, 700,000 new infections of HIV/AIDS would be prevented every year (Global Campaign for Education, 2004).

Limitations of this Study

These ambiguities reveal one of the limitations of research about sexuality. For this most private of behaviors, the only source of data we have is what people say about themselves (or possibly about their perceptions of other people), and we have no guarantee that these self reports are accurate.49 Furthermore, while people often

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49 Some researchers have chosen to ask people about their perceptions of the sexual behavior of their friends, as a means of triangulating self-reported data. For instance, Shuey et al.’s 1999 study, which reported a dramatic decrease in sexual activity among adolescents in Soroti, asked respondents to report whether they had been sexually abstinent in the past year, as well as to report whether or not
have strong opinions about what constitutes right and wrong sexual behavior, there is no guarantee what relationship their values and intentions will have to their behavior. For instance, a 1995 study of women in Mbale, Uganda found that of the adolescents and young adults surveyed, many more were sexually active than approved of premarital sexual activity. While 61.5% of respondents disapproved of premarital sexual relations, 81.3% were sexually experienced at the time of the survey (Agyei et al., 1994). The opposite phenomenon also has been observed, in Uganda and elsewhere. For instance, a survey conducted by Straight Talk in Masaka in 1995 found that although boys publicly made statements such as “It’s not possible to live without sex,” in private they admitted they were having “very little sex indeed.” One 19-year-old boy stated that he was teased for being a virgin, but that he thought “normally those who tease haven’t had [sex]” themselves (Straight Talk, July 1995).

The purpose of the current study was to address attitudes, values, and perceived norms regarding sexuality and sexual behavior. This study cannot address the actual sexual behavior of the study participants. Yet it is notable that the youth in this study so overwhelmingly expressed the same clear values about what was right and wrong regarding adolescent sexuality. It may be that “some have different ideas” out in the real world, but in the context of the focus group discussions youth were very much in agreement on what the “right” ideas were. The belief that youth should not initiate sex before the age of 18 years, and that sex before that age was dangerous and a threat to a “bright future,” was both a personal value held by youth in this study, and a strong social norm within their communities.

It is possible that the participants were expressing this interpretation of personal values and norms in response to the researcher, either because she was an adult and thus a perceived authority figure, or because she somehow betrayed a personal bias. This is one possible weakness of this study. In fact, the researcher did have certain expectations, in that she anticipated that abstinence would be the major behavior and norm discussed by youth. She also anticipated that religious beliefs would be a major

they thought their three closest friends of the same gender had been sexually abstinent in the past year. These third-party data were found to be similar to self-reported data.
influencer of attitudes and values regarding sexual activity, as Uganda is heavily religious\textsuperscript{50}, and as participation in religious activities has been shown to have a negative correlation with adolescent sexual activity in studies conducted in the United States (Thornton & Camburn, 1989; Murry, 1994; Beck & Cole, 1991).

While abstinence was the main behavior discussed by youth, this theme was clearly generated by the youth themselves, as the researcher did not specifically inquire about abstinence, and the word was not part of the focus group discussion questionnaire. Youth often asked the researcher at the conclusion of the focus group discussion what in particular she was trying to find out from Ugandan youth, and what her own views were on adolescent sexual behavior, suggesting that they did not perceive an “abstinence bias” on the part of the researcher and were not able to discern her personal beliefs during the course of the focus group discussion. Furthermore, the researcher’s expectation that religious belief would be a major theme of the results of this study, was not borne out. While some youth did discuss the importance of religious beliefs, the main reason that youth discussed for not engaging in sexual activity was that they wanted to complete their educations and obtain “bright futures,” a theme that was not anticipated by the researcher.

Another potential weakness in this study is the fact that the researcher was an American and an outsider, and may not have been as able to understand and interpret the experience of Ugandan youth, as would a member of their culture. The researcher’s “outsider” status may have also affected the response of the participants. A related weakness is that most focus groups were conducted in English, which may have limited participants’ ability to express themselves, while the focus groups that were conducted in local languages are limited by the quality of the translation that was done. Other weaknesses include the small sample size (especially for out-of-school youth) and the fact that participants were self-selected, which may have led to

\textsuperscript{50}The vast majority of Ugandans claim to be either Muslim or Christian. One-third (33%) of the population is Roman Catholic, one-third (33%) is Protestant, 16% is Muslim, and 18% claim indigenous beliefs (CIA, 2004). The vitality of religious communities in Uganda can also be seen in their involvement in AIDS prevention, the destigmatization of AIDS, and care for those with HIV/AIDS.
a bias among study participants. In addition, as research was conducted in only two sites (albeit in different parts of the country), the youth in this study cannot be assumed to be representative of youth in Uganda as a whole. Uganda is very diverse ethnically, and youth in different ethnic groups may have very different experiences and personal attitudes and values than do the youth in this study.
The premise of the current study is that HIV prevalence has fallen dramatically among youth in Uganda, and that such a trend likely has its cause in behavior change among youth. If so, then the causes of this behavior change deserve investigation, especially as similar behavior change among youth has not occurred in other countries in Africa where the AIDS epidemic is as severe, or more severe, than in Uganda. While this study cannot address the extent to which the attitudes, values, and perceived norms expressed by youth in this study were sincere, or the extent to which these attitudes, values, and norms were driving sexual behavior, epidemiological data suggests that to a large degree adolescent sexual behavior in Uganda is consistent with the attitudes, values, and norms expressed by the youth in this study. The results of the current study can therefore be viewed as a possible explanation for behavior change among youth in Uganda.

There is an urgent need for more research into the behavior and subjective experience of youth in Uganda. If Uganda is to provide an AIDS prevention model to the rest of the world, as many hope (such as under the United States government’s PEPFAR plan), the experience of Ugandan youth may also serve as a model to youth in the rest of the world. Research of Ugandan youth therefore has the potential to benefit youth around the world. This research should also be done for the sake of Ugandan youth. In spite of Uganda’s remarkable success against the AIDS epidemic and its current low HIV prevalence compared to other countries in Africa, HIV incidence among Ugandan youth is still orders of magnitude greater than among youth in high-income countries, and is unacceptably high. Uganda should not relinquish the fight against AIDS among its youth or any part of its population. To continue to aggressively approach AIDS prevention, the various governmental, non-governmental, and community-based organizations engaged in AIDS prevention need the most accurate information possible to augment already successful prevention strategies.
If delayed sexual debut has been the critical behavior change among Ugandan youth leading to declining HIV prevalence, there is a need for a better understanding of this specific behavior. This need has not yet begun to be addressed by the published literature. Another serious gap in the research of youth in Uganda and Africa is the experience of out-of-school youth. These youth are at a greater risk of negative outcomes of early sex, including HIV/AIDS, and are often unreached by AIDS prevention strategies. Despite the difficulty of conducting research with out-of-school youth, as opposed to conducting research with in-school youth, researchers should consider it a priority to broaden our base of knowledge about out-of-school youth as well as in-school youth, as HIV/AIDS endangers the lives of all youth.

While it seems that Uganda’s AIDS prevention strategy among youth has been very successful, it is not clear whether this strategy has been equally successful or appropriate for all youth. Further research will ensure that AIDS prevention among youth in Uganda is continued, strengthened, and extended to all youth, so that all youth can live healthy lives free of HIV/AIDS and other harmful outcomes of early sex, and claim the “bright futures” they envision.


MacPhail, C., Campbell, C. (2001). "I think condoms are good but, aiii, I hate those things": condom use among adolescents and young people in a South African township. *Social Science and Medicine, 52*(1), 1613-1627.


APPENDICES
Appendix 1: Focus Group Discussion Questionnaire

1. Why do boys and girls have relationships? What makes them want to have relationships? What good things can there be in relationships? What bad things can there be in relationships?

   *Probe:* Do you prefer relationships with girls or boys? What do boys and girls get from relationships? When are boys and girls old enough for relationships? Why?

2. Why do boys and girls have sexual relationships/play sex? What makes them want to have these relationships? What good things can there be in these relationships? What bad things can there be in these relationships?

   *Probe:* What do boys and girls get from these relationships? At what age are boys and girls old enough for sexual relationships/playing sex? Why?

3. What have people told you about relationships and sex? Who told you? What did you think about what they told you? Did you agree or disagree?

   *Friends:* Do you and your friends talk about sex and relationships? What do they tell you? Do you agree? Do you have the same opinions as your friends?

   *School:* Have your teachers or other people at school talked to you about sex? What did they tell you? Did you agree?

   *Parents:* Have your parents talked to you about sex? What did they tell you? Did you agree?

   *Church/Mosque/Religious Institution:* Has anyone at your church/mosque/religious institution talked to you about sex? What did they tell you? Did you agree?

   *Media:* Have you gotten any information about sex from the radio or newspaper? What information did you get? What did these things tell you to do? Did you agree?

   *Government:* What is the government saying to people your age about sex and relationships? What is it telling you to do?

4. What do you think is the *best* thing for young people your age to do, in the area of relationships and sex? Do you think this is possible? Why or why not?
Appendix 2: Informed Consent Documents

(for participants)

I am doing a study about what young people in [Soroti/Masaka] think about relationships and sex. I am doing this study because I know that young people in [Soroti/Masaka] are making good decisions about relationships and sex, and I want to know why, and what people and things are helping them to make these decisions. I want to invite you to talk with me about these things. I will talk to you and several other [girls/boys] at the same time. I am inviting you because you are a young person in this town. We will talk for an hour or two, and I will record the talk on a tape recorder. Everything that we say during the talk will be kept private. I will not tell anyone what you said during the talk, and I will do everything I can to make sure that no one talks about what you said during the talk, so that you will not be hurt or embarrassed. I hope that you will enjoy being part of this group talk. You only have to be part of this talk if you want to. You not have to, and if I ask any questions during the talk that you do not like, you do not have to answer. If you decide later that you do not want to be part of the group talk, you can leave, even during the talk.

Do you have any questions that you would like to ask me?

Would you like to be part of this group talk?
- Yes
- No
I am doing a study about what young people in [Soroti/Masaka] think about relationships and sex. I am doing this study because I know that young people in [Soroti/Masaka] are making good decisions about relationships and sex, and I want to know why, and what people and things are helping them to make these decisions. I want to invite your child to talk with me about these things. I will talk to your child and several other [girls/boys] at the same time. I am inviting your child because [he/she] is a young person in this town. We will talk for an hour or two, and I will record the talk on a tape recorder. Everything that we say during the talk will be kept private. I will not tell anyone what your child said during the talk, and I will do everything I can to make sure that no one talks about what your child said during the talk, so that your child will not be hurt or embarrassed. I hope that your child will enjoy being part of this group talk. [He/she] only has to be part of this talk if [he/she] wants to. [He/she] does not have to, and if I ask any questions during the talk that [he/she] does not like, [he/she] does not have to answer. If you decide later, or your child decides, that [he/she] does not want to be part of the group talk, [he/she] can leave, even during the talk.

Do you have any questions that you would like to ask me?

Would you like your child to be part of this group talk?

☐ Yes
☐ No