

**EXPLORING COMMUNITY SUPPORT OF ADOLESCENTS' SEXUAL
REPRODUCTIVE HEALTH IN THE ACHOLI SUB-REGION, UGANDA**

by

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DECLARATION

I declare that **EXPLORING COMMUNITY SUPPORT OF ADOLESCENTS' SEXUAL REPRODUCTIVE HEALTH IN THE ACHOLI SUB-REGION, UGANDA** is my own work and that all sources that I have used or quoted have been indicated and acknowledges by means of complete references and that this work has not been submitted before for any other degree at any other institution.



10 February 2017

.....

SIGNATURE

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ABSTRACT

Aim

The study explored the community role in support of adolescents' sexual reproductive health (ASRH) in Acholi sub-region, which was affected by over two decades of LRA war. The study aimed at establishing the impact of the war on Acholi socio-cultural norms of adolescents' socialisation on sexual matters by exploring the effects of the war, mass media and the modern education system on the socio-cultural norms of socialisation and compared with the current modes of promoting sexual education among adolescents as mandated by the national adolescent health policy; the study then assessed the community responsiveness to ASRH needs. Based on the findings, community strategy for enhancing community response to adolescent health was developed.

Methods

Exploratory, descriptive and case study methodology was used to execute a three-phased concurrent study with five sub-studies. Data were collected from selected participants and respondents including teen mothers, guardians, midwives, parents, adolescents, local, cultural and religious leaders as well as policy makers, technocrats and implementers at the community and district levels. The study was implemented in Gulu, Kitgum and Pader districts of Northern Uganda.

Results

The study results found that the LRA war greatly impacted on the Acholi tradition of socialising children; the war destroyed the socio-cultural, economic and family protection structures. The teen mothers' case study vividly documented the stories. Confounded by the influence of mass media and modern education system, the Acholi community is experiencing what the study called '*intergenerational cultural shock*' in which the old and young generations are shocked and amazed with the cultural difference.

Conclusion

In a bid to improve community responsiveness to adolescent health needs, amidst the societal changing contexts and emerging new youth cultures, the study proposes a community model and a strategy to promote community participation in ASRH but with many implications to policy, programs, and further research as detailed under the recommendations.

Key concepts

Acholi sub-region; adolescents; adolescent health policy; adolescent sexual reproductive health; community responsiveness; community; role; community strategy; cultural shock; health systems; Lord's Resistance Army; socio-cultural norms, socialisation.

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Who am I to live and have this as part of my success if it were not God? So first of all, I say thank you God for your grace and love, you have always answered my prayers so
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Dedication

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LIST OF ABBREVIATIONS

ADH	Adolescent Health
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARLPI	Acholi Religious Leaders Peace Initiative
ASRH	Adolescents Sexual Reproductive Health
ASRHE	Adolescents Sexual Reproductive Health Education
CDC	Centre for Disease Control and Prevention
CRC	Convention on the Rights of the Child
DEO	District Education Officer
DH	Department of Health
DHO	District Health Officer
EFA	<i>Education Funding Agency</i>
EMIS	<i>Education Management Information System</i>
FGD	Focus Group Discussion
FHI	Family Health International
HEAT	Health Education and Training
H/C	Health Centre
HIV	Human Immunodeficiency Virus
ICDP	International Conference on Population and Development
IDI	In-depth Interview
IDPs	Internally Displaced Persons
IEC	Information, Education Communication
IRIN	Integrated Regional Information Networks
IT	Information Technology
KII	Key Informant Interview
LC V	Local Council 5
LC	Local Council
LRA	Lord's Resistance Army
MakSPH-HDREC	Makerere College of Health Sciences, School of Public Health, Higher Degree, Research and Ethics Committee
MoESST	Ministry of Education, Sports, Science and Technology
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
PRB	Population Reference Bureau
PTA	Parents Teachers Association
RH	Reproductive Health
RHU	Reproductive Health Uganda
SRH	Sexual Reproductive Health
STFU	Straight Talk Foundation Uganda
STIs	Sexually Transmitted Infections
SYP	Safeguard Young People
TAP	The Access Project
TASO	The AIDS Support Organisation
TBAs	Traditional Birth Attendants
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UCC	Uganda Communication Commission

UNCST	Uganda National Council for Science and Technology
UNISA	University of South Africa
UNCRC	United Nations Convention on the Rights of the Child
UNFPA	United Nation Population Fund
UNHCR	United Nation High Commission for Refugees
UNICEF	United Nations Children's Fund
UPE	Universal Primary Education
UPFI	Uganda Peace Foundation Initiative
VHTs	Village Health Teams
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The Acholi sub-region of Uganda, the area of focus under the current study, was affected by over two decades of civil war of the Lord Resistance Army (LRA). The war caused breakdown in the social and family systems (Beard 2011:4). Children who were born during the war in the Acholi sub-region have grown into adolescents and others have become young adults. Acholi sub-region forms part of Northern Uganda and according to UNFPA (2008:40), Northern Uganda recorded some outstanding negative indicators on adolescents' sexual reproductive health (ASRH). The region recorded the highest proportion of key indicators compared to the national average: teenage pregnancy of 23.6% compared to 19.2%, unsafe abortion of 70% compared to 54%. Adolescent start at child bearing was 30.3% as compared to 24.9% (UNFPA 2008:41-54). These outstanding negative ASRH outcomes have been of great concern and motivated the conduct of the current study with a special focus on understanding the role of community in supporting ASRH.

Most often adolescents' sexual encounters are unplanned and do not involve use of contraceptives, thereby exposing them to the risk of unwanted pregnancies (Ojo, Aransiola, Fatusi, Akintomide & Awolowo 2011:30-31). Adolescents who engage in early sexual relations are at a higher risk of unintended pregnancies which may lead to high maternal mortality, unsafe abortion and high prevalence of sexually transmitted infections (STIs), including Human Immunodeficiency Virus (HIV) that causes Acquired Immune Deficiency Syndrome (AIDS) (Dejong, Shepard, Roudi-Fahimi & Ashford 2007:64).

With regard to sexual and reproductive health information, Chandra-Mouli, McCarraher and Williamson (2014:12), report that adolescents often lack basic reproductive health information and skills to negotiate sexual relationships. This is compounded by the lack of strong and stable relationships with their parents or other adults with whom they can talk to about their reproductive health concerns. In such instances, such adolescents have difficulties in accessing reproductive health services.

Parents and other adults in the community play a major role in supporting adolescents to access ASRH. According to UNFPA (2007:2), the community plays a role of offering guidance to adolescents by giving information on ASRH as well as creating a supportive environment that could influence adolescents to seek ASRH information and services.

However, in any war and conflict settings (as was the case for the Acholi sub-region), reproductive health risks for adolescents become greater and these are attributed to forced sex, increased risk-taking and reduced availability of and sensitivity to ASRH services (Women's Refugee Commission and Save the Children, United Nations High Commission for Refugees (UNHCR) & United Nations Population Fund (UNFPA) 2012:1). The study investigated the role of the community in support or non-support of adolescents on matters pertaining to sexual reproductive health during and after the war.

1.2 BACKGROUND TO THE STUDY

During the International Conference on Population and Development (ICPD) in 1994, over 179 countries signed the programme of action for the protection and promotion of the rights of adolescents to reproductive health education, information, care and a reduction in sexually transmitted infections and pregnancy (Kalembo, Zgambo & Yukai 2013:33).

Over the years tremendous progress has been registered in promoting the ICDP action plan. Globally it is estimated that a total of 1.2 billion people are adolescents and this contributes 18% of the world population. Close to 90% of this population live in the developing world (UNICEF 2012:3-4). Globally, adolescents still face enormous challenges which vary from individual to individual and from community to community (Shiferaw, Gatahun & Asres 2014:11).

The global community in which adolescents are growing up in the 21st Century is quite different from that of their parents (Dejong 2010:71). There are numerous factors that affect the lives of adolescents and young people today including: globalisation, information, education and communication and this is gradually producing a new global youth culture characterised by increasing urbanisation, use of electronic communication like cellular phones, internet, radios and television (UNFPA 2008:2). Some of these have

become vital sources of information including information on ASRH among some communities.

Studies have shown that adolescents' sexual reproductive health education (ASRHE) has some positive impact in addressing the attitudes, norms and risk perception about risky sexual behaviors and practices among adolescents (Kalembo et al 2013:35-36). Some studies have shown improvement in the level of knowledge on ASRH amongst adolescents resulting from the technological sources of information used by some adolescents. Other factors such as the ability to read and write and the longer duration spent in school have become protective for the in-school adolescents in such a way that they may marry late; can easily access SRH information and commodities including modern family planning methods (Santelli & Schalet 2009:1).

In developed countries in Europe, deliberate policy recommendations were made to make contraceptives accessible to adolescents. As a result, Netherland's teenage pregnancies were reduced eight times as compared to those of United States of America (Santelli & Schalet 2009:4-5).

The situation of ASRH for developing countries is different and is characterised by high numbers of unintended adolescent pregnancies with associated high level of maternal mortality, unsafe abortion, STIs including HIV and AIDS. These continue to pose a myriad of challenges to development (Dejong 2010:72).

According to Guttmacher Institute (2010:1-2), the annual number of unintended pregnancies among Asian countries was 2.7 million, in Sub-Saharan Africa it was 2.2 million and in Latin America, 1.2 million. Limited access to and utilisation of contraceptives accounted for 93% of unintended pregnancies in Asian countries, 92% in Sub-Saharan Africa and 83% in Latin America. Unsafe abortion among adolescents was 2.5 million out of 19 million unsafe abortions reported in the same year among developing countries.

In Uganda the adolescents' sexual health picture is not different. According to UBOS (2013:118-119) and UNFPA (2008:59), adolescent start of child birth was 24.9%, teenage pregnancy among 10-19 years old stood at 24% and this is worse for out-of-school adolescents which was at 42.7%. This has continued to pose moral, social and public health problems like negative outcomes for the babies and the teen mother as well. The

same report indicates an estimated 44% of the 7,200 annual maternal deaths in Uganda occur amongst females aged 15-24 years and the risk of maternal death is twice higher amongst teenage girls aged 15-19 years, compared to women in their 20s. For those under 15 years of age, the risk of maternal death is five times higher (UBOS 2013:123).

Access to reproductive health (RH) services by adolescents, especially the unmarried ones, is marred by a number of challenges ranging from limited knowledge about the existence of RH services to disapproval of adults on the use of contraceptives by adolescents. In many societies premarital sexual activity is unacceptable and therefore access to contraceptive information for the unmarried adolescents is not approved (Chandra-Mouli, McCarroher & Williamson 2014:12; Guttmacher Institute 2010:1).

To overcome these barriers, it is important to enhance the understanding of influential community leaders, parents and other community stakeholders on adolescents' needs for sexual reproductive health information and services including contraception (Chandra-Mouli, McCarroher & Williamson 2014:12). In line with the current study, the role of community in support of ASRH will be explored with the aim of developing strategies to enhance community participation in ASRH.

1.2.1 The community

A community is a construct and can be defined either geographically or socially. Geographically, a community is recognised by attributes tied to physical appearances or locations such as natural boundaries while a social community consists of people who share common social attributes like language, customs, class and ethnicity among others (United Nation Population Fund, Pathfinder, Save the Children, Care International and Advocates for Youth 2007:4). Members belonging to a community derive their support through on-going interactions that create an identity and a strong feeling of belonging, bonding and togetherness and these feelings determine members' relationships; the bonding/ togetherness is referred to as a '*sense of community*' (Pretty, Bishop, Fisher & Sonn 2006:2).

A strong sense of community (bonding and togetherness) creates a feeling that each member matters and it is believed that individual needs of each member will be fulfilled through members' commitment to being together. The commitment by members therefore

becomes a social wealth or capital that translates into quality relationships. These relationships can be formal or informal to create society safety nets (Pretty et al 2006:3).

On the basis of the community as a social wealth and capital, community members support their everyday relationships, become more accessible and welcoming to members, reinforce shared experience, create sociable gathering and promote community stewardship (McMillan & Charis 1986:4). Refer to sub-section (1.11 below) for details on community members that will be targeted to explore their role in support of ASRH.

The current study will explore and establish the kind of social wealth (relationships) among adolescents, their parents and other community adults that influence adolescents' sexual reproductive health. It will explore the community- adolescents' relationships (social wealth and capital) that should translate into everyday positive interactions, create supportive environment that encourage access to ASRH services, create sociable opportunities to dialogue on ASRH and explore the community stewardship, leadership and engagement on issues of ASRH.

However, it is important to note that community social wealth (relationships) can be affected by both internal and external factors. Internal factors include socio-cultural norms, values, perception and prioritisation; while the external factors include: the existing laws, policies and environmental conditions among others. Both internal and external factors may create problems, could deter community involvement or support and its ability to engage on matters of ASRH (UNFPA 2007:8; Advocates for Youth 2002:4).

1.2.2 Factors that influence community bounding (social wealth and capital)

According to African Union (2013:5), the adult-adolescent relationships are predominantly authoritarian in which adults set strict rules for monitoring the behavior. Any perceived deviation is accompanied by harsh sanctions. Such authoritarian relationships discourage parents from directly communicating with their children about sexuality (African Union 2013:5-6). For instance, Shiferaw, Getahun and Asres (2014:11-12) indicate that, of the 61.9% adolescents who accessed ASRH information, only 36.9% had received it from their parents, 88.7% had expressed the importance of discussing ASRH with parents.

Over 20% reported lack of knowledge and poor communication with parents as a key hindrance for parents.

In addition, the inter-generational difference between parents and their children in the modern times has increasingly led to the development of conflicting and divergent views that hinder effective communication and information transfer including ASRH information from parents to the young generation (Wamoyi, Fenwick, Urassa, Zaba & Stones 2010:6). Exploring how to improve and promote positive social interaction between adolescents, their parents and other adults, as well as establishing the techniques, knowledge and skills to enhance positive adolescent-parent communication is critical to promote ASRH information and services.

In societies where sexual abuse and coercion are predominant, health risks for adolescents are increased. According to UNFPA and PRB (2012:3), in Sub-Saharan Africa, for some girls, their first sexual experience is with a “*sugar daddy*”, that is, somebody already married, who provides clothing, school fees, and books in exchange for sex. In Uganda, 40% of 400 randomly selected primary school students who were sexually active reported being forced to have intercourse (PATH 1998:3). Understanding the underlying factors that promote such acts and exploring the preventive measure by the community could reinforce healthy adolescents’ sexual reproductive health in the community.

In India, arranged marriages of girls younger than 14 years old are still common. Sexual exposure occurs at ages 9-12 years as older men seek young girls as sexual partners presumably to protect themselves from STIs including HIV and AIDS. In some cultures, young men are expected to have their first sexual encounter with a prostitute (UNFPA & PRB 2012:3-4).

Adolescents living in unsafe environments are exposed to SRH problems. Such children are often involved in “survival sex” where they trade sex for food, money, protection or drugs. According to UNFPA and PRB (2012:5), 40 % of 143 street children surveyed had their first sexual encounter with someone they did not know. All had exchanged sex for money, were all sexually abused, and 93% had been infected with an STD. In Thailand, an estimated 800,000 prostitutes were under age 20 in 1998 and of these, 200,000 were

younger than 14 and some were sold into prostitution by parents to support other family members.

The community sense is a social wealth and capital to protect, and supports its members to meet their needs (Pretty et al 2006:3). In a post-war situation like the Acholi sub-region where the protective systems for children were destroyed, the current study intended to explore the role of community in support of ASRH during and after the war and as well generate strategies that could enhance community support of ASRH.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The Acholi form part of the Luo ethnic group and they live in the Northern sub region of Uganda. The northern Uganda experienced over two decades of the Lord's Resistance Army (LRA) war that lasted between 1986-2006 that caused breakdown in the social and family set up systems (Beard 2011:4). In such a situation, social services such as health, education and road networks were disrupted; adolescents who became sexually active when there were few protective and social services as highlighted above could not access quality sexual reproductive health. Girl children became more vulnerable to sexual abuse and exploitation which in turn increased their vulnerability to sexually transmitted infections including HIV and AIDS, unwanted pregnancies and unsafe abortion (Women's Refugee Commission et al 2012:2).

The two decades of civil war in the Acholi sub-region eroded the social-cultural fabric (the protective values and norms) and it resulted in immense moral decadence among the population. Women and girls became victims of sexual abuse such as rape and defilement by rebels and soldiers. The sexual abuse increased the sexual reproductive health risk (Beard 2011:5; Patal, Schecher, Sewankambo, Atim, Oboya, Kiwanuka & Spittal 2014:2).

The war caused people to be internally displaced persons' (IDPs). As a result, over 1.8 million people were forced into IDPs camps. With congestion in the camps and redundancy, there was increased moral decadence characterised by exchange of sex for money and other material gains, which increased risky sexual behaviours (Beard 2011:4). The risky sexual behaviours resulted in myriad health outcomes. According to Uganda AIDS Commission (UAC 2010:5), Northern Uganda had a higher HIV prevalence (8.2%)

much above the national prevalence (6.4%), teenage pregnancy at 23.6% as compared to the national average of 19.2%, unsafe abortion at 70% as compared to 54% national average, adolescent start of child bearing was 30.3% as compared to the national average of 24.9% (UNFPA 2008:41-54).

Some children became orphans as a result of the war. Of the 2 million orphans estimated in Uganda, 4% are in the North (UBOS and ICF International Inc 2012:21). In addition, the war caused 'secondary' parental absence (parents living apart from the children) as parents were forced to send their children to safe places through night commuting. Each night in Gulu town for instance an estimated 25,000 night commuters were reported. Of these approximately 14,000 were children who found custody under verandas, bus parks or churches where they spent the cold nights (Catholic Relief 2004:4). In a situation of 'secondary' parental absence (such children lacked care and protection of adults), they became more vulnerable to sexual abuse and exploitation, which exposed them to sexual and reproductive health risks.

It is about seven years since the war in Northern Uganda ended. The above highlighted statistics on indicators of ASRH outcomes have been of concern and a motivation for the current study. The problem investigated was that little information exists about the role played by the community to support adolescents' sexual reproductive health during and after the war. It is presumed that by exploring the state of affairs during the said period, and by evaluating the *status quo*, the study will help close the gap in the literature by establishing more definitively how adolescents in Acholi sub-region have been affected by the presence of community support or lack of it.

1.4 AIMS OF THE STUDY

The purpose of the study was to investigate the role played by the community stakeholders in the Acholi community in support of adolescents' sexual reproductive health during and after the war era. The ultimate aim was to develop strategies that would enhance further community involvement in the adolescents' sexual reproductive health.

1.5 OBJECTIVES OF THE STUDY

The study had three major objectives that included, to

- i. study the effects of the role played by community stakeholders on adolescent's (Teen mothers) handling of SRH experiences
- ii. establish how socio-cultural factors influence adolescents' sexual reproductive health (ASRH)
- iii. identify health systems factors that influences the community role in support of ASRH

From the study objectives, the following research questions were developed:

- i. How has the role played by community stakeholders impacted on adolescents (teenage) mothers' ability to handle sexual reproductive health?
- ii. To what extent do socio-cultural factors influence ASRH?
- iii. How has health systems influenced community role in support of ASRH and taking in to account the findings of the study, what strategies would best address the issue of community involvement in ASRH?

1.6 SIGNIFICANCE OF THE STUDY

Adolescents contribute 18% of the world's population and they are the fastest ever growing population (UNFPA 2012:8; Larsen 2010:1). Adolescents are tomorrow's parents, and the reproductive and sexual health decisions they make today will affect the health and wellbeing of their communities and of their countries for decades to come. The negative health consequences experienced by adolescents can pass from one generation to the next. Due to physical, emotional, biological and psychological changes associated with adolescence, adolescents have greater risks to sexual reproductive health risks such as unintended pregnancies with associated high level of maternal mortality, unsafe abortion, and acquisition of STIs including HIV and AIDS. The community has a big role it plays to support ASRH (UNFPA 2007:2).

There have been various ways which the community can follow to promote uptake of ASRH and among others; the community can offer information on available health services, where to get the services, under what condition, use of referral system and provision of funds or vouchers (WHO 2009:7).

The Acholi sub-region, which was affected by civil war caused a breakdown in the social and family protective systems, eroded fibers and norms. There are some outstanding negative indicators on ASRH. However, little information exists on the role of community in supporting ASRH. The present study will contribute towards understanding the role of community stakeholders in supporting ASRH in communities affected by war and conflict. The findings on community role in support of ASRH could apply to other communities experiencing war and conflict.

Additionally, the study findings generated new knowledge, hence adding to the body of existing knowledge about community support of ASRH. The development of community strategy to improve the participation of different community stakeholders including parents, guardians, teachers, local, and opinion of cultural and religious leaders could enhance further community involvement and participation in ASRH that could improve the uptake and utilisation of ASRH information and services by adolescents.

The community strategy document could be used to lobby policy makers, planners and ministry of health to adopt practical recommendations that can enhance further community involvement and participation in ASRH.

The knowledge gained will also be important for education purposes especially for those students interested in this area, which is likely to stimulate further research into this topic.

1.7 RESEARCH DESIGN AND METHODOLOGY

According to Babbie (2008:122), a research design is the process of focusing one's perspectives for the purpose of the study and involves a set of decisions regarding what is to be studied, in which population and what methods to use. In the current study, mixed methodology was used to study the real life contextual experiences to understand multi-level perspectives and cultural influences on ASRH (this was the qualitative strand). The quantitative strand employed the questionnaire method to generate data from the adolescents on the magnitude and frequency of constructs under the current study. Use of mixed methods facilitated the understanding of the meaning (qualitative strand) and the magnitude (quantitative) (Creswell, Klassen, Plano Clark & Smith 2010:4). Case study design using exploratory and descriptive techniques and related methods was used to collect both the qualitative and quantitative data. Qualitative data were given more

priority and quantitative data were secondary to supplement the qualitative data. The study had three phases with 05 (five) sub-studies. The timing for the data collection was concurrent and embedded within the design (Creswell 2011:64-69).

In order to achieve the objectives and ensure that the study process was coherent, key selected community stakeholders including: teen parents, parents/guardians to adolescents, health workers, counselors, senior woman teachers, cultural and religious leaders, policy implementers and makers were included. Different sampling techniques were used to select the study participants and respondents for data collection and analysis. This was done in order to achieve methodological triangulation, which ensures the validity and trustworthiness of results. Chapter 3 presents the research design and methodology in detail.

Table 1.1: Study populations and sources of data

	Phase I Objective 1: To study the effect of the roles played by community stakeholders on adolescent's (Teen parents) handling of SRH experiences	Phase II Objective 2 To establish how socio-cultural factors influence adolescents' sexual reproductive health (ASRH)	Phase III study objectives Objective 3 To identify health systems factors that influence community role in support of ASRH
Data source	Sub-study I <ul style="list-style-type: none"> • Teen parents • Parents and guardians of teen parents • Midwife 	Sub-study I Cultural and religious leaders Sub-study II Adolescents and their parents from the community Sub-study III Adolescents (600) 300 in school (Primary and Secondary) 300 from the community	Sub-study I Policy makers and implementers DHO/ADHO (1 person) DEO/ADEO (1 person) LCV, secretary for health (2 people) MoH (1 person) MoESST- (officer in charge school health (1 person) MoGLSD (officer in charge children affairs, and culture and family affairs (2 people)
Method of data collection	In depth interviews (IDI) Key informant interviews (KII) Document reviews	KII and FGD Questionnaire and FGD KII and FGD	KII
Nature of data	Qualitative	Quantitative and Qualitative	Qualitative

Phase I sub-study I

Phase I had one sub-study which was purely qualitative and involved a case study that targeted adolescent parents (teen parents), adolescents' guardians/parents and the midwife that supported teen parents to access antenatal care (ANC) services. Using the

health facility as an entry point and taking in to the consideration the level of health care facility, from the district hospital, health sub-district (H/CIV) and health Centre three (H/CIII) at sub-county level, one facility per each level was randomly selected using simple random sampling. Three (03) health facilities were selected per district, making a total of 9 health facilities for the three districts. Midwives working in the ANC in the selected health facilities were purposely selected and interviewed as key informants. A total of 8 out of the nine selected midwives were interviewed as key informants.

For the teen parents and guardians, the health facility ANC registers were used to generate the sampling frame and using simple random sampling; two teen parents were selected per facility and were invited by the midwife to come with their guardians using the appointment system. The appointment dates were then shared with the researcher. When the teen parents came, they were briefed about the purpose of the interviews and sought their consent before asking both the teen parent (s) and their guardians to participate in the IDI. The interviews were conducted on a one-on-one basis in a private room that ensured privacy for both the teen parent (s) and their guardians. A total of 29 IDIs were conducted (15 teen mothers and 14 guardians).

Interview guides were used for both KII and IDI; and the data were recorded using voice recorder and field notes. The voice recordings were transcribed and expanded notes generated from the filed notes. Using Atlas-ti, the primary documents were exported and basing on the codes developed, the data were analysed and reported using themes, quotes and frequencies.

Phase II

Phase II had three sub-studies. It targeted key community stakeholders including religious and cultural leaders, and parents of other adolescents in the community. The details for the sub-studies under phase II are presented below:

Phase II sub-study I and II

Religious and cultural leaders were targeted for Phase II sub-study one. These two institutions were purposely selected. The office of the Acholi paramount Chief- Ker-Kwaro Acholi under the leadership of Rwot David Acana mobilised the different chiefdoms who

were invited for a focus group discussion. A total of 8 chiefdoms attended the FGD that was facilitated in the offices of the paramount chief in a convenient and conducive environment. While for the paramount chief, a KII was conducted using a key informant guide.

For the religious leaders, the offices of the Acholi Religious Leaders Peace Initiative (ARLPI) coordinated interviews for the religious leaders for both KII with the most top religious offices for the catholic (Archbishop) and for Church of Uganda, the Bishop and the Sheik for the Muslim community. For the FGD, a total of 08 religious leaders representing all the religious denominations were purposely selected and invited through ARLPI. Two FGDs (one for cultural leaders and one for religious leaders) were conducted independently using an FGD guide. A total of three KIIs out of four planned KIIs were conducted with the leaders of the cultural (01) and religious institution (02). The data were recorded using voice recorder and field notes. The voice recordings were transcribed and expanded notes generated from the filed notes. Using Atlas-ti, the primary documents were exported and basing on the codes developed, the data were analysed and reported using themes, quotes and frequencies.

Phase II sub-study II

Parents of adolescents from the community and adolescents were targeted for this phase. Using the administrative structures (Uganda Bureau of Statistics 2014), simple random sampling was used and three (03) villages were selected. Using the local council (LC) structure, the chairperson LC I was supported to purposively select 10 parents who live in his village for a focus group discussion. One FGD comprising 10 parents was held per district and three FGDs were also held for adolescents from the same village with the parents. The chairperson of the village identified a convenient and private central place for the FGDs with parents and for adolescents. The interviews for the parents and adolescents were conducted on the same day but in different locations.

Phase II sub-study III

Phase II sub-study III was purely quantitative. Data were collected from 600 adolescents. The total number of adolescents sampled was proportional to the adolescent population per given district. For instance, for Gulu district, 270 was assigned to the district, for

Kitgum, it was 170 and for Pader had 160 adolescents. Fifty percent of this number per district was assigned to in school interview setting and the other 50% for out of school interview setting.

Using the local council chairperson of the villages selected for parents FGD, the LCs were asked to mobilise households with adolescents 10-19 years in their village to come to a central place. Adolescents who turned up at the venue (which was either at a community center, play field or at the church), using a raffle system, paper numbering to the equivalent numbers of respondents were written and put in a box then the adolescents were invited to pick and those who picked the labeled papers were recorded and they took part in the cross sectional survey.

Phase III sub-study I

Phase III had only one sub-study which was mainly qualitative. It targeted policy makers and implementers both at the districts and national levels. At the district level, the policy arm included: the district chairperson Local Council five (LCV), the vice and/or the secretary children's affairs; the implementers included; the District Education Officer (DEO), District Health Officer (DHO), senior woman or male teachers and counselors.

At national level the following were included: the Commissioner adolescents Health at Ministry of Health, Commissioner, School Health Programme at Ministry of Education, Commissioner Communication and Mass Media, at Uganda Communication Commission, Commission Family, Culture and Children Affairs at Ministry of Gender, Labour and Social Development.

A total of 18 key informants was purposively selected and interviewed as key informants using key informant guide.

1.8 RESEARCH SETTING

The Acholi sub-region, Northern Uganda was affected by over two decades of LRA civil war. The region comprises 7 districts. However, the study was conducted in three districts of Gulu, Kitgum and Padre. The decision for having only three districts was based on the period of establishment (for 10 years and above). Comparatively, these districts have

more established administrative structures and systems as compared to the newly created districts that were formerly part of these three districts. The estimated population of the three districts is 908,300 people; Gulu having 407,500, Kitgum with 257,600 and Pader with 243,200 and with an estimated 23.2% of young people aged 10-19 years in the three districts translating in to a total of 210,478 adolescents (UBOS 2013:5). These young people (adolescents) were born during the conflict and post conflict era.

From the district level, the local government administrative structures including: the county, sub-county, the parish and the village as the smallest local administrative unit were considered in the selection of study sites. The same principle was considered for the district health systems structure that comprises: a hospital at district level, health sub-district at county level, health centre III at sub-county level, health centre II at parish level and the Village health teams (VHTs) at village level. The latter (health systems structure) was used to select study sites.

All the health facility units were listed (forming a sampling frame) at district level up to the sub-county level (H/C III). These formed clusters, and multistage cluster sampling was used to select study sites from the district up to sub-county level forming two cluster levels:

- (i) Health sub-district (HC IV) as the primary cluster level one
- (ii) Sub-county (HC III) as the secondary cluster level two

Multistage cluster sampling was used, for the district level. The district hospital was purposively selected, for the primary cluster, one health sub-district HC IV was selected using simple random sampling from the sampling frame. For the secondary multistage, all the HC III at the different sub-counties were listed and only one HC III was selected using simple random sampling.

1.9 ETHICAL CONSIDERATIONS

Ethics deals with matters of right and wrong. *Collins English Dictionary* (1991:533) defines ethics as “a social, religious, or civil code of behaviour considered correct, especially that of a particular group, profession, or individual”. To ensure that the study met the prescribed ethical standards, the researcher obtained permission to conduct the study

from the University of South Africa (UNISA) and the Makerere University College of Health Sciences, School of Public Health *Higher Degrees, Research and Ethics Committee* (MakSPH-HDREC). Furthermore, the researcher respected the respondents' and participants' right to self-determination and voluntary participation; fair treatment and protection from harm (beneficence), and anonymity, confidentiality and privacy.

1.9.1 Right to self-determination and voluntary participation

The right to self-determination is based on respect for persons and indicates that people are capable of controlling their own destiny. They should be treated as autonomous agents, who have the freedom to conduct their lives as they choose without external controls (Burns & Grove 2012:158). Explaining the purpose and significance of the study, and potential benefits, if any, to the respondents and participants ensured the right to self-determination. The researcher also informed them that participation was voluntary, required their consent, and they could choose to participate or not. Furthermore, they had the right to withdraw from the study at any time without penalty.

1.9.2 Right to fair treatment

The right to fair treatment is based on the ethical principle of justice, which holds that each person should be treated fairly (Burns and Grove 2005:189). To ensure fair treatment, the researcher explained in details to the participants the terms and condition of participation, the role of the participant and the researcher in the study and the agreement were followed; for instance the time duration, the venue, and the sitting area.

1.9.3 Right to protection from discomfort and harm

The right to protection from discomfort and harm is based on the ethical principle of beneficence. It states that one should do good and, above all, do no harm (Burns & Grove 2005:190). Discomfort and harm can be physical, emotional, economic, social or legal. In this study, there were no risks of exposing the respondents and participants to discomfort or harm.

1.9.4 Privacy, confidentiality and anonymity

Privacy is the freedom an individual has to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns & Grove 2012:158). Respondents' and participant's privacy is protected if informed consent to participate is given and signed voluntarily before participation.

Confidentiality means that information provided by participants will not be divulged or made available to any other person. Anonymity is when even the researcher cannot trace the data to specific subjects (Brink 1998:51). To ensure the respondents' and participant's anonymity, they were not asked to provide their names. Instead, the researcher assigned numbers to the interviews. The researcher emphasised that all information would be treated as strictly confidential.

1.10 SCOPE AND LIMITATIONS OF THE STUDY

The study was conducted in three districts of Acholi sub-region including Gulu, Kitgum and Pader out of the seven districts that form part of the Acholi sub-region. The conflict affected the entire Acholi sub-region and other neighbouring districts. The findings documented in this report may not represent the experiences of those from the other districts due to socio-cultural and structural differences.

Due to the post conflict setting and the experiences that the community had as part of rehabilitation and resettlement program, some study participants especially the teen parents had false expectations on tangible benefits for the baby and as well for themselves including sponsorship to do vocational skills development to enhance their economic prospects. The researcher clearly explained the purpose of the research; made no promises of assistance, but stressed that the findings would be presented to policy makers for policy change or programme design.

Most of the data were collected retrospectively in regard to the community experiences and how the war impacted the life of the Acholi community; retrospective data brings in recall bias. The researcher used both methodological and data triangulation to control for the bias.

1.11 DEFINITION OF KEY CONCEPTS

Adolescence: This is a journey from the world of the child to the world of the adult. It is a time of physical, emotional biological and psychological changes as the body matures and the mind becomes more questioning and independent (WHO 2002:5; Neema, Musisi & Kibombo 2004:6). During adolescence some of the key developmental traits include: desire for self-autonomy and independence; start to establish intimate relationships, self-identity and attraction to the opposite sex as well as becoming adventurous (Petersen, Bhana & Swartz 2012:413). During adolescence, the adolescents are faced with life-threatening health risks attributed to sexual and reproductive issues such as unwanted pregnancies and sexually transmitted infections including HIV and AIDS. These categories of people are referred to as adolescents.

Adolescents: These are young people of a certain age brackets. Different scholars refer to varying ages. According to UNICEF (2009:5), people falling between the ages of 10-19 years are considered as adolescents. Whereas, Letsapa (2010:6) defines adolescent as people from the age of 14 to 24; the current study considered the UNICEF definition and will include those aged 10-19 years. The current study considered individuals who were born during the period 1996- 2005. Retrospectively, these children fell between the ages of 10-19 years. Those born earlier than 1996 are now young adults and may not have remembered their adolescence time and experience.

Adolescent sexual reproductive health: By definition reproductive health is a state of complete physical, mental, emotional and social wellbeing in all matters related to reproductive health systems, its functions and processes. It includes sexual education, enhancement of life, personal relations; counseling and care related to reproduction and sexually transmitted infections (UNFPA 2008:34). Adolescents' reproductive health therefore looks at specific age category of people and in this case, those aged 10-19 years. Specific adolescent sexual reproductive health issues include:

- Lack of awareness and correct information on unwanted pregnancies and STIs
- Early sexual debut with associated early unintended pregnancies
- Unsafe motherhood
- Non-use on contraceptives (FP including condoms)
- Unsafe abortion

- High maternal mortality
- Limited access to adolescents friendly services

In the current study, the above listed ASRH issues were explored in line with community support to enhance positive ASRH needs and services.

Adolescents' risky sexual behaviors and practices: Thupayagale-Tshweneagae (2010:27) defines adolescent risky sexual behaviors as all factors that contribute to unplanned sexual activity including lack of information, lack of skills to resist peer pressure, limited friendly counseling services for adolescents, poverty, cultural values and norms that give young women a low social position, and little power to resist persuasion or coercion into unwanted sex and transactional sex among others. In the current study, all risk factors that predispose adolescents to the risk of sexual reproductive health both at individual level, family, Institutional and societal were explored.

Barriers to sexual reproductive health: The *Oxford English Dictionary* (2007), "barrier" is an obstacle that prevents progress, movement or access. The current study considered the following as key barriers that bar adolescents from accessing sexual reproductive health: limited knowledge and awareness on ASRH by adolescents and lack of skills by the community to discuss sexual reproductive health issues with adolescents

Community: is a construct and it can be defined either geographically or socially:

Geographically: A community is recognised by attributes tied to physical appearances or locations such as natural and administrative boundaries (Community Pathways to Improved Adolescent Sexual and Reproductive Health 2007:4). In this study, the geographical community included the Acholi sub-region and targeting three districts of Gulu, Kitgum and Pader as administrative structures.

Socially: A community consists of people who share common social attributes like language, customs, class and ethnicity (Akinyele et al 2007:4). The social community that was considered in the current study included: Adolescents, parents/guardians, teachers, and health workers, cultural, local council and religious leaders whom adolescents live and interact with in the Acholi sub-region of Uganda. Briefly, an understanding of each of the social community targeted is summarised below:

Parent/Guardian: This was either biological or a care taker of adolescent and should have been living together under the same roof during the time of study.

Teacher: Were persons directly responsible for counseling and guidance to adolescents in schools (for instance the woman teacher).

Health worker: A person mandated to provide health care services directly or in charge of planning and administration of adolescents related reproductive health services. For instance midwife/district health officer and district health officer in charge maternal and child health.

Village health team: The lowest health systems structure under Uganda MoH. It's the village level structure and has 5 membership teams (VHTs). The VHTs are charged with the responsibility of promoting basic primary health care at household and community level in a village where they live.

Cultural leaders: These were leaders of cultural institution whose mandate was to promote cultural values and norms for moral cohesion in a society. The Acholi paramount chief, the Rwot Acana and his chiefdom structures were targeted.

Local council one (LC1): The lowest government of Uganda administrative structure that promotes leadership at village level. It has five executive members. One or two members of the committee (chairperson and the secretary for children and youth affairs) were targeted for this study as respondent/participant.

Religious leader: This was a person recognised within a particular religion as having authority within that body. Leaders of the following religious body were targeted to be part of the study participants: Catholic, Church of Uganda and Muslim religious leaders. The Acholi Peace Initiative an umbrella organisation was the lead institution for mobilising the religious leaders of the different sects.

Community support: This included actions and steps taken by the community (social community) to: help adolescents avoid risky sexual behaviors and practices and empowering adolescents to avoid early sexual debut, helping adolescents to prevention

sexually transmitted infections (STIs), unwanted pregnancies, unsafe abortion and its associated high maternal mortality.

This support among others included:

- Giving information and guiding adolescents on how to delay early sexual debut.
- Giving information on dangers of early sexual debut.
- Counseling adolescents on safe sex practice.
- Giving information on contraceptives.
- Counseling adolescents on how to avoid unwanted pregnancies including information on contraceptives and where ASRH services are found.
- Providing transport and any other facilitation (user fee) to adolescents in need of RH services.
- Empowering adolescents especially girls on how to protect themselves from unintended pregnancies and encourage the girl child to still maintain a free, less coercive sexual relationship with boys.

Health facility: These were government aided health facility. In the current study, this word was interchangeably be used with health unit.

Health unit levels: Using the health systems structure of Uganda, the following are the different levels that were considered:

- District Hospital
- Health sub-district is H/C IV
- H/C III
- H/CII
- VHTs structure

Teen parents: This term referred to both girls and boys who have had a child when they are aged 10-19. The word was used interchangeably with adolescent parents, adolescent mother/or father.

1.12 OUTLINE OF THE STUDY

Chapter 1 introduces the problem under investigation, outlines the background to the problem, states the aim and objectives of the study, and briefly describes the research design and methodology.

Chapter 2 presents the literature review on ASRH and community participation in ASRH. This enabled the researcher to compare and contrast the findings of this study.

Chapter 3 describes the research design and methodology, including the population, sampling, data collection and analysis, as well as validity, reliability and trustworthiness, and discusses the ethical considerations.

Chapter 4 presents interpretation of the findings according to the different study phases (phase I, phase II sub-studies I-III, and phase III) the data were collected from different study participants and respondents as detailed above.

Chapter 5 presents the discussions on the integrated results with what other researchers have done.

Chapter 6 presents community strategies for enhancing community participation in adolescents' sexual reproductive health (ASRH). The strategies were consolidated from findings from the different study phases. The last part of chapter 5 proposes an integrated community model for enhancing community responsiveness to adolescents' sexual reproductive health.

Chapter 7 presents conclusions and key findings of the study.

Chapter 8 presents the conclusion, limitations and recommendations.

1.13 CONCLUSION

This chapter described the research problem, the aims, objectives, significance and design and methodology of the study, and ethical considerations, and defined key concepts. Adolescents are heterogeneous; such as those affected by conflict and live in

unsafe environment, orphaned, married, unmarried, in school and out of school and those engaged in transactional sex among others. Such heterogeneity impacts on the adolescents' sexual reproductive health choices and particularly, the current study explored the adolescents' sexual reproductive health needs for those affected by war and conflict in the Acholi sub-region that had over two decades of LRA civil war and established how the community supported the adolescents on matters pertaining to their SRH during and after the war era.

Chapter 2 reviews the literature on child growth and development with special focus on adolescence and the community role and participation in ASRH and policy related to enhancing community responsiveness to ASRH.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews literature related to the present study. Literature review is undertaken to assist researchers to comprehend and extend their knowledge of the phenomenon under study (Polit & Beck 2008:105). According to Babbie and Mouton (2001:565), the purpose of a literature review is “to determine the extent to which the topic under study is covered in the existing body of knowledge”.

In the current study, both theoretical and empirical sources were reviewed. The theoretical sources looked at stages of child development. Taking into consideration adolescence; which is a stage in human development as a child grows and transits to become an adult; an understanding of these transitional stages provides a deeper understanding on what risk factors pre-dispose adolescents to the risk of sexual reproductive health outcomes. Empirical literature provided a critical analysis of issues affecting adolescents’ sexual reproductive health with the view of identifying gaps for the current study to address.

2.2 THEORETICAL PERSPECTIVES ON CHILD DEVELOPMENT STAGES

Theories involve constructing abstract interpretations that can be used to explain a variety of situations in the social world. The theories are used in the current study to explain child growth and development in terms of physiological, cognitive and social emotional development. This is in a bid to comprehend the process, stages and characteristics of child development with a special focus on the adolescent stage.

In terms of physical growth, the development is seen on the body, and the changes occur in a relatively stable, predictable sequence. Some key characteristics under physical development include: changes in bone thickness, size, weight, height and movement (The Goodheart [Sa]:70). While, cognitive growth, (sometimes known as intellectual development), is the process that people use to gain knowledge and language through

reasoning and imagination. Language and thoughts are a result of cognitive development. It forms part of the essential requirement for planning, remembering and problem solving. As children grow, mature and gain experience with their world, cognitive skills also grow (The Goodheart [Sa]:71).

Cognitive development and social-emotional development are interlinked. Learning to relate to others is an aspect of social development, and on the other hand, emotional development involves feelings and their expression. Trust, fear, confidence, friendship, humor, timidity, interest and pleasure are some of the key social-emotional traits (The Goodheart [Sa]:72). Children develop social-emotional skills as they relate with others. It should be noted that all the three stages of physical, cognitive and social-emotional development are linked to one another. Development in one area can strongly influence another area (The Goodheart [Sa]:73).

2.2.1 Theories of child growth and development

The works of the following theorists, Erik Erikson (1902-1994) the theory of psychosocial development (Patel 2016:2) and Lev Vygotsky (1896-1934) the theory of socio-cultural and ecological theory (State of New South Wales (NSW) 2006:3) are discussed.

2.2.1.1 *Theory of psychosocial development (Erik Erikson 1902-1994)*

Patel (2016:2) has noted that Erik Erikson believed that development occurs throughout one's lifespan and his theory emphasises the social and emotional aspects of child growth and development. Children's personalities develop in response to their social environment and this at the same time helps children in developing their skills for social interactions. In his eight stages, he believed that social crisis or conflict occurs and they require solution that is satisfying personally and socially. Maturity and social forces help in resolution of these forces and therefore parents, teachers and peers play important roles during the transitional stages by providing social opportunity and support to help children (adolescents) overcome each social conflict and crisis. Erikson theory highlights the common characteristics during these stages of social crisis as: trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, industry versus inferiority (The Goodheart [Sa]:76-77).

The psychosocial conflicts and crisis during the adolescent stage if not well supported may have long-term effects on the child (adolescent) as the child grows. Parents, peers and teachers play vital roles in supporting children transit through these stages. The negative forces such as mistrust, shame, guilt and inferiority may be of particular concerns since these negatively impacts on the child.

2.2.1.2 Socio-cultural and ecological theory of development (Lev Vygotsky 1896-1934)

Lev Vygotsky believed that children learn through social and cultural experiences. Interactions with peers and adults help children in this process. While interacting with others, children learn the customs, values, beliefs, and language of their culture. Language is an important tool for learning (The Goodheart [Sa]:81).

Lev Vygotsky presents learning as a process and this process is in a scale referred to as *zone of proximal development* and within the zones, on the extremes, there are tasks that a child can perform without support and on the other extreme, it is very difficult for the child to accomplish certain tasks even though the child is supported. In the middle, the child needs help in order to accomplish a task. The middle level is known as *scaffolding* which is 'guided learning'. Through social interaction, *scaffolding* helps children to learn and therefore parents, peers and teachers provide opportunity for social interaction for children (The Goodheart [Sa]:82) through the process of *scaffolding*.

Based on these two theorists, an understanding of the social conflicts (the eight stages) and how these forces are supported (*scaffolding*) helped the researcher to explore, examine and establish the role of community in support of ASRH.

2.2.1.3 Socio-ecological model

Social ecological model (SEM) describes the interactive characteristics of individuals and their environment that underlie health outcomes. The model recognises individuals as embedded within the larger social systems that include the family, peers and friends (basically these are relationships), institutions and the broader society at large. These systems interact and their interactions influence health outcome.

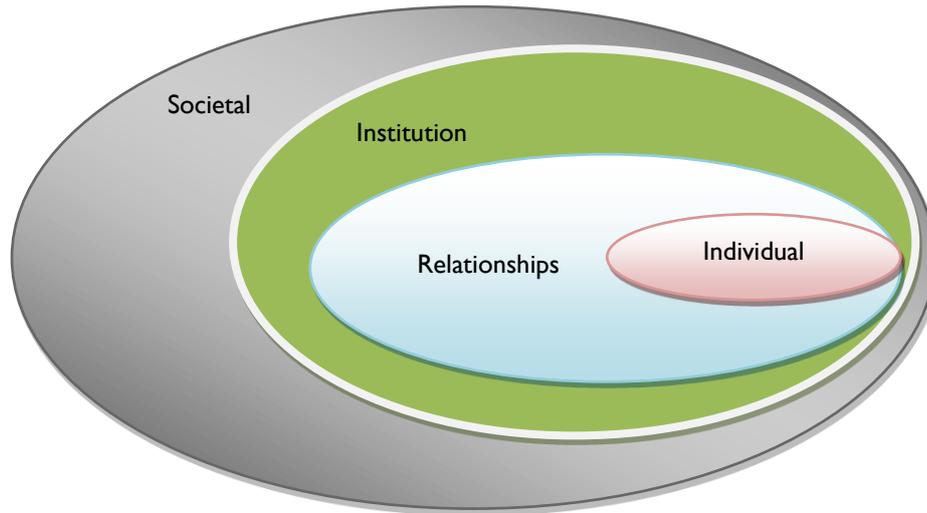


Figure 1.1: The Social Ecological Model

(The Social-Ecological model, a framework for prevention adopted from Centres for Disease Control and Prevention (CDC), National Centre for Injury Prevention and Control 2013)

From the SEM, the individual level, there are some health risks predisposing factors including gender, age, education status, skills, beliefs and attitudes (Brown 2011:1). Interventions for prevention and or promoting health at this level should focus on improving knowledge, building skills and changing attitudes and beliefs among individuals (for the case of the current study, the support by the community stakeholders in regard to individual adolescents characteristics (table 1.1) to enhance ASRH. The current study explored and established the role of community stakeholders in supporting ASRH during and after the war period in Acholi sub-region.

The relationships level consists of the immediate family members, relatives, peers and friends whose interactions either positively or negatively influence individual response (Brown 2011:2). This is dependent on the kind of social capital/wealth that was built among the networks of relationship. The current study evaluated the effects of the role played by the community on adolescents' reproductive health experience during and after the war era and critically assessed the kind of social capital that adolescents had with the community stakeholders.

The institutional level looks at different social places that gather people for instance schools, health units and hospitals, religious institutions and community based organisations. The characteristics of these places influence health outcomes. The current study established how such institutions like schools, health centres, hospitals and religious places and other community gathering centres support ASRH and critically looked at the influence of the existing laws and policies that impact the work of the targeted community stakeholders in promoting ASRH.

The societal levels are normally the broader community context including societal cultures, values and norms (University of Oregon 2006:20). The current study explored how the socio-cultural factors including the Acholi cultural norms and values, beliefs and practices influenced the role of community stakeholders in supporting ASRH.

Based on the findings from all the different levels of the SEM, and considering the health systemic factors that influence the community role in support of ASRH, the study proposes strategies that would enhance community involvement in the adolescents' sexual reproductive health.

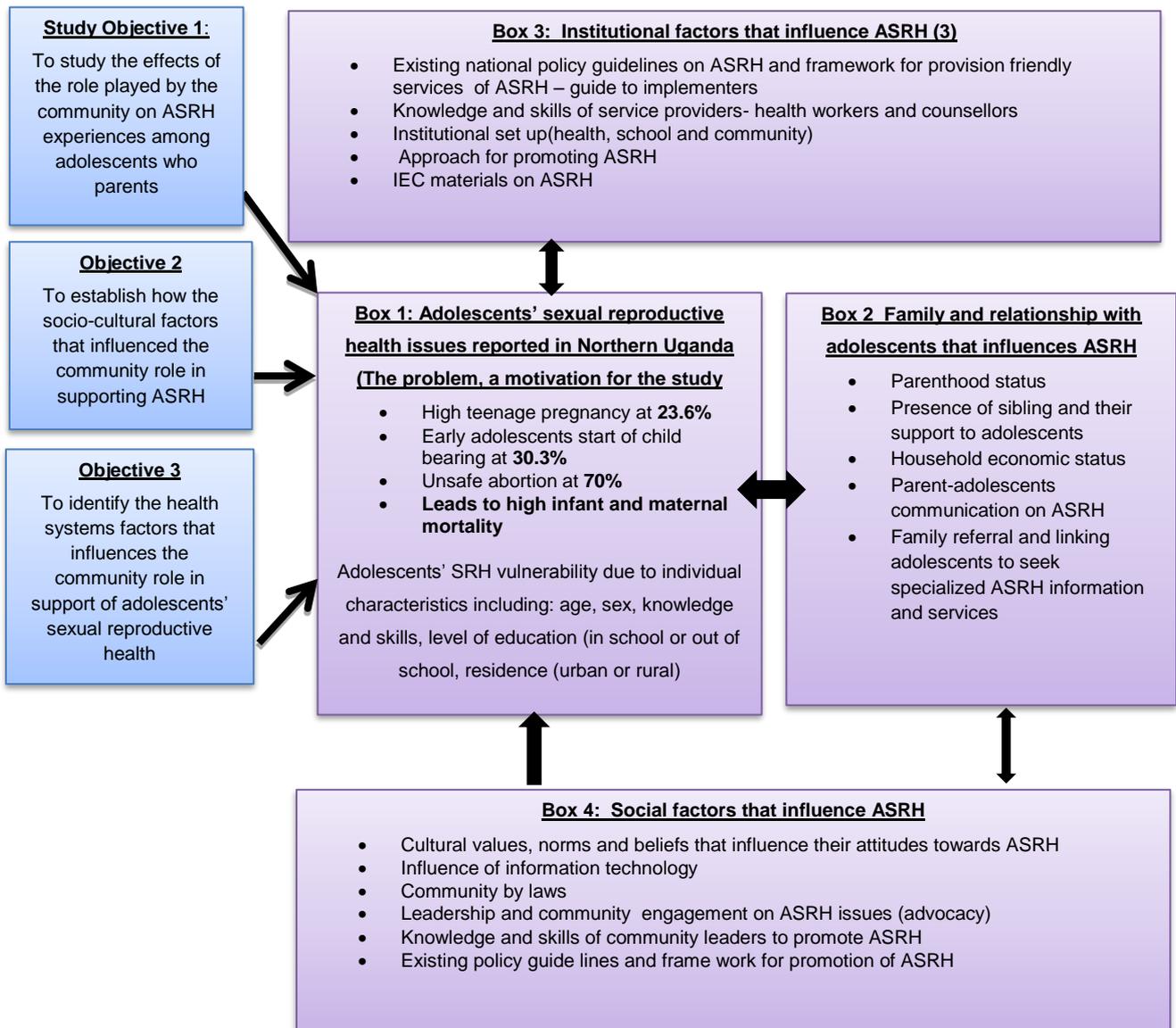


Figure 2.2: Conceptual framework

The conceptual framework depicts the influence of society factors (**box 4**) on the conceptual framework), the institutional factors (**box 3**), and immediate relationships (**box 2**) that impact on the adolescents sexual reproductive health outcomes reported in northern Uganda (**box 1**), adolescents individual characteristics that may expose them to the risk of negative SRH outcomes indicators (in the indicators **highlighted** in bold percentages and motivated the researcher to conduct the current study).

With the three major study objectives (box 1-3 on the left hand of the conceptual framework), the study attempted to understand and answer the study questions to the problem (see questions under chapter one, sub-section 1.5).

In relation to the subject under study, the kind of relationship between adolescents and their immediate environment such as parents, peers and relatives influences their sexual reproductive health outcomes. These relationships are impacted by the broader institutional and societal factors such as policies and cultural norms and values.

2.3 CHARACTERISTICS OF THE ADOLESCENT STAGE

Adolescence commences with the onset of puberty and can range from as early as 10 years to as late as 20 years. It is a transition period from childhood to adulthood, a journey characterised by physical, emotional biological and psychological changes as the body matures and the mind becomes more questioning and the quest for independence sets in, adolescents develop desire and attraction towards the opposite sex which may lead to intimate sexual relationship (Petersen et al 2012:413).

The World Health Organization categorised adolescents as those aged between 10 to 19 years (UNICEF 2009:5). Globally it is estimated that a total of 1.2 billion fall in this category of 10-19 years which contributes 18% of the world population and close to 90% of this population live in developing world (UNICEF 2012:3-4).

2.3.1 Adolescent sexual reproductive health

During adolescence, sexual decision-making and related behavior have significant implications for the health and development of adolescents. Among adolescents, sexual encounters are often unplanned and involve non-use of contraceptives, thereby carrying the risk of unwanted pregnancies (Ojo et al 2011:30-31). Adolescents who engage in early sexual debut are at higher risks of unintended pregnancies which may lead to high maternal mortality, unsafe abortion and high prevalence of sexually transmitted infections (STIs) including Human Immunodeficiency Virus (HIV) that causes Acquired Immune Deficiency Syndrome (AIDS) (Dejong et al 2007:1).

2.3.2 Adolescent's sexual reproductive health heterogeneity

Adolescents are not a homogeneous group of people, irrespective of the uniformly defined period of adolescence. Studies have reported inter-related factors that differently impact on adolescents and their sexual health. Among these factors is age (younger adolescents 10-14 and older 15-19 years), gender (boys and girls), the married and unmarried, those in school and out-of-school, the disabled, adolescents living as refugees or in internally displaced camps, adolescents living with HIV and AIDS, adolescents sex workers, and as migrants (Health Education and Training (HEAT) 2011:2; UNPFA 2012:9; DH 2013:4-5).

2.3.3 The influence of information, education and communication (IEC) on ASRH

Adolescents growing up in the 21st Century are living in an environment which is quite different from that of their parents (Dejong et al 2007:1). There are numerous factors that affect the lives of young people today including: globalisation, information education and communication and this is gradually producing a new global youth culture characterised by increasing urbanisation and its common features such as use of electronic communication, cellular phones, internet, radios and television. Some of these have become very vital sources of information including information on adolescent sexual health among some communities (UNFPA 2008:2).

Some studies have shown improvement in the level of knowledge on ASRH among adolescents. On top of the above listed sources of technological information used by some adolescents in accessing information on SRH, other factors such as the ability to read and write, and the longer time spent in school are also protective for the in-school adolescents and such adolescents therefore may marry late, can easily access sexual reproductive health information and commodities including the modern family planning methods (Santelli & Schalet 2009:1).

2.4 ADOLESCENTS' SEXUAL REPRODUCTIVE HEALTH OUTCOMES

Globally, the negative health outcomes of adolescents' sexual reproductive health are myriad and vary across continents. The outcomes include unintended pregnancies with associated high level of maternal mortality, unsafe abortion, sexually transmitted

infections (STIs) including Human Immunodeficiency Virus (HIV) that causes Acquired Immune Deficiency Syndrome (AIDS) Dejong et al 2007:2).

According to Guttmacher Institute (2010:1-2), the annual number of unintended pregnancies among Asian countries was 2.7 million, in sub-Saharan Africa was 2.2 million and in Latin America was 1.2 million; limited access to and utilisation of contraceptives accounted for 93% of unintended pregnancies in Asian Countries, 92% in Sub-Saharan Africa and 83% in Latin America. Unsafe abortion among adolescents was 2.5 million out of 19 million unsafe abortions reported in the same year among developing countries.

In Uganda the adolescents' sexual health is not any different. According to UBOS (2013:118-119), teenage pregnancy among 10-19 year olds stood at 24% and this has continued to pose moral, social and public health problem, including negative outcomes for the babies and the teen mothers as well.

The same report indicates an estimated 44% of the 7,200 annual maternal deaths in Uganda occurs amongst females aged 15-24 years, the risk of maternal death is twice higher amongst teenage girls aged 15-19 years, compared to women in their 20s. For those under 15 years of age, the risk of maternal death is five times higher (UBOS 2013:123).

It is against this background that the current study intended to explore the role of the community in support of adolescents' sexual reproductive health with an aim of improving adolescents' sexual reproductive health outcomes.

2.5 COMMUNITY PARTICIPATION IN ADOLESCENT SEXUAL REPRODUCTIVE HEALTH

It has been recognised that community involvement in adolescents' sexual reproductive health and other health issues is very vital as it creates a supportive environment that helps to influence adolescents' access to ASRH information and services as well as to empower adolescents to make healthful decisions (UNFPA 2007:2).

2.5.1 Approaches used to promote community participation in ASRH

The community comprises individuals, institutional structures and larger societal norms and systems (refer to the socio-ecological model in sub-section 2.1.3). Their positive interactions and involvement promotes positive social change, which are necessary for improving the health of communities including ASRH for sustained positive health impacts (UNFPA 2007:3).

Over the years, different strategies and approaches have been used by the community to promote ASRH and among others: the school based ASRH programme in which adolescents sexual health form part of school curricula, the peer led counselling, information, education and referrals programs whereby adolescents peers engage other adolescents in dialogue sessions to promote their sexual reproductive health; the mass media in which a wide spectrum of ASRH issues are promoted; community based interventions such as dialogues, films and shows that seek to influence positive behaviour among adolescents and lastly, the health facility community outreaches programs in which health workers promote education and sexual reproductive health information and commodities including the modern family planning commodities (Kalembo et al 2013:34).

As depicted in Figure 2.3, the capacity, in terms of knowledge and skills, of the community (individuals, institutions and societal systems) determines how the community interacts and gets involved in matters of ASRH and the community involvement translates to positive change in terms of uptake of ASRH. However, these are influenced by existing laws, policies, and societal norms.

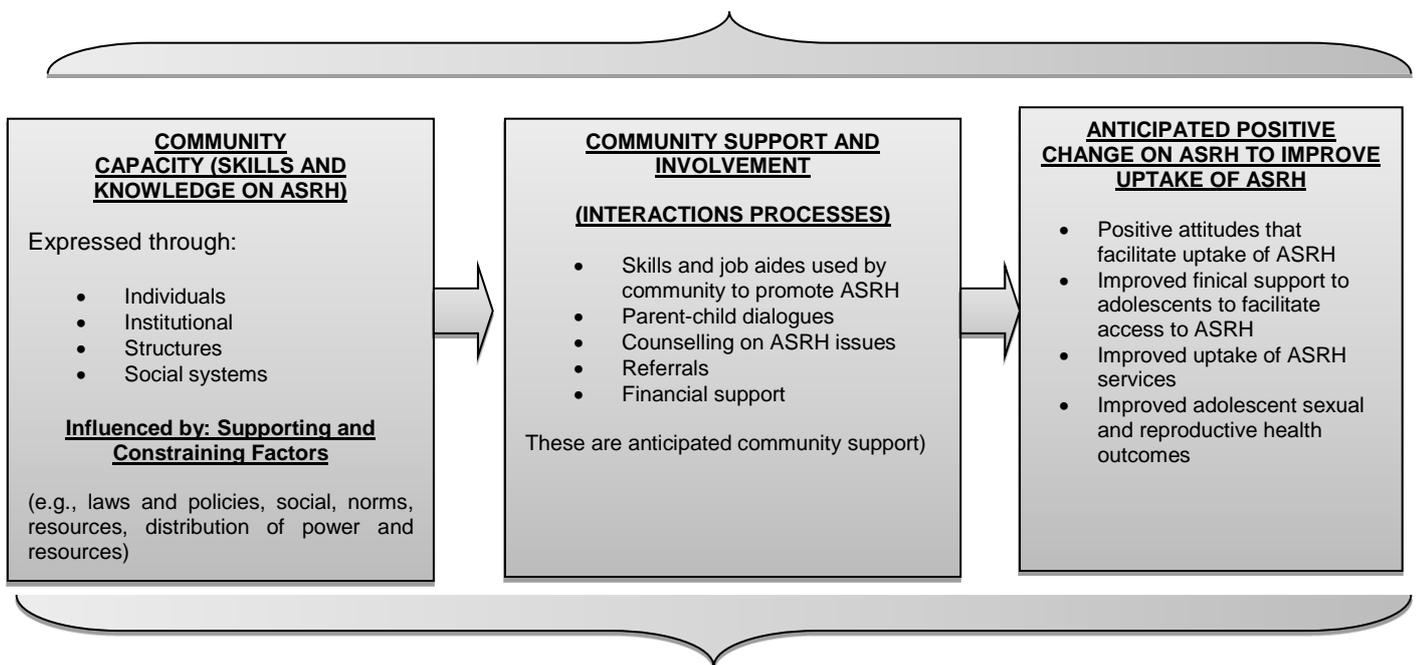


Figure 2.3: Design and framework on community support and involvement on ASRH (Adopted from UNFPA 2007:

2.5.2 Factors that influence community participation in ASRH

Despite the different community approaches (refer to 2.3 - above) there are numerous underlying community spheres including social, cultural, economic and political forces and realities that influence how community act on issues that affect them (UNFPA 2007:4).

2.5.2.1 Socio-cultural beliefs and practices

In many African communities, adult-adolescent relationships are predominantly authoritarian with adults setting strict rules for monitoring the behaviour of adolescents and harsh sanctions to any perceived deviancy. Such norms discourage parents from directly communicating with their children about sexuality (African Union 2013:5-6).

Exploring how such norms can be improved to promote positive social interaction between children and adults, is ideal for positive adolescents' sexual reproductive health

information and services. Establishing the techniques, knowledge and skills that could be developed to improve child- parents' communication is another critical area to explore.

2.5.2.2 Unemployment among young people

In developing countries, some studies have shown that nearly half of the total young population survive on less than \$2 a day (Larsen 2010:1). According to Guttmacher Institute (2010:3), the cost per unintended pregnancy averted by use of modern contraceptives among women aged 15-19 years range from \$43 in middle East Asian Countries to \$117 in Sub-Saharan Africa. With the reported amount of \$2 per day implies that such young people may not prioritise health care, including sexual reproductive health, due to the cost that may be directly or indirectly paid. Understanding how adolescents and young people are supported and who supports them to meet the cost of sexual reproductive health is an important part of the current research.

2.5.2.3 Influence of modern communication technologies

In developed countries, increasingly adolescents are becoming the leading subscribers to mobile phones and users of computers mainly for social networking (Selkie, Benson & Moreno 2011:205-207). The expansion of the electronic technologies provides opportunities for a wide range of information, education and communication including sexual and reproductive health.

The use of such technologies varies from area to area. In developed countries, the Pew survey in America reported that 800 tens aged 12-17 along with their parents revealed that 78% owned a cell phone; of these 47% owned smart phones and say they would connect to the web on their smart device.

Similarly, in developing countries, there is evidence of use of mobile phones among adolescents. According to Van Heerden, Norris and Richter (2009:303), 70% of adolescents in South Africa with some significant variation among white adolescents; 95% compared to black and coloured adolescents (67% and 63%) use the mobile phone respectively. Little information is available on use of mobile phones among adolescents in other developing countries including Uganda.

Additionally, due to more exposure, increasingly young people have developed divergent and conflicting views with the older generation (due to generational gap) and this hinders effective communication and transfer of information and education among older generation and the young generation (Wamoyi et al 2010:2).

In addition, the intergenerational gap that affects parent/adult- adolescent communication needs to be bridged. Understanding what strategies could be helpful to enhance positive adult-adolescents' communication.

2.5.2.4 The influence of family and community participation in ASRH

Families and communities play a central role in adolescents' health and development (WHO 2009:4). Their participation could increase the scope and effectiveness of adolescent friendly health services through increasing demand by adolescents for sexual reproductive health services by providing information about service availability and where they are (WHO 2009:5).

However, adolescent sexual reproductive health remains a sensitive issue in many communities. It is not very clear what information families and communities offer to influence adolescent sexual health, stimulating their acceptance and support for adolescents to improve uptake of services by adolescents is paramount (WHO 2009:6).

There are various roles that the community plays to promote and generate demand to improve access to sexual reproductive health services, and among others are: offering information on available health services, where to get the services, under what condition, use of referral system and provision of funds or vouchers (WHO 2009:7).

According to Neema *et al* (2004:21), youth in Uganda face multiple barriers to accessing sexual and reproductive health information and services, sometimes services may not exist at all or where they exist, the services are not affordable, unfriendly and in some cases are opposed by adults so adolescents are not attracted to seek reproductive health services.

It is therefore critical to establish the role of the community in influencing the responsiveness of health systems to meet the SRH needs of adolescents and to develop strategies that could enhance community support of ASRH.

2.5.2.5 *The influence of war, conflict and disaster*

In any war and conflict settings, reproductive health risks for adolescents are higher, and this is attributed to forced sex, increased risk-taking and reduced availability of and sensitivity to ASRH services (Women's Refugee Commission and Save the Children, UNHCR, UNFPA 2012:1).

In addition, during conflict or a natural disaster, family and social structures are often disrupted; educational and other social services like health are discontinued. Adolescents who therefore became sexually active when there were few protective and social services like education and health services could not have access to quality sexual reproductive health.

Girl children become more vulnerable to sexual abuse and exploitation during such times, which in turn increases their vulnerability to sexually transmitted infections including HIV and AIDS, unwanted pregnancies and unsafe abortion (Women's Refugee Commission et al 2012:2).

Some of the negative consequences of the war on the Acholi community included: the social-cultural fabric (the protective values and norms) was eroded and this resulted in immense moral decadence among the populace. Women and girls became victims of sexual abuse such as rape and defilement by rebels and soldiers. The sexual abuse increased the sexual reproductive health risk (Beard 2011:3; Patal et al 2013:2).

Over 1.8 million people were forced into being internally displaced persons (IDPs) camps, with congestions in the camps and redundancy; there was increased moral decadence, rape, defilement, exchange of sex for money and other material gains which also increased risky sexual behaviours (Beard 2011:4). The risky sexual behaviours resulted in a myriad of outcomes.

According to Uganda AIDS Commission (2010:5), Northern Uganda had higher HIV prevalence (8.2%) much above the national prevalence (6.4%) and second to the Kampala and central region with 8.5% teenage pregnancy and or adolescents who had had their first child between age of 15-19 in northern Uganda stood at 25.6% (UBOS and ICF International Inc 2012:67).

As a result of the civil war, some children have become orphans since they lost one or both parents. There are over 2 million orphans in Uganda, the North alone ranked second to Karamoja with 4.0% and 4.9% of children as total orphans respectively (UBOS and ICF International Inc 2012:21). Children who live with both or one parent have some level of social protection and guidance.

Some children in the Acholi sub-region experienced '*secondary*' parental absence in their lives. During the war time some children looked for safety 'belts' through night commuting. Every night in Gulu town alone an estimated 25 000 night commuters were reported, of these approximately 14 000 were children who found custody under verandas, Bus parks or Churches where they spent the cold nights (Catholic Relief 2004:4).

In such a situation of '*secondary*' parental absence, such children lack care and protection of adults. They become more vulnerable to sexual abuse and exploitation, which exposes them to sexual and reproductive health risks. It is about five years since the war in Northern Uganda ended. However, little information exists on the community support of adolescents' reproductive health issues. With the above highlighted negative impact of the war on the Acholi community, the current study will bridge the information gap by definitively highlight the role of community in support of ASRH.

2.6 INTERNATIONAL STANDARDS AND ADOLESCENTS' RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH INFORMATION

The human rights of adolescents, including vulnerable sub-groups, are protected under several declarations and conventions in international law including: The Universal Declaration of Human Rights (UDHR) that mentions the right to health under the right to the highest attainable standard of living (UDHR Article 25).

The Constitution of the World Health Organization, which defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity and declares that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (WHO 1946).

The UN Convention on the Rights of the Child: Adolescents are entitled to rights under the Convention on the Rights of the Child (CRC) until age 18. These rights are listed below, with examples of how they relate to ASRH:

- The right to the highest attainable standard of health, including the right to reproductive health.
- The right to impart and receive information and the right to education, including complete and correct information about SRH.
- The right to confidentiality and privacy, including the right to obtain RH services without consent of a parent, spouse or guardian. Conducting a virginity (hymen) examination on an adolescent without her consent would also be a violation of this right.
- The right to be free from harmful traditional practices, including female genital cutting and forced early marriage.

In addition, The Convention on the Rights of the Child (CRC) defines all persons aged up to 18 years as children, except where “marriage or economic emancipation occurs earlier” (e.g. at 15 or 16 years). As such, they are granted special protections and entitlements such as the right to education, health care, information and personal development, and the freedom from certain adult responsibilities. The International Labour Organization (ILO) in the 1973 minimum age convention defines child labour as occurring at 14 years or younger, is prohibited except for light work, domestic labour, and work in a family enterprise. The betrothal of children younger than 15 years is also prohibited, and countries are urged (but not required) to set a minimum age for marriage of 18 years for both sexes (Lloyd 2005:474-477).

The 1995 Beijing Women’s Conference expanded the definition of reproductive health to include sexuality: The human rights of women include their right to have control over and

decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

International agreements such as those adopted at the International Conference on Population and Development (ICPD) in 1994, the Fourth World Conference on Women in 1995 and the World Summit on Children in 2002 have extended the scope of the CRC by affirming the right of all adolescents to receive sexual and reproductive health information, education and services in accordance with their needs (International Planned Parenthood Federation [IPPF] 2000; The United Nations [UN] Committee on the Rights of the Child 2003a and b). Key phrases from these documents¹ emphasize that:

- The promotion of mutually respectful gender relations as well as appropriate information and health services is essential to enable adolescents to deal *in a positive and responsible way with their sexuality*.
- Reliable information disseminated through public health campaigns, the media, and the educational system should be designed to ensure that young people acquire knowledge about their health, especially information on sexuality and reproduction.
- Formal and non-formal education should encourage behaviour that protects adolescents from early and unwanted pregnancy, sexually transmitted infections (STIs) including HIV and AIDS, and sexual abuse, incest and violence.
- Adolescents' access to information and services must not be restricted by legal, regulatory or social barriers or by the attitudes of health care providers.
- Programmes must safeguard adolescents' rights to privacy, confidentiality, respect and informed consent and to non-discrimination.
- The declarations urged that governments, nongovernmental organisations and the private sector prioritise programmes such as education, income-generating opportunities, vocational training, and health services for adolescents, including services related to sexual and reproductive health.
- At the ICPD, government representatives agreed that "Full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality" (MoH 2011:3).

From the international perspective on the human rights (which are also applicable to adolescents), countries have adopted standards that form a “template” of age-graded adolescents’ rights and protections that national laws and policies are expected to comply with (MoH 2011:2). Since that time, policy-making, programming and research initiatives at international, national and local levels have been directed to articulating and meeting the needs of adolescents living in diverse circumstances.

Initiatives were directed to school retention and education (including sexuality education and life-skills training), health care (including sexual and reproductive health), and legal issues such as age of consent and minimum age for marriage. However, older adolescents aged 15–19 years have drawn the lion’s share of attention, while the special needs and concerns of younger adolescents aged 10–14 years; some of whom are already sexually active have been relatively neglected (MoH 2011:3).

In most countries, adolescents are classified by national laws and policies as minors who have not yet reached the age of majority or consent (which is 18 years by the Ugandan law (UNCRC 2004:31). Therefore, minors are typically considered too young to sign contracts, to drink alcohol or obtain a driver’s licence, to buy cigarettes or view “adult” movies, to enter the paid labour force, to vote, to consent to sexual intercourse (especially with older partners), to marry, to serve in the armed forces, or to be held to the same standards of criminal responsibility as adults

In addition, minors are subject to the authority of parents or guardians who are (assumed to be) legally and morally responsible for their supervision and support, and who may wield considerable authority over their schooling, labour, health care, living situations, social and sexual behaviour, marriage prospects and other aspects of their lives. As boys and girls pass through their adolescent years, they are confronted with a variety of risks and protective factors that are inherent in the individual and the immediate environment, both of which influence their behaviour (MoH 2011:4).

Making adolescents’ immediate environments more supportive may be a more effective route to changing behaviour than increasing their individual knowledge and skills. Moreover, building protective factors, such as keeping young people in school and making schools safer and more responsive to girls’ and boys’ needs and aspirations, may

be a more effective and feasible way of maintaining safe behaviour than the attempt to reduce individual and environmental risks directly (MoH 2011:4).

The question remains as to how best to identify the processes through which protective factors (variously referred to in the meeting as “social capital” or “health assets”) can be strengthened among young people in communities, neighbourhoods, families and schools and to determine who does this best (e.g. teachers, social workers, parents, community leaders) and how. We need to understand the larger picture of how communities do-or could, with special programmatic initiatives – support adolescents in their transitions from childhood to adulthood. This step requires a paradigm shift away from simply thinking about how best to deliver information and services to adolescents who want and need them, towards a more global view of prevention and harm reduction that begins at the societal level and filters down through multiple institutional layers to the individual.

2.6.1 The Uganda national context of ASRH policy framework and service standards

Adolescent sexual and reproductive health (ASRH) is of national concern in Uganda because of the broad based pyramid with a youthful age structure where adolescents constitute 23.3% of the total population (MoH 2011:4).

Regional policy frameworks like the Continental Policy Framework for Sexual and Reproductive Health and Rights and Maputo Plan of Action 2007-2010 and Article 16 section (c) of the African Youth Charter (2006) support the provision of Youth Friendly reproductive health services including pre-natal, peri-natal, antenatal, post-natal and contraceptives services (ibid).

Cognisant of these policy frameworks, MoH designed the National Policy Guidelines and Service Standards for Sexual Reproductive Health and Rights of 2011 and the Health Sector Strategic Plan II (2010/11-2014/15) which recognise the relevance of providing a comprehensive package of sexual and reproductive adolescent-friendly health services through a supportive and conducive environment as a way of increasing service coverage for Reproductive Health (RH) amongst adolescents (Uganda Ministry of Health 2011:5).

The National Policy and service standards for SRH and rights recognises that adolescents should be able to access promotive, preventive and curative health services depending on their maturation stages and the family as a basic unit of the community is the best place to address the basic needs of adolescents (food, shelter, education, health care, social and economic support, spiritual development and overall well-being) (ibid).

According to national adolescent health policy (Uganda Ministry of Health 2011:10), as a pre-requisite for sustainable ASRH outcomes certain enablers need to be re-reinforced:

- A safe and supportive environment.
- Accurate information and values about health and development needs.
- Life skills to protect and safeguard their health.
- Counseling services.
- Access to a wide range of services addressing their health needs including ASRH.

In order to achieve the above, promotion of adolescents friendly services needs to be done in a manner that ensures availability and accessibility by all young people including those in conflict and hard to reach environments. Adolescents and the community at large shall be sensitised on the existence of the adolescent health services to ensure sustainability and acceptability. Parents, communities and leaders should be able to appreciate to enable them support adolescents to access ADFHS services in the communities, schools and health facilities (Uganda Ministry of Health 2011:7).

Given the age differences among adolescents, the challenge has been finding a 'good fit' service delivery model which responds to the entirety of the age groups with the available resources for effective service delivery. Notwithstanding the age differences, other challenges that have been attributed to the poor ASRH service seeking behaviour of adolescents include sub-standard services (e.g. lack of privacy, poor attitude of service providers), long queues at delivery points and long waiting time (Uganda Ministry of Health 2011:10).

In a bid to mitigate the challenges highlighted above, the government of Uganda through the Ministry of Health has defined the core elements of the health care package and the standards services package that providers need to follow under different settings and contexts so as to meet the needs of the adolescents (Uganda Ministry of Health 2011:5).

Adolescent health, including sexual reproductive health, needs have been addressed holistically with special mechanisms, partnerships and inter-sectorial collaboration between various stakeholders through a national process that led to the development of the adolescent health policy guidelines and service standards as detailed in the policy document of Ministry of Health 2011.

The Adolescent Health Policy and Services Standards not only address delivery of adolescent friendly services but also emphasise and focus attention on psychosocial services, child abuse, drug abuse and substance abuse with the hindsight of the rapid growth and development of adolescents and the impact on their behaviour and thinking. As such, clear policies have been included to address the above-mentioned challenges, and these are:

- All adolescents with psychosocial needs will be provided with psychosocial support and services.
- All adolescents will be provided with information and guidance on traditional practices including early/ forced marriages, female genital mutilation and polygamous marriages and their impact on their health. Additionally, communities are to be sensitised about their role in the prevention of child abuse.
- All adolescents will be provided with information and guidance on substance and drug abuse and the impact of its use on their health and the community and service referral points.

The policy details how health can be promoted within the schools environment and it advocates for the health and well-being of the learner while taking into account the environments i.e. the school staff and the surrounding community. The school health related policy underscores:

- The need for primary schools and post-primary institutions to provide a favourable environment for provision of school health programmes.
- The provision of training for matrons, school nurses, school councillors to deliver adolescent friendly services.
- A comprehensive school health programme which includes reproductive health, health education and physical activities.

At community level, the policy makes a strong commitment to issues of advocacy for child protection and rights, and calls for resource commitment for ASRH services. However, for community arm, the policy does not clearly articulate how the community including families, religious, cultural and local and institutions and communities can effectively fulfil their mandate.

2.7 GAPS IN THE LITERATURE REVIEWED

Adolescents' sexual reproductive health remains a heterogeneous subject with different factors influencing the health of adolescents across different communities. But vividly, from the literature reviewed, the following gaps were identified:

- Little information exists on the community stakeholders especially the role of parents, in a definitive manner, what role do they play in supporting ASRH. In addition, knowledge and skills gaps still remain a big hindrance in promoting parent/adult-adolescent communication on matters pertaining to ASRH was noted.
- In addition, the mandate of the community in influencing and responding to the ADH policy still remains elusive. While for the other sectors such as health and education, the strategies and the logistical requirement are existent.
- It is not very clear what information families and communities offer to influence adolescent sexual reproductive health in stimulating their acceptance and support for adolescents to improve uptake of services by adolescents.
- The information gap on the use of information and technology (IT) as well as the use of social media by adolescents to access ASRH is yet another critical gap that was identified.
- The war eroded social and cultural norms and values. What is not clear in definite terms is, how the war impacted ASRH and what remedies the communities and stakeholders are having to support ASRH.
- The policy does not clearly articulate the “how” of the community responsiveness in fulfilling the policy mandate; that is, how can families, religious groups, cultural groups and local institutions effectively fulfil their mandate.

2.8 CONCLUSION

This chapter presented the literature review, which was carried out in line with the study objectives. In some detail, it looked at issues of child growth and development, factors that influence adolescent health and particularly sexual reproductive health, the roles of community basing on the individual, institutional and societal factors (socio-ecological model).

Chapter 3 describes the research design and methodology.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the research design and methodology including data collection and analysis, population and sample, measures taken to ensure validity, reliability, and ethical considerations. Both quantitative and qualitative approaches were used and are discussed in detail below.

3.2 RESEARCH DESIGN

The main purpose of a research design is to explain how one is to obtain answers to the research question (Kumar 2011:94). According to Polit and Beck (2012:396), a research design refers to “deciding how to measure empirical phenomena, how to identify causal connections and how to generalise findings”. Salazar, Crosby and Diclemente (2006:75) define a research design as “the strategy the investigator chooses for answering the research question. Its ultimate use is to guide data collection and analysis”. Mouton (2003:24) refers to research design as a plan or blueprint of how researchers intend to conduct their research in a given environment, while Kumar (2011:74) defines a research design as a procedural plan adopted by researchers to answer questions validly, objectively, accurately and economically. A research design thus refers to identifying and developing the procedures required to undertake a study, namely conceptual and operational plans, and emphasises the importance of quality in these procedures to ensure validity, reliability and trustworthiness (Kumar 2011:16).

Existing literature was reviewed for purposes of informing the study design as well as tools for data collection. According to Royse (2008:24), the general purpose of a literature review is to gather previously published and unpublished material in the research field, which will in turn inform the study design. Babbie (2008:124) points out that reviewing the designs of previous studies using the same technique may give researchers a head start in planning a study. The literature review also informed the researcher on sampling

techniques, and data-collection methods including the design of the structured interview schedule for quantitative research (Phase II, sub-study III).

A case study design was used in the current study. According to Yin (2009:93), a case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. Case study design was used to explore and describe the role of community stakeholders in support of ASRH employing both qualitative and quantitative methods.

The current study followed a three phased approach with five sub-studies, sampling and collecting data from the target study setting included data from teen mothers, their guardians and midwives (phase I), cultural and religious leaders (phase II, sub-study 1), parents of other adolescents from the community, counselors, senior woman and male teachers (phase II, sub-study 2) and other adolescents using structured interviews (quantitative, phase II, sub-study 3) and phase III which was the last phase targeted policy makers and implementers both at the district and national level. (Refer to details on study population under 3.6).

3.2.1 Qualitative approach

Cargan (2007:47) points out that qualitative research obtains data by interviewing, using open-ended questions. Phases I, Phase II, sub-study 1 and 2 and phase III of this study were qualitative as they obtained textual data from teen mothers, their guardians, health workers (phase I), cultural and religious leaders (phase II sub-study 1), parents, adolescents, senior male and woman teachers and counselors (sub-study 2) and phase III policy makers and supervisors both at the district and national level using an interview guide (IDI, KII and FGDs).

3.2.2 Quantitative approach

Quantitative research gathers data using mainly numerical variables and enables researchers to quantify variation in a phenomenon during analysis. According to Cargan (2007:47), a study that is quantitative uses a system of counting using standardised measuring instruments. Burns and Grove (2001:20) point out that quantitative research

uses structured tools to generate numerical data and uses statistics to interpret, organise and represent collected data.

Phase II sub-study 3 was quantitative as it used a standard instrument to collect data (the structured interview). Statistical calculations were done for both descriptive statistics and inferential statistics. Descriptive statistics generally describe the basic features of the data in a study. They provide simple summaries about the sample and the measures. In the current study, these included tables indicating frequencies and percentage, pie charts and graphs. Inferential statistics normally help in trying to reach conclusions that extend beyond the immediate data alone. In the current study, these included chi-square calculations, giving probability values (p-value) (Polit & Beck 2004:451-510).

3.2.3 Triangulation

Triangulation, among other things, involves using different designs to study the same phenomenon. According to Salazar *et al* (2006:165), triangulation is a way to obtain a multidimensional view of phenomena of interest involving multiple data sources and methods. Babbie and Mouton (2001:275) refer to triangulation as “the use of multiple data-collection methods” while Babbie (2008:123) refers to it as “the use of several different research methods”. Researchers should always endeavour to engage different methods of data collection while studying a particular phenomenon (Guion 2002:2; Kumar 1999:10; Pope, Ziebland & Mays 2000:115; Schutt 2001:168, 209; Wysocki 2001:82).

This study was triangulated because it collected both qualitative and quantitative data and used different methods of data collection. At the same time, different pieces of data were collected from different populations. For example, in phase I data was collected from teen mothers, their guardians, midwives, in phase II from cultural and religious leaders, adolescents and parents, teachers, and counselors from the community, and in phase III from policy makers and supervisors both at the district and national level.

Using two approaches in a study enables researchers to check consistency and validity of the research outcome. In other words, triangulation makes the researcher confident of the validity of the findings (Salazar *et al* 2006:165). This study used triangulation as the methods and used both quantitative and qualitative methods. However, each of the methods have strengths and weaknesses, hence using both quantitative and qualitative

approaches reduced weakness while maximising the strengths (Babbie 2008:123). Whereas qualitative data are richer, it is time consuming, the results cannot be generalised. On the other hand, whereas quantitative data is more efficient in testing hypotheses, it may miss contextual detail.

3.3 RESEARCH METHODOLOGY

Research methodology is a plan of how the research is to be conducted, or the procedures that are to be used to collect and analyse data. According to Wysocki (2001:6) and Schutt (2001:396), research methodology is a plan of action including a set of skills, insights and tools needed to help understand the what, how and why of research. Babbie (2008:6) defines research methodology as “the science of finding out”. Blaikie (1993:7) defines methodology as “the analysis of how research should and does proceed including discussions of how theories are generated and tested, the kind of logic used and how particular theoretical perspectives can be related to particular research problems”.

In order to review and describe the role of community stakeholders including parents, teachers, health workers, cultural and religious leaders in support of adolescents’ sexual reproductive health with a specific focus on a post conflict setting a case of Acholi sub-region in northern Uganda, the current study used three methodological approaches, namely exploratory, descriptive and case study, soliciting both quantitative and qualitative data.

3.3.1 Exploratory

The exploratory approach investigates the nature of a phenomenon, the manner of existence, and related factors as well as characteristics in order to gain additional information on the situation. Exploratory research is done to increase the researcher’s knowledge on the phenomenon and provides valuable information for further investigations and usually asks the “how” questions (Babbie 2008:97; Polit & Beck 2006:21). The current study asked how the role of community stakeholders influenced ASRH in the Acholi sub-region during and after the LRA civil war.

3.3.2 Descriptive

Descriptive research attempts to systematically describe a situation (including attitudes towards a situation) or phenomenon or service usually asking “what” questions (Kumar 1999:9; Polit & Beck 2006:189). According to Babbie (2008:99), descriptive studies define situations and events.

The purpose of descriptive study is to describe phenomena in real life situation. Through descriptive design, concepts are described and relationships identified” (Burns & Grove 2001:52). Descriptive approach was therefore used to describe what role the community stakeholders played or did not play in supporting adolescents on matters pertaining to their sexual reproductive health experiences during and after the war.

3.3.3 Case study

According to Yin (2009:93), a case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. In addition, a case study design is considered when the focus of the study is to answer “how” and “why” questions; and when the researcher cannot manipulate the behavior of those involved in the study; and wants to cover contextual conditions because it is believed that they are relevant to the phenomenon under study (Baxter & Jack 2008:545).

It involves an intensive exploration of a single unit of study such a person, family, group, community or institution. Although the number of subjects tends to be small, the number of variables involved is usually large and case studies are good sources of descriptive information; and uses both qualitative and quantitative elements (Burns & Grove 2001:255).

3.4 PHILOSOPHICAL PARADIGMS

A paradigm is described as a general perspective on the complexities of the real world. For human inquiry paradigms are often characterised in terms of the ways in which they respond to basic philosophical questions on ontology, epistemology, axiology and methodology (Polit & Beck 2008:13). In the research setting it forms the assumptive base

from which the researcher goes about producing knowledge (Saks & Allsop 2007:17). For the purpose of this study two broad paradigms were used, namely the positivist paradigm and the naturalistic/interpretivism paradigm.

3.4.1 The positivist paradigm

According to Walsh (2001:12), a positivist approach is where researchers maintain a distance between themselves as research experts and the goings-on in the research settings. The positivism approach was used in the quantitative phase (phase II, sub-study III); the researcher took a position of an interested outsider in that the information given by respondents was all treated with utmost respect. Besides, careful construction and pre-testing of the interview schedule ensured objectivity. According to Russell (2000:15), a positivist approach helps the researcher to maintain objectivity and avoids influencing or being influenced by the respondents.

3.4.2 The naturalistic paradigm

According to Walsh (2001:12), the naturalistic approach is based on the “idea that knowledge is something that people create continuously and that no fixed objective reality exists independently of peoples’ culture”. During phase I, phase II, sub-studies I, II; the researcher took the naturalistic approach. The researcher did not set out to get generalisable facts on the role of community stakeholders in support of ASRH. Unstructured in-depth interviews were carried out for different targeted participants in the community.

3.5 ORGANISATION OF THE STUDY

3.5.1 The study setting

The Acholi sub-region has a total of seven districts including: Agago, Amuru, Gulu, Kitgum, Lamwo, Pader and Nwoya. The study was conducted in three districts out of the seven; including Gulu, Kitgum and Pader. These districts were considered on the grounds that they were the original districts of Northern Uganda with better administrative and social services. The other 4 were part of these three districts which were split 5 years ago i.e. out of Gulu district emanated Amuru and Nwoya, Lamwo sprung from Kitgum and

Pader from Agago. The estimated population of the three districts is 908 300 people. The population of Gulu accounts for 407 500 people of this number whereas Kitgum and Pader account for 257 600 and 243 200 respectively. An estimated 23.2% of the population are young people aged 10-19 years translating in to a total of 210 478 young people aged 10-19 years (UBOS 2013:5).

The study participants were drawn using both the administrative structures (district, county, Sub-county, parishes and villages) and the health systems structures (hospital at the district level, health sub-district and county level and health centre III at sub-county level) that according to Uganda Ministry of health (MoH) offer antenatal care services). Parishes and villages were only considered for the community respondents (adolescents and their parents).

3.6 STUDY PHASES

The study had three phases with 5 sub-studies including:

- Phase I: teen parents, their guardians and midwives (Qualitative study)
- Phase II sub-study 1 and II, targeting parents, local, cultural and religious leaders (Qualitative study)
- Phase II sub-study III (Quantitative study)
- Phase III policy makers and supervisors (Qualitative study)

Phase I, phase II sub-studies one and two involved sampling, collecting and analysing data from the targeted participants from all the three districts. The study was organised both at the district level, health facility and community level and targeted both institutions and individuals.

3.6.1 Study populations

The target study populations for these phases and sub-studies included teen parents, guardians to teen parents, midwives, cultural and religious leaders, parents, adolescents, counselors, senior woman and male teachers and policy makers and supervisors. The adolescents (teen parents or the other adolescents from the community are the direct

beneficiaries of ASRH and other community stakeholders (participants of the study) have direct or indirect roles that impacts on ASRH.

3.6.2 Sampling procedures

According to Burns and Grove (2001:365), a sample denotes the selected group of people or elements and it is a representative of the study population. Sampling refers to the process of selecting a group of people, events, objects or other elements representative of the population under study.

In the current study, non-probability and probability sampling were used to select elements. Non-probability sampling is where not every element of the population has an equal opportunity for selection in the sample and normally it does not increase representativeness but it addresses the specific research needs (Burns & Grove 1999:238). Probability sampling is where every element has an equal chance to be included in the study; multi stage cluster sampling and simple random sampling were used to select health facilities and local administrative units like villages as detailed below.

3.6.2.1 Selection of health facility, village and schools for the study sites

Basing on the government of Uganda administrative units and health facility for the study districts were used and formed the sampling frame from district to sub-county units forming three level clusters (primary, secondary and tertiary level clusters). Multistage cluster sampling was used to select study sites from the district up to sub-county level.

Health facility study sites

At the district level, study sites were purposively selected. Multistage I- primary cluster level: was the County level, at this level, one health sub-district (H/C IV) was selected from the sampling frame using a simple random sampling. Multistage II- secondary level was at sub-county level, at this level, one H/C III was selected using simple random sampling from the sampling frame developed. In total 03 health facilities were selected per district (in total 9 health facilities for the study).

Table 3.1: List of health facilities which were randomly selected

District	Name of health facility selected	Number of participants per facility
Gulu	Gulu regional referral Hospital	Two(2) teen mothers and a guardian each
	Lalogi HC IV (health sub-district)	Two(2) teen mothers and a guardian each
	Cwero HCIII (sub-county level)	Two(2) teen mothers and a guardian each
Kitgum	Kitgum General Hospital	Two(2) teen mothers and a guardian each
	Omiyanyima HC IV(health sub-district)	Two(2) teen mothers and a guardian each
	Okidi HC III(sub-county level)	Two(2) teen mothers and a guardian each
Pader	Pajule HC IV (health sub-district)	Two(2) teen mothers and a guardian each
	Pader HC III (sub-county level)	Two(2) teen mothers and a guardian each
	Kilak HC III (sub-county level)	Two(2) teen mothers and a guardian each

Village study sites

From the secondary level cluster, all the villages in the sub-county were listed to form a sampling frame from village and using simple random sampling one village was selected from where community participants were drawn. One village per district (03 villages for the study).

Table 3.2: List of villages selected by district

District	Name of villages	Targeted respondents and participants
Gulu	Gulu Prisons zone	Adolescents and Parents
	Kasubi	
	Bwonagweno	
Kitgum	Ayul	Adolescents and Parents
	Omiyanyima	
	Okidi	
Pader	Lila	Adolescents and Parents
	Pader Town council	
	Kilak	

Schools study sites

Through the district education officer (for each of the three districts), a list of all primary and secondary schools in the district was obtained (that formed the sampling frame). The sampling frame was clustered according to primary and secondary school level and in each district two primary school and two secondary schools were randomly selected using simple random selection. In total 4 schools per district were selected (12 for the study).

Table 3.3: List of schools selected by district

District	Name of schools p (secondary)	Name of schools (primary)
Gulu	Lukome SS	Pece Acoyo
	Gulu College	Koro Primary
	Gulu High school	Layibi P/S
Kitgum	Kitgum Matidi seed	Kitgum Public school
	YY Okot Memorial school	Lumule Primary
	Kitgum High school	Pandwong P/S
Pader	Pader Town College	Latanya PS
	Pader Girls school	Amoko P/S
	Atanga SS	Pader Kilak P/S

3.6.2.2 Selection of study participants

Selection of the study participants were mostly purposive, based on specific predetermined criteria. Salazar et al (2006:303) point out that purposive sampling targets and prescribes specific criteria for recruiting the sample. Recruitment of participants was therefore based on the characteristics they exhibited in relation to the research problem. Pope et al (2000:115) point out that where smaller numbers are involved, usually qualitative inquiry aimed at providing in-depth description of the phenomena is preferred.

3.6.2.3 Selection of teen parents, their guardians and midwives

Using the antenatal and postnatal registers, lists of adolescents mothers were considered. In a retrospective manner, the participants were purposively selected basing on the selection criteria including:

- Adolescent mothers who had the most recent date of visit to health centre.
- Adolescent mother who had indicated her contacts (either phone number and or through the village health team linkage and network for ease of tracing.
- The mother who was either still pregnant or had a baby less than 12 months.

Two teen mothers were selected using the appointment system and were asked to come with a guardian. The health midwife established the contacts/location of the selected participants and invited the participants either through a phone call or the village health team (VHT) system. A total of 36 (18 teen mothers and 18 guardians) were targeted for an in-depth interviews but only 27 were interviewed. A total of 9 midwives were targeted for the study, but 8 were interviewed as Key informants. The teen mothers, their

guardians and midwives were the study participants for phase I which was purely qualitative in nature and a case study.

3.6.2.4 Selection of cultural and religious leaders

The institutions for the cultural and religious leaders were purposively selected. With the target of the paramount chiefdom structures, support was sought from the office of Acholi Kal-Kwaro, paramount chief Rwot Acana David, who supported the mobilisation of his chiefdoms from all the three districts. A total of 8 chiefdoms were invited and inclusive of the paramount chief and the staff working for Ker-Kwaro, a total of 11 cultural leaders were targeted for the study. All the 11 participated in the study.

To obtain the participation of the religious leaders, the Acholi Religious Leaders Peace Initiative (ARLPI) which is an umbrella organisation of all religious institutions that was established in the early 2000 to help mediate between the LRA and the government of Uganda so as to bring everlasting peace and an end to the LRA civil war was engaged. Working through the ARLPI office in Gulu, which was purposively selected, the head of the different religious leaders (Catholic, Church of Uganda and the Muslim) were purposively selected plus 6 other clergy members. A total of 9 religious leaders were targeted for the study and 8 participated in the study. One became so busy and did not have the time for interviews.

3.6.2.5 Selection of counselors and senior woman and male teachers

Using the NGO forum office in Gulu district, a list of development partners was obtained, through which three organisations that work with adolescents were purposively selected and these were; The AIDS support organisation (TASO), Straight Talk Foundation (STF) and Reproductive Health Uganda (RHU). The counselor or health worker in charge of adolescents programme in the respective institutions was purposively selected. A total of three counselors were targeted, one per institution and all three were interviewed.

For the schools, from the multistage and simple random sampling detailed under sub-section (3.8.2.1 above), either a senior woman or male teacher was purposively selected. A total of 12 participants were planned for the study but only 8 were interviewed. The 4

didn't participate because the school did not have a substantive teacher or the teacher was away on leave.

3.6.2.6 Selection of parents of adolescents in the community

From the cluster level of selection of village (see 3.8.2.1), the local council chairperson of the village selected (one village per district), was requested to mobilise 3 of his executive (secretary children and youth affairs, one member plus the chairperson) then 7 other households in his village that had young people (10-19 years). A total of 10 parents and local council executives participated in the study.

3.6.2.7 Selection of policy makers and supervisors

This phase targeted key policy makers and supervisors both at the district and national level. At the district level, the District health officer (DHO) District Educator officer (DEO), the chairman local council five (LCV) or the vice who is the secretary health at the district level were purposively selected. Two participants were targeted per district (a total of 6 for the three districts). At the national level, the direct line commission for adolescent health at the Ministry of Health (MoH), commissioner school health programme at Ministry of Education, Sports, Science and Technology (MoESST), Commissioner Youth Affairs and or Culture and Family Affairs at Ministry of Gender, Labour and Social Development (MoGLSD) and Commissioner Uganda Communication Commission (UCC) in Uganda communication commission were meant to participate in the research. A total of five participants were purposively selected. In total 08 out of 11 policy makers and implementers took part in the study.

3.6.2.8 Recruitment of research assistants (RAs) and field supervisors

A brief job specifications and the minimum academic qualification for the research assistants and field supervisors were developed:

- Among others; a minimum of a bachelor's degree in the field of: Education, Social Sciences, Development Studies, Social Works and Social Administration.
- Previous experience in research.
- Proficiency in both spoken and written native language (Acholi).

Basing on the specification, a call for application for research assistants was pass through peer networks in the three districts under study.

From the applications, 7 research assistants and three supervisors were interviewed and selected for the training

3.6.2.9 Training of research assistants

The researcher organized a three days training for the research assistants and field supervisors. The training covered basic research methodologies and techniques. Practical sessions including mock presentations and role-plays were carried out as part of the training.

3.6.3 Data-collection instrument

The data collection tools can either be self-developed or adopted. The researcher developed a customised data collection tools in line with the objectives of the study for the qualitative data. The data collection tools translated in Acholi language. The research assistants who are native of Acholi were trained in data collection process including clarity of the choices of words and language. During the training, research assistants did mock exercises to acquaint themselves with interviewing techniques and as well to harmonise and get a common understanding and wording of the tools. Role plays and rehearsals were done on the interview process. Among the different data collection tools developed included: in-depth interview (IDI) guide, Key informant (KII) guide and focus group discussion (FGDs) guide.

3.6.3.1 Development of data tools

The data collection tools can either be self-developed or adopted. The researcher developed the data collection tools in line with the objectives of the study.

3.6.3.2 *Structured interview guide/questionnaire*

The questionnaire has 37 items which were structured. The development of the tool was guided by the objectives of the study. The items were developed to capture the following sub sections:

- a) Social demographics information
- b) Growth and development
- c) Sexual activity
- d) Adolescent sexual reproductive health

3.6.3.3 *Focuses group discussion (FGD) guide*

For the qualitative data, the topics for interview guides were developed in line with the study objectives. The questions were open ended and as such the interviewer had the liberty to probe

3.6.4 *Data-collection instrument for qualitative study (phases I, II sub-studies 1 and 2, phase III)*

The researcher set the agenda with the help of the interview guides (see annexures 1 and 11). According to Babbie (2008:335), an interview guide is “a general plan of inquiry including the topics to be covered”. Interviews of this nature rely on the interviewer following up with probes to get in-depth information on topics of interest (The Access Project [TAP] 1999:10).

The main advantage of using an interview guide was that the researcher was able to solicit in-depth and rich information about adolescents’ health and in particular sexual reproductive health. At the same time, both verbal and non-verbal communication was observed, recorded and used in the analysis. The challenge, however, was that the researcher had to deal with volumes of textual data during the analysis.

3.6.5 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or specific objectives, questions or hypothesis of a study (Polit & Beck 2008:67, 367). It is the process of gathering information needed to answer the research questions. The current study used different methods to collect data from the participants for phase I, phase II sub-studies I and II and phase III.

3.6.5.1 Data collection methods

The following methods were used in the current study: Interviews: including focused groups discussions (FGDs) and in-depth interviews (IDI) Key informant interviews (KII), and as well as direct observation.

3.6.5.2 Interviews

Interviewing is a technique of gathering data from humans by asking them questions and getting them to react verbally. There are many different ways of conducting interviews which may include structured, semi-structured and unstructured interviews. Semi-structured interviews and unstructured interviews are widely used in qualitative research. Semi-structured interviews consist of a list of open-ended questions based on the topic or areas the researcher intends to study (Harrell & Bradley 2009:6). The following interview methods were used in the current study.

3.6.5.3 In-depth interviews

This involves conducting intensive individual interviews one-on-one with respondents to explore their individual perspectives on a particular idea or situation and their thoughts are individual perception about the situation or experience. It provides detailed information about personal thoughts and it is used in situations in which participants are not comfortable talking openly in a group and also where the researcher wants to distinguish individual opinion about an experience (Boyce & Neale 2006:3). In the current study, the researcher used in-depth interviews to explore and describe the experiences of 15 teen mothers and 14 guardians of the teen mothers using an in-depth interview (see annexure 1 for the guide).

3.6.5.4 Key informants interviews

This involves interviewing a select group of individuals who are likely to provide the needed information, ideas and insights on a particular subject. Normally a small number (15-35) of informants are interviewed and they are selected because they possess information needed and interviews are conducted using interview guide in an informal atmosphere that facilitate informal discussions, allowing for probing questions and generation of field notes. Key informants interviews help generate descriptive information and to understand underlying motivation and attitudes of a target population as well as to generate suggestions and recommendations for the phenomena under study (Kumar 1989:1-2). In the current study a total of 27 KII targeting health workers, counselors, senior woman and male teachers, cultural and religious leaders as well as policy makers and supervisors were interviewed using KII guide (see annexure 5 for the KII guide).

3.6.5.5 Focus group discussions:

This is a method that brings together a small number of subjects to discuss the topic of interest. The group size is kept deliberately small (8-12 people), so that its members do not feel intimidated but can express opinions freely. A topic guide to aid discussion is usually prepared beforehand and the researcher usually 'chairs' the group, to ensure that a range of aspects of the topic are explored. The discussion is frequently tape-recorded, then transcribed and analysed. In the current study, a total of 8 FGDs were conducted using FGD guide (see annexure 6 for the FGD guide). Cultural leaders had one FGD that comprised of 10 cultural leaders; religious leaders had one FGD that comprised of 8 participants; parents of adolescents (one FGD per district comprising of 10 participants) and adolescents (one FGD per district that comprised of between 10-12 participants)

3.6.5.6 Direct observation

This is the act of noting a phenomenon in the field setting using the five senses of the observer and often with an instrument. Observation is based on the research purpose and questions. The researcher may be a complete participant, participant as an observer, non-participants or complete observer (Creswell 2013:166). In the current study, the

researcher took the part of a complete participant by engaging fully with the people and using an observational checklist (see annexure 9 for check list).

3.6.5.7 Recording interviews

Babbie (2008:340) emphasises that the greatest advantage of field research is the presence of an observing; thinking, and recording researcher. The researcher used both tape recording and took field notes during the interviews. The researcher worked with trained research assistants to take the field notes. The training of research assistants on the aim and objectives of the study, research design and methodology, and their role as a note taker helped to acquire the necessary skills in field notes taking. In taking notes, verbal and non-verbal expressions were as well recorded.

3.6.6 Qualitative study data analysis

Babbie (2008:415) defines qualitative data analysis as “the non-numerical examination and interpretation of observations for purposes of discovering underlying meanings and patterns”. Data collected during phase I and phase II sub-study 1 and 2 from were analysed qualitatively. Qualitative data analysis in this study was explicit and strongly informed by the aim and objectives of the study. Data analysis in these qualitative phases started as soon as the researcher had the first transcripts. Data analysis in qualitative research begins when data collection begins. In addition, analysis continued as the researcher committed to fully understanding what the data said (Lofland, Snow & Anderson 2006:151).

The analysis involved inductive and deductive reasoning (Pope et al 2000:115). Data analysis was determined by both the research objectives (deductive method) and multiple readings and interpretations of the raw data (inductive method). Thus the findings were derived from both the research objectives and the findings arising directly from the analysis of the raw data. The data collected were voluminous including field note and tape recordings. The researcher developed expanded field notes and transcripts from the recordings and all were analysed using atlas ti computer software to facilitate data searching, sorting and copying into separate files (Babbie 2008:414).

3.6.6.1 Data coding

Babbie (2008:422) defines coding as “classifying or categorising different pieces of data in order to be able to easily retrieve pieces of information one may be interested in later”. Coding followed Strauss and Corbin’s (1998:54) three steps, namely open, axial and selective coding. Babbie (2008:422) defines open coding as “the initial classification and labelling of concepts”; axial coding as “a re-analysis of the results in open coding aimed at identifying the important general concepts”, and selective coding as “building on the results of open and axial coding to identify the central concepts. Polit and Beck (2004:584) describe open coding as “where data are broken down into different parts while comparing differences and similarities” axial coding as “where the researcher develops categories and links them together” and lastly selective coding as “where the findings are integrated and refined”.

3.6.7 Trustworthiness

In qualitative research, validity and reliability relate to whether the findings of the study are true and certain, commonly known as trustworthiness (Guion 2002:1). Findings are true if they accurately reflect the real situation, and are certain if they are backed by evidence. In other words, there are no good grounds for doubting the results of a study. According to Rolfe (2006:305), trustworthiness can be divided into credibility, which corresponds with the concept of internal validity; dependability, which relates to reliability; and confirmability, which is largely an issue of presentation. Trustworthiness therefore enables the readers not to doubt the findings, conclusion, or recommendations based on the data (TAP 1999:9).

3.6.7.1 Dependability

Dependability includes activities that increase the probability that credible findings will be produced. Polit and Beck (2004:434) refer to dependability as “evidence that is consistent and stable; that is to say, stability of data over time and conditions”. In this study, the researcher carefully logged all sessions dealing with interpretation of data and kept track of how coding evolved. All notes were saved for future reference. Moreover, the researcher ensured that all interviews were transcribed as soon as possible, within the same day.

3.6.7.2 Confirmability

Confirmability refers to the objectivity or neutrality of the data to allow for agreement between two or more independent people about the relevance or meaning of the data. Polit and Beck (2004:435) define confirmability as “the degree to which study results are derived from characteristics of participants and the study context, not from bias of the researcher, and may involve a deliberate systematic collection of materials and documentation right from data collection, through analysis and report writing”. In this study, both the researcher and the research assistant generated field notes and interview transcripts, which were used during analysis. Moreover, at the end of the interview, the researcher went over the main points with the interviewer, as a way to reconfirm certain pieces of information. The researcher generated notes on verbal and non-verbal communication and documented the entire process of interviewing, such as when and where interviews were done. Data analysis and report writing was an all involving process in which the researcher immersed herself in the data and documented all the processes (Polit & Beck 2004:435).

3.6.7.3 Credibility

Polit and Beck (2004:434) define credibility as “the criteria for evaluating data quality in qualitative research, referring to confidence of truth of the data or the faith that can be put in the researcher and this may relate to the researcher’s qualification and experience”. In this study, the researcher holds a Master’s degree in Public Health, which training included qualitative research methods, and has had over 15 years’ working experience in public health field with particular focus on adolescents and young people affected by sexual reproductive issues including HIV and AIDS. The researcher trained the research assistant in qualitative research techniques. In addition, during the interviews, the researcher endeavoured to avoid leading questions. The researcher conducted interviews in a relaxed environment and ensured that the transcription of the interview recordings were as soon as possible, within the same day.

3.6.7.4 Triangulation

Triangulation involves using different designs to study the same phenomenon. According to Salazar et al (2006:165), triangulation is a way to obtain a multidimensional view of phenomenon of interest involving multiplicity in data sources and methods. Babbie and Mouton (2001:275) refer to triangulation as the use of multiple data collection methods while Babbie (2008:123) refers to it as the use of several different research methods. According to Polit and Beck (2004:430), triangulation can also enhance credibility, as its aim is to overcome the intrinsic bias that comes from single method, single observer and single theory studies.

Different types of triangulation may be considered such as method, data, and analysis triangulation. In method triangulation, the researcher used both quantitative and qualitative methods to study the role of community in support of ASRH during and after the LRA war in the Acholi sub-region, Uganda. In data triangulation, which is the use of multiple sources of data for purposes of validating conclusions, the researcher used both interviews and observation and also recorded verbal and non-verbal communication. In other triangulations, the researcher interviewed participants at different times of the day and dates (time triangulation), collected data from two different study sites (space triangulation) and collected data from different levels of individuals (person triangulation)

In analytic triangulation, the researcher used three main data analysis techniques to analyse the same data set. The researcher used thematic analysis, an inductive process where the themes emerged from the data and were not imposed by the researcher. The researcher collected and analysed data concurrently, which helped link what is known and what was needed to know. In comparative analysis, the researcher continuously compared and contrasted data from different participants until the researcher was satisfied that no new issues arose. Finally, the researcher used content analysis, where data was coded by content before it was analysed (Morse, Barrett, Mayan, Olson & Spiers 2002:8; Polit & Beck 2004:431).

3.7 PHASE II, SUB-STUDY III: QUANTITATIVE STUDY

Phase II sub-study three was purely quantitative. Adolescents aged 10-19 years were included in phase as respondents. The study respondents were drawn from the three districts.

3.7.1 Sampling

It is essentially difficult to interview every individual in a study population. For this reason, a representative sample was selected. Cargan (2007:235) defines sampling as “a means used to draw a representative number of elements from a larger population”. Kumar (1999:19) emphasises that in sampling, it is important to avoid bias in the selection of a sample and necessary to achieve maximum precision for a given outlay of resources. A small but representative number of units are scientifically selected to provide a fairly true reflection of the sampled population being studied.

Generally, the use of large sample size possible is good. Cargan (2007:237) maintains that the larger the sample, the more representative it is of the population and the more likely results will be accepted. Nevertheless, it is advisable to make an extra effort to obtain a representative rather than a very large sample size. Therefore, the eventual sample size is usually a compromise between what is desirable and what is feasible. The main aspects considered in determining sample size from a population include the objectives of the study, the need for more variation in the sample, and the ease of handling data collected.

3.7.2 Sample size

The sample size of adolescents was computed using Cochran formula of:

$$n = \frac{Z^2 N p q}{(N-1)e^2 + Z^2 p q}$$

Where;

n=sample size

N=population of adolescents 10-19 years

P=proportion of adolescents with access to sexual reproductive health services assumed to be 0.5

q=proportion of adolescents without access to sexual reproductive assumed to be 0.5

e=margin of error assumed at 4% within the true value

z=confidence level (will consider 1.95 for 95% level of confidence)

Using the formula and the estimated population size presented in section (3.7.1 above with 23.2% of young people aged 10-19 years in the three districts translating in to a total of 210,478 young people aged 10-19 years (UBOS 2013:5), the sample size n was 598.4 rounded to 600 adolescents from the three districts. This was then proportioned according to the specific district proportion thereby giving a sample size of: 270 for Gulu, 170 for Kitgum and 160 for Pader.

3.7.3 Sampling procedures

Six hundred (600) adolescent were targeted for the survey, 50% from school (both primary and secondary level) and 50% from the community. Using the multistage sampling (under sub-section 3.7.1 above), the villages (three villages) and the 12 schools were targeted for sample selection. For schools, upper primary up senior 6 (high school grade) were considered. The class register for the day of interview was used as the sampling frame.

An equal number of students were assigned per school. Boys, girls and mixed schools were selected. Each school had total respondents of 25 adolescents. A total of between 5-10 respondents per class were selected using a simple random sampling. The class room attendance registry on the day of the interview. A total of 300 adolescents were selected and all were interviewed from the schools in a convenient and private locations or rooms. While for the sampled villages, the local chairpersons of the villages were asked to mobilise young people 10-19 years in their village through the parents/guardians of the adolescents. The adolescents were asked to convene at community center (church, community hall).

A total of 100 adolescents were expected per village. The duration for the interviews per village lasted between 4-5 days; each day an average of 20-25 adolescents were interviewed (total number of adolescents expected per village was 100). All the

adolescents who turned up for the interviews were sampled using systematic sampling technique. Adolescents who turned up per day were lined up and using a draw system to determine the beginning number, a secret paper number system labeled 1 and 2, therefore, every odd or even number was drawn from the line depending on first number picked each day. The village that could not raise the number (100), the next village was conveniently selected and the parents were requested to send their adolescents children in their households.

Adolescents who were not picked for the interviewed had an opportunity to be talked to in a group just to ensure that they were not disappointed and as well to impart some knowledge to them regarding growing up as an adolescent.

3.7.4 Data collection

The researcher collected data from the selected adolescents per village that were sampled through directly interviewing the respondents using a structured interview schedule. In a structured interview, the interviewer asks the same questions in the same order with no variation in the questions asked (Cargan 2007:105). Interviews are one of the most common procedures in research. One of the advantages of interviews is giving the researcher an opportunity to observe the subject's non-verbal language. Because of the ease of use and wide applicability in demographics, attitude, social relationship and social environment, interviews dominate social sciences measurements of the verbal type (Salazar et al 2006:80).

Structured interviews with individuals are designed to obtain information on why, what, where, when and how, mainly through closed questions that have logical (yes/no, true/false, agree/disagree), numeric, and/or other answers that can be easily coded for tabulation (Boynton 2005:29; WHO 1996:26). According to Babbie (2008:291), interviews can be done by telephone, face to face or by means of postal questionnaires. The researcher used face-to-face structured interviews. Babbie (2008:291) emphasises that face-to-face interviews reduce misunderstandings, as there is a chance to explain the question, and decrease the possibility of many "don't knows".

3.7.5 Questionnaire

A questionnaire is a printed self-report form designed to elicit information that can be obtained through written of the subject (Burns & Grove 2005:389). According to Oppenheim (1992:100), a questionnaire can be self-administered or administered through face-to-face interviews. In this study, the researcher used structured interview schedules to ask a set of structured questions while recording the answers. Use of structured interview schedules assumes that the interviewer has control over a set list of questions that have been formulated and which are to be answered as they are rather than being rephrased or reordered, discussed or analysed (Cargan 2007:105).

The data-collection instrument was a 37 items structured interview schedule (see annexure 9). It consisted of 4 sections (labelled A-D) namely:

- A Social demographics information
- B Growth and development
- C Sexual activity
- D Adolescent sexual reproductive health

3.7.6 Pre-testing of data-collection tool

Wording of questions is crucial in determining the nature of data collected. Salazar et al (2006:98) maintain that it is usually necessary to conduct a pre-test before the final instrument is prepared. Babbie (2008:283) points out that the surest protection against errors is to pre-test the questionnaire in full or part.

According to Polit and Beck (2006:296), a pre-test is a small-scale trial of the data-collection instrument to determine clarity of questions and whether the instrument elicits the desired information. In this study, the data-collection instruments were pre-tested in order to determine whether all respondents would understand the questions and instructions in the same way, and how relevant the questions were. Fifteen adolescents were randomly selected from Limo village, Division, Gulu Municipality. Based on the responses obtained, the interview schedule was revised before embarking on full data collection. Pre-testing the instruments therefore was another way of increasing their validity and reliability.

3.7.7 Data analysis

Black (2002:21) points out that numbers and statistics by themselves are of little interest and are difficult to make any sense of. Thus data analysis is a critical step in research. Russell (2000:419) defines data analysis as “the search for patterns in the data and for ideas that help explain why those patterns are there in the first place”.

The data collected under phase II, sub-study three (quantitative study), it was coded, collated, entered into a computer using Epi data version 2.1, and finally transformed before analysis, using the Stata version 12.0. Coding involved deciding in advance in which columns in the data set each variable was to appear; collation involved arranging all the collected information uniformly; data entry involved entering data into the computer using a computer keyboard terminal, and finally data transformation involved correlating different variables in the data set (Martinez-Pont 1997:20).

Both descriptive and inferential statistics were calculated. The data was displayed using graphs, tables and pie charts, often indicating proportions (percentage). Chi-square values were also calculated to obtain probability values (p-value) in order to assess the relationship between key variables (Behr 1983:40; Polit & Beck 2004:451-510; Russell 2000:526; Schutt 2001:347; Wysocki 2001:281).

3.7.8 Validity of the study

Validity has to do with truth, strength and value. Validity therefore relates more to the strength of the conclusions, inferences or propositions. Russell (2000:46-47) defines validity as the “accuracy and trustworthiness of instruments, data, and findings in research”. According to Guion (2002:2), ensuring validity helps make researchers’ evaluation more credible and thus provides information they can defend with confidence. In this study, several forms of validity are discussed below and how the researcher dealt with each to minimise the threats. Furthermore, the study promoters (were academic associates who were not necessarily appointed supervisors, but the researcher consulted when and where it was necessary and three specialists in the area of adolescents programming reviewed the interview schedule and made suggestions, which the researcher included.

3.7.8.1 Face validity

Face validity refers to subjective judgment on whether the research instrument appears to measure what it is supposed to measure (Burns & Grove 2001:400; Cargan 2007:232). In this study, face validity was maintained by constructing questions relevant to the study aim and objectives.

3.7.8.2 Content validity

Content validity relates to knowing whether the entire interview items reflect the entire range of meanings (Cargan 2007:232). This ensures that all items to be included in the instrument(s). The researcher developed the interview schedule after the literature review as mentioned above.

3.7.8.3 Construct validity

Construct validity measures whether concepts relate to each other as expected (Cargan 2007:232). Construct validity emphasises that concepts are measured adequately and logically and relationships between variables are identified with the instrument. Burns and Grove (2001:232) add that construct validity includes the definition of variables in line with existing literature and differentiates between respondents who possess the trait and those without the trait. In this study, the interview schedule was based on the literature reviewed and the theoretical framework.

Threats to construct validity may include inadequate pre-operational explication of constructs where a researcher does not define concepts very well before measuring them. The researcher operationally defined all concepts (see chapter 1, section 1.11).

The other threat to construct validity relates to social threat such as hypothesis guessing, where participants base their behavioural responses on what they think the study is about. At the same time, participants may be fearful of the study to the point that it influences their response. The researcher avoided these threats by standardising the interview schedule, and assuring the participants of confidentiality and anonymity.

3.7.8.4 Internal validity

Internal validity asks if there is a relationship between the programme and the outcome seen. In other words, it looks at causal relationships (Polit & Beck 2004:214). Similarly, Burns and Grove (2005:215), internal validity is the extent to which the effects detected in the study are a true reflection of reality rather than the results of extraneous variables. In the current study, the following measures were taken to minimise threats to internal validity.

Threats to internal validity

Polit and Beck (2004:213-219) recognise several threats to internal validity. History threat occurs when an historical event affects one's study group such that it leads to the outcome. In the current study, the questions asked were part of the normal development of an adolescent and for the historical LRA war, the researcher explained thoroughly that the study was for academic purposes and not related to rehabilitation programme and so this did not affect internal validity.

Similarly, maturation threat, which usually occurs within the participants during the course of time as a result of passage of time, did not occur as this was a cross-sectional study done over a fairly short period of time.

Another threat to internal validity is the testing threat, which occurs when the act of taking a pre-test affects how that group does on the post-test. The researcher guarded against this type of threat by avoiding pre-testing of the interview schedule in the same populations under study. Instead, the researcher pre-tested the interview schedule among fifteen respondents in a different community with similar setting within Acholi community. Based on the responses obtained, the interview schedule was revised before embarking on full data collection.

A mortality threat to internal validity occurs when subjects drop out of the study, and this leads to an inflated measure of the effect. The current study was cross sectional in nature and therefore it did not suffer this type of threat as all invited respondents were all interviewed.

3.7.8.5 External validity

According to Polit and Beck (2004:217), external validity refers to the “generalisability of the research findings to other setting or samples”. In other words, how well the results tell us about other related settings. Findings can only be generalised to other populations if the sampling was random. The current study employed random sampling techniques to select the final sample, achieving external validity.

3.7.8.6 Threats to external validity

A threat to external validity is an explanation of how one might be wrong in making a generalisation. There are mainly three major threats to external validity because there are three ways a researcher could be wrong – people, places or times. According to Burns and Grove (2001:232), threats may relate for example to settings where interviews are conducted from and key events in the study area. Threats may also relate to a possibility that there are unusual types of people who were included in the study. The researcher employed several measures to overcome threats to external validity.

First was the sampling techniques used. Cluster sampling, and random selection of the sample within each cluster, ensured equal chances of being included into the sample.

Secondly, interviews were not all conducted in one day but rather spread out to different days and times. More so, the researcher, through the literature review, described the ways the context of the current study may differ from the others. Information about the degree of similarity between various groups of people, places even times with regard to ASRH were explained.

3.7.9 Reliability of the study

Reliability is the consistency of one’s measurement, or the degree to which an instrument measures something the same way each time it is used under the same condition with the same subjects (Polit & Beck 2004:416). In other words, it is the repeatability of one’s measurement. Although the researcher did not employ stability tests and internal consistence estimations, the interview schedule was subjected to several pre testing and revisions that ensured a reliable tool was used to collect the data. Experts were asked to

review and advice on the interview schedule. Besides, the strategies used to improve face validity and content validity described above also helped reduce threats to reliability.

3.8 ETHICAL CONSIDERATIONS IN ALL THREE PHASES

Ethics deals with matters of rights and wrong. *Collins English Dictionary* (1991:533) defines ethics as “a social, religious, or civil code or behaviour considered correct especially that of a particular group, profession or individual”. Research that involves human beings as subjects should be conducted in an ethical manner to protect their rights. Polit and Beck (2008:167) emphasise that when people are used as respondents, ‘care must be exercised in ensuring that the rights of the respondents are protected’. And according to the *Belmont commission report; it elaborates* three key principles for ethical considerations including: *Respect for person and autonomy, Beneficence and Justice* (Babbie 2013:33). To ensure that the study met the prescribed ethical standards, the researcher upheld the following: approval and permission to conduct the study; participants’ voluntary informed participation; wellbeing; anonymity; justice, and confidentiality (Burn & Grove 2001:196).

3.8.1 Research approval

When the research proposal was fully developed, the researcher applied to the Department of Health Studies, University of South Africa (UNISA), to conduct the study and received a letter of approval (see annexure 13). Once approval was obtained from UNISA, the proposal was submitted to the Higher Degree, Research and Ethics Committee, Makerere College of Health Sciences, School of Public Health Makerere University Kampala for country level approval, and the researcher received a letter of approval (see annexure 14).

3.8.2 Right to self-determination and voluntary informed consent

The right to self-determination is based on the ethical principle of respect for persons and indicates that people are capable of controlling their own destiny (Burns & Grove 2005:181). The participants’ right to self-determination was ensured by explaining into details the purpose and the significance of the study, obtaining their informed consent and or assent for minors and emphasised that participation was free and voluntary and

that they had the right to withdraw from the study at any time without any negative effects on their relationship with their respective service providers and the community at large in which they live. In addition, the participants were informed of non-monetary associated benefits for their participation and sought their informed consent and or assent form by signing on the form respectively (see annexure 1).

3.8.3 Anonymity

Research subjects need to be reassured that they will not be identified through the research; in other words, they should remain anonymous (Boynton 2005:101). The respondent's and participant's names and identity were not disclosed, but descriptive titles were used such as health worker, teen parent, adolescent, parents of adolescents, senior woman teacher, counselors, cultural and religious leader and policy maker and supervisor in all the three study phases. The research assistant was well trained on measures for keeping anonymity such as the use of pseudo names while taking notes.

3.8.4 Confidentiality

Boynton (2005:101) points out that participant need to be reassured that what they reveal during the interview will be treated as private information. The researcher ensured that all information collected from the respondents and participants was kept confidential. Accordingly, the researcher tried to expunge possible identifying materials when presenting the research findings. Both the researcher and the research assistant had to acquaint themselves with national guidelines for research involving humans as research participants, published by the UNCST (2007:1-223).

3.8.5 Participants' well being

The UNCST (2007:4) defines the principle of subjects' well-being as "doing no harm and avoiding deliberate infliction of harm or evil on participants". To ensure the respondents' well-being and avoid physical or psychological harm, the researcher avoided questions that were likely to cause psychological discomfort. For example, the researcher avoided asking individuals on their sexual experiences.

3.8.6 Justice

Justice refers to the ethical obligation to treat each person in accordance with what is morally right and proper and to give each person what is due to him or her (UNCST 2007:4). The researcher informed the respondents and participants that refusal to participate in the study would not mean denial of other benefits they would otherwise be entitled to receive.

3.9 FIELD EXPERIENCES AND CHALLENGES

Some of the experiences from the field were unexpected, although they did not warrant changing the research design. Some of the pre-selected respondents declined participation in the interviews under the pretext of being busy and opted to delegate. Three key informants were not replaced since they were purposively selected. In other instances, the assumed caretakers who accompanied the teen mothers have not lived together for sometimes and therefore did not have enough experience to share in the interviews; five teen mothers did not have substantive guardians for the interviews.

The bureaucratic process in some institutions demanding a fresh ethical clearance by their institution review board (IRB) could not be accommodated within the field data collection period. Five participants from the institution were not replaced.

Some parents and adolescents from the communities, who were not included in the sample, wondered why they had not been selected and asked if they too could be interviewed as well.

3.10 CONCLUSION

This chapter described the research design and methodology of the study in detail. The study used a concurrent approach in collecting, processing and analysing both quantitative and qualitative data in three different phases. Phase I involved teen mothers, their guardians and midwives as participants; phase II involved cultural and religious leaders, parents, adolescents, senior male and woman teachers and counselors, and phase III involved policy makers and supervisors both at district and national level.

The next chapter (Chapter 4) discusses the data analysis, findings and interpretation of the results from Phases I, II and III with all the sub-studies.

CHAPTER 4

PRESENTATION OF FINDINGS

4.1 INTRODUCTION

Chapter 4 presents the results of the study according to different phases from both the qualitative and quantitative strands. Findings are presented according to the different sources used to collect data. The findings are presented starting with Phase I, then Phase II sub-studies 1 and 2 and Phase III study.

The results presented answered the following research questions as outlined in Chapter 3:

- i. How has the role played by community stakeholders impacted on adolescents (teenage) mothers' ability to handle sexual reproductive health?
- ii. To what extent do socio-cultural factors influence ASRH?
- iii. How has health systems influenced community role in support of ASRH
- iv. What strategies would best address the issue of community involvement in ASRH?

4.2 QUALITATIVE FINDINGS

Numerous data sets were collected under the qualitative strand which covered Phases I-III.

Phase I was a case study that targeted teen mothers, their guardians and midwives.

Phase II, sub-studies 1 and 2 were key informant interviews and focus groups discussions with different study participants that sought to generate feedback.

Phase III documented issues surrounding community responsiveness on matters pertaining to adolescents sexual reproductive health. The utmost aim was to develop a community model for enhancing community responsiveness on ASRH. The results generated from phase III are detailed under section 4.9.

4.2.1 Phase I case study results

Phase I had three different categories of participants; the teen mothers, their guardians and the midwives. The information gathered from the guardians and the midwives was used for triangulation of the information collected from the teen mothers. Table 4.1 summarises the demographic characteristics of the Phase I participants and relationship profiles.

Table 4.1: Teen mothers age, guardian relationship to teen mothers their age and occupation

Teen mothers (pseudonyms)	Age of T/Ms	Level of education for T/Ms	Guardian relationship with T/Ms	Age of guardian	Occupation of guardian
P1	14	DRP LP	Mother	47	Peasant farmer
P2	14	DRP LP	Mother	45	Peasant farmer
P3	14	DRP LP	Aunty	49	Peasant farmer
P4	15	DRP LP	Husband	18	Peasant farmer
P5	15	Secondary	Mother	59	Peasant farmer
P6	15	DRP LP	Husband	22	Peasant farmer
P7	16	DRP LP	Grandmother	50	Peasant farmer
P8	16	DRP LP	sister	18	Hair dresser
P9	17	DRP LP	Husband	19	Peasant farmer
P10	17	DRP LP	Mother	48	Peasant farmer
P11	16	DRP LP	Husband	21	Peasant farmer
P12	17	DRP LP	Mother	46	Peasant farmer
P13	17	DRP LP	Grandmother	60	Peasant farmer
P14	17	DRP LP	Mother	42	Peasant farmer
P15	18	DRP LP	Did not bring guardian	N/A	N/A

Key: DRP LP = Dropped at lower primary; T/Ms = Teen Mothers; N/A = Not applicable

4.2.1.1 The total number of study participants (teen mothers)

A total of 15 teen mothers out of the expected 18 (planned total) participated in the study. One teen mother declined to participate and withdrew from the study midway. The other two (2) teen mothers withdrew due to bureaucracy encountered during the process of obtaining permission from the hospital administration which would have necessitated another ethical clearance for the hospital. Given the attained response rate (83%), the researcher did not require any replacement and therefore collected data from 15 teen mothers.

Fourteen (14) of teen mothers who participated were under the consenting age (less than 18 years) and therefore children by law (UN Convention on the Right of the Child 1997:31). Teenage pregnancy remains a critical matter to teenage mothers and the community at large. Studies show that most teen pregnancies are unplanned and around half of these end in an abortion. For many teens who become parents, bringing up a child is incredibly difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty (Crown 2010:7).

4.2.1.2 *The total numbers of guardians and their basic characteristics*

Each of the 15 teen mothers who turned up for the interviews were asked to come with a guardian; that is, someone whom the teen mothers considered to be their caretaker. The information detailing the basic characteristics of the guardians was generated as part of rapport building in which the guardians were asked to briefly talk about themselves by way of introduction, the relationship with the teen mothers, the age and the kind of economic activities done (occupation).

Only 14 of the fifteen (15) teen mothers that participated in the study brought a guardian and characteristics are outlined in Table 4.1. The result shows that a greater proportion of the teen mothers' guardians were their own mothers (43%); this was followed by husbands at (29%), grandmothers came third with 14%, and the least numbers were for sisters or an aunty at 7%. During interviews, the guardians reported that they were living together with the teen mothers. The majority of guardians (64%) were adults aged above 35 years; adolescents aged 18 and 19 years comprised (21%) of the guardians, while 14% of the guardians were young people aged between 20 and 22 years. All the guardians were peasant farmers except one who had a hairdressing business.

The gender perspective of females as carers was evident as the majority (71%) of guardians were female (grandmother, mother, an aunty and a sister). Early adult parenthood was 30%, and comprised teen mothers who lived with the spouses (husbands) aged between 19-22 years. A greater proportion (70%) of the teen mothers were living with other caretakers (own mothers, grandmothers, sister and an aunty) and not with the man responsible for the pregnancy.

4.2.1.3 The total numbers of the midwives and their basic characteristics

The researcher asked midwives who participated in the study to share their work experience in terms of professional field of training and the years of work experience. Table 4.2 summarises the basic information collected from the health workers.

Table 4.2: Participants' characteristics – the midwives

Participant	Professional training	Gender	Work experience
1	Midwifery	Female	5 years
2	Midwifery	Female	15 years
3	Counsellor	Female	9 years
4	Counsellor	Female	5 years
5	Nursing	Female	5 years
6	Midwifery	Female	08 months
7	Midwifery	Female	7 years
8	Midwifery	Female	11 months
9	Midwifery	Female	32 years
10	Midwifery	Female	08 months
11	Midwifery	Female	6 years

A total of 11 female midwives were interviewed as detailed in Table 4. 2. All the health workers (midwives, nurse and counsellors) reported to have attained the basic professional training required for the job. The majority (73%) of the service providers had worked for more than 5 years and reported to have accumulated a wealth of experience that helped them perform their task with ease. A few (27%) service providers had worked for less than a year.

4.3 EXPERIENCES OF TEEN MOTHERS

Teen mothers experienced the harsh realities of life after they became pregnant. Some of the teen mothers were already terrified by their circumstances as espoused in this quote:

“I have many challenges, if my baby is sick, I stay-up alone at night since my grandmother is now old, buying other requirements for the baby, I can't afford them since I don't work and generally care for the baby ...” said a 15 years old teen parent living with a grandmother, Lalogi H/C IV, Gulu District.

Most of the issues that negatively impacted teen mothers were being school dropouts, lack of finances and living arrangements.

4.3.1 School dropout

The results show that 73% of the teen mothers had dropped out of school prior to their pregnancy and only 27% had dropped out due to teen pregnancy. The teen mothers gave- dropping out of school as the main cause for their pregnancy as they had nothing meaningful to occupy them as espoused in the following quote:

“I was already out of school and I did not have much to do ..., I then looked for a job as housemaid...during my work time, I ended up getting a man ...” a 15 years old teen mother from Pajule H/C IV Pader District.

School dropout was also closely related to being orphaned and poor household socio-economic conditions.

4.3.1.1 Orphan-hood

The majority (80%; (n=12) of the teen mothers were orphans who had lost one or both parents. Twenty-five percent (n=03) were double (total) orphans; 75% were half orphans (n=09) who also happened to be paternal orphans. The experiences of being orphaned prior to teen pregnancy were critical as depicted in some of the qualitative interviews with the participants.

“My father died during the war time and since my mother was alone and had a lot of difficulties in providing the basics for us ..., life was so difficult, I dropped out of school and got married” 17 years old teen mother from Kilak H/C III, Pader District

“We were 7 children in total, my father died when I was young during the conflict time. Since life was difficult at home, my mother each day struggled to get the basic needs we needed at home ...” 16 years old teen mother, Omiyanyima H/C III, Kitgum District.

4.3.1.2 Socio-economic characteristics of the teen mothers' households

The socio-economic characteristics of the households where the teen mothers lived are summarised in Table 4.3 below.

Table 4.3: Socio-economic characteristics of the teen mothers' households

Participant code	No of Siblings	Person living with teen mother at the time of the interview	Activities teens engaged in prior to pregnancy
P1	7	Single grandmother	Schooling
P2	4	Aunty	Domestic work
P3	6	A step parent	Domestic work
P4	6	Single Grandmother	Paid domestic work
P5	7	Single mother	Schooling
P6	5	Husband	Paid domestic work
P7	7	Parents	Schooling
P8	6	Husband	Paid domestic work
P9	7	Parents	Schooling
P10	6	A step parent	Paid domestic work
P11	8	Husband	Domestic work
P12	9	Husband	Paid domestic work
P13	12	Single mother	Paid domestic work
P14	5	Single Grandmother	Domestic work
P15	7	Single mother	Paid domestic work

The households had a relatively big number of dependants and/or siblings with an average of 7 siblings per household. The major source of livelihood reported by the guardians was peasant farming (Table 4.1 above). Also, 53.4% (n=08) of the families were single parent (woman) headed households and these were the teen mothers' own mothers, grandmothers or aunts. About 33.3% teen mothers lived under step-parenthood, with one non-biological parent; and 13.3% (n=02) had both parents alive and were living together.

The causes of single parenthood were attributed to death which mostly occurred when the teenagers were young. The study did not seek to establish the exact causes of the deaths because of the sensitive nature of the subject, which would have potentially affected the feelings of the participants and affected the interviews.

In terms of economic and productive activities, the majority of teen mothers (46.6%; n=07) was engaged in paid domestic work in a nearby business centre or in another district. Some teen mothers (26.7%; n=04) supported the household adults with subsistence activities, and the rest 26.7% (n=04) were still at school.

4.3.1.3 The characteristics of the men who impregnated the teen mothers

The researcher also explored the characteristics of the men who impregnated the teen mothers. The teen mothers were asked to narrate the circumstances under which they

fell pregnant as well as who was responsible for the pregnancy. The information collected is summarised in Table 4.4.

Table 4.4: The category of men who impregnated the teen mothers

Category of man responsible	No of teen mothers	Additional comment
Out of school	12	Of the 12, eleven teens were already out of school and one was in school
A school mate	03	The three teens were in school

Pregnancy by a school mate

Four (04) teen mothers out of the fifteen were still in school at the time they conceived. Of these 04, three (75%) had been impregnated by a school mate and these were all in upper primary (P.5-P.7). One teen mother in secondary school (S.2) together with 11 teen mothers who were out of school was impregnated by a man from the community. All the teen mothers were able to identify the responsible man. Teen mothers who were impregnated by a school mate were all in upper primary level (P.5- P.7) and all were aged between 15-18 years indicating child to child sex. The community especially the parents of the girls could not allow the teen mothers to live together with the person responsible for the pregnancy. As one participant narrated ...

“I was called and informed about the sickness of my daughter who was then living away from me, I picked her up and took her for medical care and later the health worker told me that my daughter was pregnant ... I asked my daughter about who had impregnated her and she told me it was a fellow school mate. They were both children and as a mother I could not allow my daughter to get married so I took her back with me and pledged to support her ... but since then I have been blamed by the community that I had failed to protect my daughter from having sex ...” 49 years old guardian of teen mother, Cwero H/C III, Gulu District.

4.3.1.4 The current guardianship and custody of the teen mothers

The teen mothers were asked to talk about the guardian they lived with at the time of the interview. Out of the 15 teen mothers, four (26.7%) were living with the man responsible for the pregnancy as wife and husband. These fourteen mothers were accompanied by the husband as a guardian. The ages of the men (husbands) ranged between 18-22 years which was an indication of young marriage.

“I am a 19-year-old a husband to my wife. I dropped out in P.7, my father died and I only have my mother. I felt I had grown and needed a wife so I got one and now I’m living together with my wife who is now expecting ... she is about 4 months pregnant”. A husband to a 18 years old teen mother Kilak H/C III, Pader District.

The other eleven (73.3%) teen mothers were living with other caretakers. Of the eleven, 27.3% (03) had child-to-child sex that ended up in a pregnancy and therefore the community could not allow the teens to live together as a husband and wife. The other (08) teen mothers (72.7%) were living with other caretakers as the man responsible for the pregnancy had denied the pregnancy and/or had disappeared. The denial and disappearance was a result of among other, fear of being arrested for defilement, lack of resources to start a family and already having family and not being prepared add a new one.

Some of the direct quotes below were taken from the stories of the teen mothers.

Participant 01

“I was so sickly ... when I went to the hospital the health worker after examining me told me that I was pregnant and asked me to come with the man who impregnated me ... when I told him he refused and then disappeared, feared being arrested for defilement and since then I have not seen him, am told he went to Kampala ...” a 14 years old teen mother from Pajule H/C IV, Pader District.

Participant 02

“When I told my boyfriend that I was pregnant he denied and threatened me that if I disclose him then I will suffer the consequences more. So I had no fallback position but I remember crying, crying and crying with no help ...” a 15 years old teen mother Lalogi HCIV, Gulu District.

Participant 03

“...I also asked my daughter about who was responsible for the pregnancy and she just kept quiet and would start crying whenever I asked her. Up to now I don’t know who is responsible and I also stopped asking her” a guardian to teen mother Lalogi HCIV, Gulu District.

4.3.2 The key findings relating to the teen mothers

From the information gathered from the teen mothers, the following is a summary of the key findings:

- Sixty percent (60%; n=09) of the teen mothers were orphans.
- Close to 54% (n=08) of the households were single women headed.
- The family sizes were large with an average of 7 dependants or siblings per household.
- Step-parenthood was reported at 33.3% (n=05) among the households of the teen mothers.
- Close to 47% (n=07) of the teens were engaged in paid domestic work (house maids) prior to their pregnancy.
- Child-to-child sex was 75% (n=11) in school teens who conceived while in primary level of education with a school mate indicating early sexual debut.
- Close to 27% (n=04) of the teens were living as husband and wife and were still under 24 years a demonstration of young marriage.
- Single child parenting was common as about 73% (n=11) of the men responsible either denied the pregnancy or disappeared.

The above findings denote the lived experiences of the teens before, during and after teen pregnancy. The socio-demographic characteristics of the family and households status in which the teen mothers lived were critical issues and included: growing up as orphans, living in predominantly single female-headed households, a relatively large numbers of dependants and siblings, survival on subsistence farming among others. These factors directly and indirectly influenced the live experiences of the teens before and after teen pregnancy.

4.3.3 Knowledge about adolescence and ASRH among teen mothers

In this sub-section, the researcher explored the understanding of adolescence (puberty) and knowledge on ASRH among teen mothers. The process involved using the aspects listed and summarised in Table 4.5. These relate to key characteristics of adolescence and the package of ASRH information and services to gauge the knowledge level about

adolescence (puberty) and adolescents sexual reproductive health information among teen mothers. The information in the tables has been routinely used as a “gold” standard for gauging the level of knowledge among teen mothers. The researcher compared the views collected from the teen mothers (Colum A) (under Table 4.6) below with the minimum package for ASRH.

Table 4.5: Pubertal characteristics

<p>Box 4.5a Characteristics of adolescence stage in girls</p> <p><u>Body changes (Physical)</u></p> <ul style="list-style-type: none"> • Development of breasts • Growth of pubic hair • Body odour • Enlargement of private parts • Menstruation • Smoothing of the skin • Soft voice • Development of pimples 	<p>Box 4.5b Characteristics of adolescence stage in boys</p> <p><u>Body changes (Physical)</u></p> <ul style="list-style-type: none"> • Deepening of the voice • Growth of pubic hair • Body odour • Enlargement of private parts • Wet dreams • Development of pimples
<p>Box 4.5c Social, emotional and experimentation characteristics, these may happen to both boys and girls</p> <ul style="list-style-type: none"> • Attraction to the opposite sex (social and emotional) • Sexual desires begin (social and emotional) • Mood changes (emotional) • Urge to discover new things (exploration) 	
<p>Box 4.5d Package of ASRH information and services that adolescents need</p> <ul style="list-style-type: none"> • Information about body changes during adolescence (physical) • Need to be aware about attraction to the opposite sex (social and emotional) • Risks of unplanned pregnancy • Pregnancy prevention (abstinence) • Pregnancy prevention (use of contraceptives) • Abortion and the risks of unsafe abortion • HIV&AIDS and other STIs/STDs • Condom • Methods of family planning, birth control and contraceptives 	

(National Adolescent policy guidelines and service standards,
Uganda Ministry of Health 2011)

The researcher asked the teen mothers to talk about their experience of growing up. Using the query reports, Table 4.6 below presents the key emerging themes. Column A details the information collected from the teen mothers; using column B as the *gold* standard for the package of information on ASRH, and column C as conclusive remarks

on the level of knowledge and information on adolescence (puberty) and SRH among teen mothers (A compared with B).

Table 4.6: Knowledge about adolescence and ASRH among teen mothers

Information generated from the teen mothers on ASRH (A)	The minimum package of ASRH and understanding of adolescence (B)- Gold standards	Conclusion of the knowledge level of teen mothers regarding ASRH (C)
<ul style="list-style-type: none"> • Discussed timing of sex after period to avoid pregnancy • The science teacher taught about our bodies and body changes and peer pressure • The senior woman teacher also told us girls to be careful especially for those who already are experiencing periods • we discussed how to dress up when in period, the risk of becoming pregnant and others • Learned about HIV/AIDS and pregnancy • Learned about early pregnancy that can lead to death • Learned about HIV&AIDS and that I should be careful and protect my life • Learned about STIs • Learned about condoms that it protects against HIV/AIDS other STIs as well as early pregnancy 	<p><u>Understanding of adolescence- Girls</u></p> <p><u>Body changes (Physical)</u></p> <ul style="list-style-type: none"> • Development of breasts • Growth of pubic hair • Body odour • Enlargement of private parts • Menstruation • Smoothing of the skin • Soft voice • Development of pimples <p><u>ASRH Package</u></p> <ul style="list-style-type: none"> • Information about physical changes • Information about social and emotional changes • Risks of unplanned pregnancy • Pregnancy prevention (abstinence) • Pregnancy prevention (use of contraceptives) • Abortion and the risks of unsafe abortion • HIV&AIDS and other STIs/STDs • Condom education • Methods of family planning, birth control and contraceptives 	<ul style="list-style-type: none"> • From the query report, 8/15 (53.3%), teen mothers shared some information regarding their knowledge on adolescence and adolescents sexual reproductive health. • The knowledge promoted among the teens prior and after their pregnancy focused on pregnancy, menstrual hygiene, HIV&AIDS and other STIs and condoms. • On adolescence and specifically on body changes, the awareness was more on menstruation and less on other changes like social and emotional development. • On ASRH, the information focused on creating awareness on pregnancy and HIV&AIDS and the associated prevention methods with scanty information that lacked details. • The parents and guardians did not have adequate knowledge and skills to talk to the adolescents about the transitional stage and its associated challenges • Conclusively, the teen mothers had limited information about adolescence, lacked comprehensive knowledge on ASRH. And these were majorly due to limited skills among parents and guardians on what information to offer and how such information could be delivered

From the qualitative interviews, the following expressions were recorded to demonstrate how the teen mothers felt about their knowledge level on adolescence and ASRH information which they received from the community stakeholders ...

Participant 01

“I remember my mother occasionally sat me down and told me to avoid playing/staying closely with boys with no much information on the implication of staying closely with boys ...” a 15 years old teen mother Lalogi H/C IV, Gulu District

Participant 02

“I recall my friends gave me information regarding menstrual care, how I should dress and care for myself when in period and also said if I messed up with boys during this time I could become pregnant ...” a 15 years old teen mother, Pajule H/C IV, Pader District

Participant 03

“I recalled when I was 14 years; I started my period and this terrified me a lot since I was not informed of such changes I recalled at one point my mother told me as a girl I should be very careful and should not mess up with boys ... This was not clear to me regarding sexual reproductive health” 15 years old teen mother, Cwero H/C III, Gulu District

Participant 04

“Sometimes back I visited a youth Centre in town and I learned some information on ASRH and also when I was still at school, some organisations came to our school and educated us about HIV and AIDS and pregnancy. I recalled them saying that for girls who become pregnant (unplanned), it’s important for them to seek medical care and counselling. So I asked my husband that we go to the hospital ...” a 17 years old teen mother Omyianyima H/C III, Kitgum District

Participant no 05

“My daughter was stubborn; I remember occasionally she walked away from me whenever I wanted to guide her. At one time I referred her to my elder brother (her uncle) to help me and talk to her ...” a guardian to a teen mother, Okidi H/C III Kitgum District

Participant no 06

“I always used my experience as a reference point about life, how I grew up as an adolescents; my experience with her father, we had a lot of gender based violence at home and I encouraged my daughter to stay and wait for the right time and the right man to marry ...” a guardian to a teen mother, Lalogi H/V IV, Gulu District

The information generated from the teen mothers shows that they had limited knowledge about adolescence as a stage of transition and also lacked adequate information on adolescents’ sexual reproductive health. Equally, the study revealed that the parents and guardians had limited knowledge and skills on what information to offer regarding adolescence and/or puberty, ASRH and also how such information could be delivered. In some instances, some parents used self-referencing (their own experiences) as a method of teaching and/or referred the teens to the extended family members (uncles, aunties and grandmothers) for support.

4.4 SUPPORT BY COMMUNITY STAKEHOLDERS ON ASRH OF THE TEEN MOTHERS

Under this sub-section, the study established the support that the community stakeholders provided to teen mothers to enhance understanding of ASRH matters. Using the information generated from codes on community support, the study established the following:

- i. Who the community stakeholders were
- ii. The ASRH support that was provided (before, during and after)
- iii. The mode and channel used to offer ASRH to the teens

4.4.1 Community stakeholders that supported teen mothers on ASRH matters

The teen mothers were asked to list the people in their community that supported them on matters pertaining to adolescents’ sexual reproductive health. They also had to detail the support received before, during and after teen pregnancy. In the conversation, the

teen mothers also mentioned the people who gave them support as they were growing up. The responses were tallied and summarised as presented on Table 4.7.

Table 4.7: Community stakeholders that supported teen mothers on issues of ASRH

S/n	Category of community stakeholders	Number of tallies for the community stakeholder category
1	Mother	8
2	Senior woman teacher	4
3	Peers	6
4	Sibling (sister)	1
5	Midwife	4
6	NGOs	2
7	Aunty	2
8	Husband	2
9	Father	1
10	VHTs	2
11	TBA	2
12	LCs	1

From the tallies, the first three commonly listed community members that offered ASRH support were: the mother with the highest number of tallies 8; followed by peers with 6 tallies; senior woman teacher and midwife had an equal number of tallies (4 tallies). The other community stakeholders including NGOs, VHTs and traditional birth attendants (TBAs) and local council (LCs) equally provided some support. Husband, aunty, father and sibling (sister) were also listed among the community stakeholders that provided the ASRH support to the teen mothers.

Some teen mothers reported to have received **support from their mothers ...**

“My mother was very supportive, when she told me what the midwife had told her that I was pregnant and asked me who the boy was ... I told her we were schooling together ... it was disheartening to her but she assured me of support and told me that she would support me in everything until I deliver since I was still young for marriage ...” a 15 years old teen mother Cwero H/CIII, Gulu District

“I remember telling her that she was growing up and she needs to take care of herself and when she’s in menstruation for people not to see her and also avoid

boys who will make her pregnant ...” a mother of a 15 years old teen mother, Lalogi H/C IV Gulu District

Support received from peers ...

Peer 01

“I used to interact with my peers and in a joking manner we would talk about pregnancy. When my period started, I got a lot of support from my peers, my friends told me how to dress when in periods, and that I should have enough panties and if possible buy pads ...” a 15 years old teen mother Lalogi H/C IV, Gulu District

Peer 02

“Even as peers, sometimes we would talk jokingly ...” a 14 years old teen mother from Pajule HC IV, Pader District

The support received from the health workers ...

“The health worker after opening a file for me checked me and counseled me on the following: nutrition, the foods I should eat and the ones I should avoid, gave me iron tablets and told me to attend regular medical checkup since they needed to monitor the baby’s development, examined whether I could give birth normally, counseled us to be faithful to one another and tested us for the HIV and AIDS and screened for STI ...” 16 years old from Omiya-anyima H/C III, Kitgum District

Support received from the husband ...

“I had not known that I was pregnant but neighbours started talking about me that I was pregnant ... I was not comfortable but since I was already staying with my husband, I did not mind so much. I accepted and agreed with my husband to go to the hospital and since then we are living together ...” a 17 years old teen mother from Okidi H/C/III, Kitgum.

Support from boyfriend ...

“We talked about unplanned pregnancy with my boyfriend but in a joking manner ...” a 14 years old teen mother from Pajule HC IV, Pader District

Support received from TBA ...

“I delivered from a traditional birth attendant (TBA). When labour started, I was alone at home and did remember what the health worker told me about the signs of labour. I sent for my boyfriend, who then was away in the garden, my mother-in-law had travelled. The TBA was called and she helped me to deliver from home” a 15 years old teen mother from Cwero H/C III, Gulu District

The findings on the category of community stakeholders that supported the teen mothers links to the socio ecological model (SEM) which describes the interactive characteristics of individuals and their environment that underlies health outcomes. The model recognises individuals as embedded within the larger social systems that include the family, peers and friends (basically these are relationships), institutions and the broader society at large. These systems interact and their interactions influence health outcomes (CDC 2013:4). From the study, the teen mothers stated that the family including the mother, father, sibling, husbands and relatives like aunties plus their peers helped them to understand issues relating to ASRH. At the institutional level; health workers and teachers were listed as part of community stakeholders that played some role in supporting the teens to meet their sexual reproductive health needs.

4.4.2 The type of adolescents’ sexual reproductive health support services provided by community stakeholders to teen mothers

In the conversation, the teen mothers were asked to mention the kind of support and guidance they received as they were growing up to enable their understanding of ASRH. The guidance and support were categorised under three sub-categories; the support rendered to them before pregnancy; during pregnancy and after pregnancy.

The ASRH support and guidance to the teens before pregnancy covered

- Guidance on how to be careful, not to move at night, in lonely and dark places
- Be respectful of self and others
- Warning about unplanned and early pregnancy, HIV and AIDS and STIs
- Telling them to avoid bad peer groups
- Wait until you mature (like when one turns s 20 years) then get married

Support during pregnancy covered

- Accompanying teen mothers to the hospital
- Talking to the health workers on the behalf of the teen mother especially on issues that the teen mother were unable to speak out
- Providing the basics needed for the teen mother and care for the pregnancy

Support after the pregnancy covered

- Providing the basics for the teen mother
- Helping to nurture the baby
- Telling the teen mothers to wait for what the future holds

The report above shows that the support provided to the teens before, during and after teen pregnancy was both physical and emotional. The physical support that was provided included sanitary related materials for menarche and the baby basics materials (clothing), while the emotional support were in form of teaching and guidance on general issues which were not so specific on sexual education and reproductive health issues.

In one of the interviews, a guardian and a teen mother concurred that by at least the age of 9; parents should have initiated some sort of sexual education to the young ones.

Participant 01

“I received the information late ... I wish I was told when I was still about 9-10 years ... a 15 years old teen mother from Pader H/C III, Pader District.

Participant -02

“I thought by then she was still very young (about 10 years then) to be told much about sexual reproductive health and I did not know what to tell her ... unfortunately I left (divorced with the father) and only called to pick her when she had conceived ... a guardian to a teen mother in Cwero, Gulu District.

4.4.2.1 The mode and channel used to support the teens on ASRH matters

In this sub-section, data are presented on how the teen mothers were asked to explain how they were guided; and the mode and channel in which they received the guidance on ASRH. Table 4.8 presents a summary of four major ways that were used to pass on ASRH information.

Table 4.8: Modes of support to the teen mothers

Mode	Circumstances under which the guidance was provided
One-on-one counselling	<ul style="list-style-type: none"> • Occasionally at home, in school and at the health facility • Making self-reference on situation that happened to them or those known to them
Group meeting	<ul style="list-style-type: none"> • In class schools • At health facility during health talks • During community meetings e.g.: Local council meetings, village saving and loan Association meetings and NGO activities (meetings)
Warning	<ul style="list-style-type: none"> • After an observation of defiant behaviour • Having made a mistake • On rumours of suspected sexual activity
Casual talk and jokes	<ul style="list-style-type: none"> • Among peers during leisure time

The results above show different modes and channels were used under different circumstances to promote ASRH. The following are some of the means of communication used: one-on-one counselling, in small groups, warning following behaviour perceived as defiant, and peer sharing that came more through jokes. According to Ola (2012:90), the power of communication cannot be under estimated in any given situation that entails passing of information from one source (sender) to the other (receiver).

Using small groups as mode and channel to communicate ASRH, matters were reported by teen mothers and these were done in different communities including in schools, in hospital (health facilities) and during community events as detailed in Table 4.8. In the

meetings, different topics were discussed with the aim of giving information to promote ASRH. The interviews with services providers (health workers), topics on HIV and AIDS became like an “ice-breaker” to discuss other topics on ASRH; a health worker had this to say ...

“When I receive mothers in the clinic, I use small groups approach during antenatal care (ANC) and talk about their major health concerns; most often the fears of acquiring HIV and AIDS is fronted easily as their major fears so I use that opportunity to talk about different topics on ASRH including pregnancy, care for the pregnancy and other topics on ANC” a health worker from Kitgum Hospital, Kitgum District

Participant 02

“In our community meetings, some of which are called by the local council chairperson, NGOs and other development programs such as village savings and loan association. In such meetings different issues are discussed including HIV&AIDS ...” a guardian to a teen mother, Pajule HC IV, Pader District

The need to substantially involve the community, the role and the contribution of the community in promoting ASRH, the challenges that impede community participation and involvement in ASRH, and recommendations for enhancing community participations have been documented (UNFPA 2007:2; FHI 2006:5-6; Women’s Refugee Commission and Save the Children, UNHCR, UNFPA 2012:16; SYP 2014:8-12).

In the discussion with the service providers including health workers and teachers, these institutions have standardised and structured programmes for delivery of reproductive health as detailed in the Adolescent Health Policy and service standards 2011; the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) 2006 teacher resource book on HIV and AIDS for post primary schools.

Regarding community gatherings, the study did not establish a standard operating procedure to systematically deliver ASRH package for the community to ensure a follow on (a cohort) of group members to receive a minimum package of ASRH. This finding is similar to that of WHO (2004:8) which reports that programmes that link reproductive health and livelihood interventions are currently being designed on an *ad hoc* basis,

without adequate organisational investment and capacity building in specific skills. However, such “linked” programmes have the potential to significantly improve reproductive-health outcomes if they receive adequate support for organisational, managerial and technical capacities that link ASRH programmes to livelihood intervention.

In addition, what remains unclear is a systematic approach and guide to discussing ASRH community. WHO (2004:1), emphasises the need for focusing ASRH according to the demographic and social patterns of adolescents since these differ from community to community and that segmentation of interventions is needed to address the diverse needs and contexts of adolescents’ lives. Also, programmes are most effective when appropriately targeted and tailored to the contexts in which young people live, and to their life circumstances.

4.4.3 Teen mothers’ coping with teenage pregnancies

Under this sub-section, the study established how the teen mothers coped with teen pregnancy. Using the information generated from codes, the following was established:

- i. How the support helped the teen mothers to cope with teenage pregnancy
- ii. Explored the challenges that affected the coping with teenage pregnancy
- iii. Described how the teen mother wished to have been supported

4.4.3.1 The support that helped the teen mothers to cope with teen pregnancy

Coping is a constructed and contextual concept, but reflects human basic behaviour and how an individual responds to social problems to maintain social well-being and satisfaction with social support and this depends on one's personal needs and the social resources provided to the fulfil those needs (Bercum 2013:15). Studies have shown that teenage mothers are physically, mentally, and emotionally not ready for parenthood as most often the pregnancy is unplanned, and as a result, the teens react to teen pregnancy differently. Most often, the teenager mother has to come to terms with the unexpected demands of being an adult, and in some cases, they also have to deal with disapproval and dissatisfaction shown by significant others like parents and relatives (WHO 2011:8; Pogoy, Verzosa, Nerlie & Ronalissa 2014:159; Dube, Marc & Nitaya 2013:60).

According to Pogoy *et al* (2014:161), teen pregnancy and childbirth therefore impose difficult long-term outcomes and have adverse effects not only on the young mother, but also on her child.

In this study, coping was used to explore the process by which the teen mothers managed to achieve physical, social, emotional and psychological well-being during their pregnancy and motherhood. The teen mothers were asked to explain how they felt about the support that helped them to cope and handle the teen pregnancy.

The responses generated on the kind of support received were grouped under the following sub-headings (a-c below):

a) Material and emotional support from the family members

Teen mothers reported that they received pledges and assurance for on-going support from their guardians, especially their own mothers. The support was material, emotional and financial and this enabled the teen mothers to get the basics for the pregnancy and baby items such as clothing after delivery.

One of the guardians had this to say ...

“I talked to my daughter again and again and assured her that I will look after her and help her in any way I could ... I felt very bad about my daughter’s pregnancy but I had to stay calm and as I pledged, I have been supporting her since then ...”

Lalogi H/C IV, Gulu District

b) The medical support received from the health facilities

The visit made to the health facility, the counselling and the medical support given by the health workers helped the teen mothers to cope with the teenage pregnancy. One of the teen mothers had this to say ...

“The counselling by the health workers was so useful, I felt very strong and encouraged since the health worker educated me on teen pregnancy and what I

should do and also I was referred to Kalongo Hospital where it would be safer for me to deliver from and in case of any emergency, the hospital is more equipped than Pader health centre III ...” A 15 years old teen mother from Pader H/C III, Pader District

c) Support from the spouse (the partner)

The teen mothers who were living together with the spouses felt a sense of protection and belonging and this helped them to cope. The following were extracts from their stories

...

Participant 01

“We have now lived for about 10 months. Basically we grow food (doing farming) to support our domestic needs and as a source of money. We sell the food sometimes to get money like today for coming to the hospital ...” an 18 years old teen mother, Omyianyima H/C III Kitgum District

Participant 02

“I am now 4 months pregnant; I have been so sickly and I could not do much to support myself. Basically I rely on my husband to provide for us ...” 16 years old Okidi H/C III, Kitgum District

4.4.3.2 Challenges that affected the coping of the teen mothers

The researcher explored the challenges that hindered the coping ability of the teen mothers. The participants were asked to talk about the challenges that could have affected their coping with teenage pregnancy. The responses generated depicted the following sub-categories of challenges:

- Community-oriented
- Family-centred
- Individual level

The challenges as highlighted by the teen mother are categorised and summarised in Table 4.9.

Table 4.9: Challenges that affected the coping of the teen mothers

Category of challenge	Challenges reported
Community-oriented challenges	<ul style="list-style-type: none"> • Denial of the pregnancy by the responsible men due to fear of being arrested for defilement • A lot of community stigma • The abandonment by the men who impregnated
Family-centred challenges	<ul style="list-style-type: none"> • Pressure from other family members especially father and the brothers for forced marriage (culturally, a girl child who conceives before marriage leaves home and joins the husband) • Blame on the girl and the mother for the teen pregnancy • Communication and lack of skills to talk to the teen mothers
Individual level challenges	<ul style="list-style-type: none"> • Fear of living together as a couple, the family expectations • Inadequate knowledge and skills to handle and take care of a baby • Inadequate knowledge of pregnancy stages • Fear about breast feeding • Lack of basic needs including food, clothing and other support needed to prepare for baby • Long distance to the facility was a big challenge due to transport problem • Self-stigma, still mindful of the looks and appearance

The findings generated at all the three levels (community oriented, family centred and individual teen mothers' level) in Table 4.9 were considered collectively and the following themes emerged:

- Stigma and discrimination
- Limited knowledge and skills to care for the baby
- Worries about their looks and appearance
- Sole parenting

Stigma and discrimination

According to Agunbiade Ojo, Titilayo and Opatola (2009:6-7) citing (Goffman 1963), stigma is “the phenomenon whereby an individual with an attribute is deeply discredited by his/her society or rejected as a result of the attribute. It is a process through which normal identity is influenced negatively by the reaction of others”. Stigma is construed as a relational attribute which is stereotyped to produce a mark that links a person to undesirable characteristics or result in discrimination.

At the family level, the fathers and brothers led in the discrimination and disapproving the teen pregnancy as a shame and a disgrace to the family. In the qualitative report, the following sentiments were captured ...

“I got a lot of blame form the community, asking why I left my daughter after divorcing and that why do I bring her home (in the new re-married home)...the brothers wanted her to get married off since having her home with the pregnancy and the baby is a shame to the family”

and again

“The community expects the girl child who gets pregnant to stay/live with the husband/boy who made her pregnant... The blame is always on both the girl and her mother not the boy. If you are not a strong mother, you may be swayed by the pressure and accept the girl to be married early...” a guardian from Cwero, Gulu District

“I experienced a lot of community stigma, many people talked about my pregnancy and wanted me married off, only my mother stood by me...”a 15 years old teen mother from Cwero H/C III, Gulu District

Limited knowledge and skills to care for the baby

This study discovered that lack of knowledge and skills of caring for and nurturing the baby coupled with limited awareness on pregnancy and its progression hindered the teen mothers' coping abilities at different stages. In the qualitative interviews, the following statements depicted the teen mothers' experiences on lack of knowledge and skills ...

Participant 01

“I feared that I may sleep on my baby at night and wondered if I sleep on the same mattress with my baby, won't I sleep on the baby? ... and every stage of my pregnancy has been very challenging, I got tired with the pregnancy and wanted it done ...” a 16 year old Cwero H/C III

Participant 02

“I do not have adequate knowledge and skills to handle and take care of a baby, and am worried of what will happen to me after giving birth ...” a 15 year old Pader H/C III

Participant 03

“The health workers told me I was still young and may not give birth normally and they advised me to plan for C-section in main hospital (Gulu Hospital) ... I wondered how I would give birth then, and I feared so much the operation (C-section) ... this is making me worry a lot and in addition, knowledge on baby care, breastfeeding and how to get other requirements for the baby like clothes and other requirements for delivery ...” a 15 year teen mother, Lalogi H/C IV

Participant 04

“As health workers, we do not have a specialised midwifery training to handle mothers with special antenatal and postnatal care such as for adolescent mothers...but with experience and plus sound judgment we assess, consult amongst ourselves and make appropriate referrals ... for very young adolescents say 14 or 15 years, since we do not have a functional theatre, we normally make early referral to the main hospital like Kitgum or Kalongo Mission Hospital” a midwife from Pajule H/C IV, Pader District

Worries about looks and appearances

The study found that the majority of the teen mothers was concerned about their looks and appearance and wondered how they would be seen in public with protruding bellies while not attired in maternity dresses. This was largely an issue with those teen mothers who couldn't afford the basic requirements for the baby and their own requirements. The self-imagination with a protruded belly created a lot of self-stigma especially among those teen mothers who were living with other guardians other than with the man responsible for the pregnancy. In most instances the teen mothers avoided public places like health centres and the market, preferring to be and engage in designated domestic chores.

In the qualitative interviews, some views on the teen mothers' concerns about their looks were highlighted ...

"I needed to look good, but my parents cannot afford even buying good clothes for me and this worried me a lot, I wondered how I will look with the pregnancy in my ordinary clothes and moving in public places like to the hospital and market places ... I like staying home and helping with house chores ..." a 15 years old, Cwero H/C III, Gulu District

"Whenever my daughter was due for her antenatal appointment, I used first to book with the midwife so that when she goes, she is attended to promptly ... she expressed a lot of fear lining up with other older women who most often were found of backbiting...and whenever I was free I would accompany her to the hospital ..." a guardian, Lalogi H/C IV Gulu District

"Very few of the teen mothers can afford to buy what they need for antenatal and personal care, we try to talk and counsel them to plan and buy the requirements but most of them rely on their mothers and yet the mothers also have difficulties in getting money...sometimes health workers come in to help and this is not professional..." a health worker from Pajule H/C IV, Pader District

The current study found that 73% (n=11) of the teen mothers had given birth before marriage, something which created a lot of anxiety. It is not surprising that major concerns centred on their physiological appearance which resulted in self-stigma with a lot of uncertainties' on their future life. The 27% teen mothers who lived as couples (wife and husband) had their own unique problems which were not centred on their looks but rather on how to fulfil their roles as recorded by one couple ...

"I am now 4 months pregnant; I have been so sickly and I could not do much to support myself. Basically I rely on my husband to provide for us ... 16 years old Okidi H/C III, Kitgum District

Teenage sole parenting

Seventy-three percent (73%, n=11) of the teen mothers were living as single teenage parents since the men responsible either denied the pregnancy or disappeared at the time of the interviews. The teen mothers were left under the guardianship of their parents and/or relatives. During the interviews it became clear that the state of sole parenting created a lot of stress among the teen mothers which impacted negatively on their coping. The hindrance factors relating to sole parenting can be classed as psychological, social, emotional and economical. Some of the qualitative reports by some teen mothers are depicted in the excerpts that follow:

Participant 01

“I have many challenges let alone having no access to basic needs ..., if my baby is sick I get so worried especially at night, I stay-up alone since my grandmother is now old ...” a 15 years old teen mother, Lalogi H/C IV, Gulu District

Participant 02

“I cannot afford to buy baby and my other requirements to prepare for my delivery, the man who impregnated me disappeared, am so worried ...” a 15 year old, Pader H/C III, Pader District

Participant 03

“I am not working for a paid job, I only help my parents at home and do house chores and yet I have many needs that my parents can't afford, “maybe if I was leaving with my boyfriend, probably he could buy them for me...” a 16 year old teen mother from Kitgum Hospital, Kitgum District

4.4.4 How the teen mothers wished to have been supported

The researcher asked the participants to explain how best they wished to have been supported. The following themes emerged from the participants' coded responses:

- Lack of timely and sufficient ARSH information

- Adequate knowledge on life skills to support healthy relationships with their peers
- Harmony and a supportive home environment

In the qualitative interviews with the participants, the following reports were depicted:

Lack of sufficient and timely ASRH information

In terms of adequacy of ASRH that teens talked about, beyond mere sharing information on how to dress up and or guidance on personal care during menstruation (menstrual hygiene), most of which, the support came from the peers.

Participant 01

“Mothers should give information early enough to their daughters say by 9-12 years a girl child should have known the basic about pregnancy and its prevention ... but my mother did not give me adequate information by saying I should stay away from boys, it did not help me actually my peers helped me more ...” a 15 year old teen mother Lalogi H/C IV, Gulu District

Participant 02

“Early guidance is important; adolescents should receive early support about what they expect to see in terms of changes in their bodies. At least by the age of 9 years, adolescents’ girls should begin to learn about adolescence...” a guardian from Okidi, Kitgum District

Harmony and supportive home environment

It was reported that there was lack of harmony in an unsupportive home environment. The teen mothers reported that they experienced a lot of gender-based violence in their households.

The majority of the teen mothers experienced difficulties in meeting their basic needs. They reported to have experienced both physical and verbal abuses. The majority sought economic survival by engaging in informal casual activities such as being housemaids in

the nearby business centres or the neighbouring districts. Those who were working away from home had become independent, and some took up adult roles at a tender age. Coupled with abundant networks of peers that influenced their choices on a day-to-day basis; some reported to have enjoyed night discos with friends, stayed out late, and had freedom and with less adult or parent supervision, the teens engaged in risky sexual activities and for some teens they were labelled prostitutes as reported by one ...

“My father used to insult me a lot, that am useless and there is nothing he expects out of me and that I am just a prostitute ...” reported by a 15 years old in Pajule H/C IV, Pader district

Participant 03

“The family members should remain united. Any conflict between the mother and the father directly impact on the children ... I wished my parents had lived together... most probably this could have not happened to me ...” a 16 years old teen mother Kilak H/C III, Pader District

In the current study, the majority of the teen mothers reported that the peers were very helpful and one had this to say:

“When my period started, I got a lot of support from my peers, my friends told me how to dress when in periods, and that I should have enough panties and if possible buy pads...” a 15 year old teen mother Lalogi H/C IV, Gulu District

The importance of life skills to adolescents

Regarding life skills, most of the teens talked about the importance of life skills, they were aware that life skills could have enabled them live a healthy relationship with their peers, which unfortunately most of the teens did not have the life skills. One teen mother had this to say ...

“We used to move together with my friend and do most of the things together such as going for night disco, markets and other busy places/centres for leisure time, if

I had life skills probably I would managed to protect myself ...” a 14 years old,
Cwero H/C III, Gulu District

4.5 FINDINGS FROM KEY INFORMANT INTERVIEWS AND FOCUS GROUP DISCUSSIONS

Phase II sub-study I and II data analysis and interpretation and findings

4.5.1 Introduction

The main objective of Phase II sub-studies I & II was to establish how socio-cultural factors influenced the role of the community in supporting adolescents’ sexual reproductive health (ASRH) on the Acholi, the community which was affected by over two decades of civil strife (the LRA war) that lasted from the years 1986 to 2006.

The above objective was achieved through the following:

- i. Explored the Acholi socio- cultural norms that influenced adolescents on sexual matters
- ii. Established the impact of the Lord’s Resistance Army (LRA) war on the socio-cultural norms of the Acholi in promoting sexual education among adolescents
- iii. Explored the influence of mass media on the socio-cultural norms of the Acholi in promoting sexual education among adolescents
- iv. Established the influence of the current education system on informing the Acholi traditional norms of teaching adolescents sexual matters

4.5.2 The ACHOLI people

Before exploring the socio-cultural norms and values that the Acholi people used to teach children and young people sexual matters, the study firstly explored who the Acholi people really are. The sub-section below provides a brief description of the Acholi as an ethnic group, their traditions, religion and family set up.

4.5.2.1 The Acholi ethnic group

Acholi is a Luo Nilotic ethnic group found in Northern Uganda. It is believed the Acholi migrated from Southern Sudan in *Bahr el Ghazal* and they settled in the present Acholi land that comprises seven districts which are: Agago, Amuru, Gulu, Kitgum, Nwoya, Lamwo and Pader (Amone, Apiyo & Okwir 2013:127).

4.5.2.2 The Acholi traditional chiefdoms

Traditionally, the Acholi were structured socially under chiefdoms headed by *Rwodi* (Chiefs). The chiefs traditionally came from one clan and each chiefdom had several villages made up of different patrilineal clans. The Acholi communities were organised in hamlets and the dwellings were in circular huts with a high peak roof furnished with a mud sleeping platform and well set-up homesteads; members of the homesteads had a strong communal responsibility and supported each family and shared the responsibility of child upbringing and this practice promoted respect and discipline among children, homesteads and families (Whitmire 2013:18).

4.5.2.3 The Acholi traditional religious practices

Prior to colonialism, the Acholi had strong traditional beliefs, norms and customs that greatly influenced the chiefdom building process and through these traditions, rituals were performed to symbolise identification, legitimation, and unification of the Acholi clan members (Whitmire 2013:20). The norms were founded on the traditional religious (spiritual) beliefs on supernatural powers that were derived from '*jogi*' the 'small gods' and through the '*jogi*', different rituals, symbols and traditions were performed during different times and occasions (Whitmire 2013:23). For instance, marriage as a ritual was defined to mean clan members who lived together were considered relatives and no one could marry from the same clan. The hamlets homestead settlement communicated and depicted the relationship and this protected the children from marrying relatives (incest) and in the event of intermarriage, traditional rituals were performed to cleanse the families from getting bad omens.

4.5.2.4 The Acholi traditional family role and socialisation of children

Organisation within the chiefdom depicted the larger Acholi traditional family settlement with three important subgroups within the domain: households, hamlets, and villages (Whitmire 2013:29). Within the domains, there were defined gender roles for men, women, boys and girls and socialisation were done according to the defined customs, for example a hamlet was the extended family dwelling that a household belonged to; within the hamlet, a communal fire was put at the centre of each hamlet and this was the family class forum, while at the village level, age-sets and initiation schools for boys were carried out for instance boys went hunting together and during such activities fathers socialised boys according to the Acholi customs. Likewise, girls participated in women defined activities where mothers socialised with girls and shared on the expected norms such as weeding, moving together with girls to fetch water and firewood. Mothers used such times to have meaningful conversations with the girl children (Whitmire 2013:30).

In one of the interviews, this was recorded ...

“The Acholi culture was very rich, different approaches were used to socialise people in to marriage preparation including: parents of both sides actively took part in identification of partners for their children, at some age when the children were considered mature, they allowed them to participate in courtship activities like Larakaraka dance, sending mature girl to visit the aunty (normally paternal aunty) and were also allowed to go market places ...” KII with cultural leader

4.5.3 The ACHOLI socio-cultural norms for sex socialisation

The study explored the specific Acholi socio-cultural traditions and norms that were used in socialisation of young people on sexual matters. From the interviews conducted with different study participants who included cultural, religious and local leaders and parents, the themes presented in Table 4.10 emerged.

Table 4.10: Emerging themes and sub-themes on the Acholi socio-cultural norms of socialisation of adolescents on sexual matters

Emerging themes	Observation on the themes	Challenges noted and eventual outcomes
The family class- the evening fire place (referred at as "wangoo")	The wangoo was a good family time for parents to teach children on different issues through stories and riddles	The stories and riddles were not documented so parents (fathers) would refer to what was told to them by their parents through word of mouth
Gender dimension in teaching children	Mothers, aunties and grandmothers taught girls. Fathers, uncles and grandfathers taught boys. Teaching were done during gender defined activities (for example during weeding, fetching water and firewood for girls) and for boys during grazing animals and hunting	The teaching was in form of stories and direct or indirect self-referencing. And these - were equally not documented
There were designated sleeping arrangements for children (boys and girls) and parents	The homesteads had different huts meant for different purposes say the kitchen (the Mother's hut (was used by girls for sleeping, a girl was not supposed to sleep alone in the hut). The father's hut (sleeping house for mother and father) which was known as "ot-otogo" and for grown up boys each had a hut also known as "ot-otogo"	The sleeping arrangement by instinct (children did not have to be told why parents had theirs, why girls would sleep together in the kitchen and why grown up boys had "ot-otogo" the fathers and boys were the ones who had the privilege to own a hut while the mothers and girls had kitchen as their own which could at the same time be used for sleeping The sleeping separation created the sense of privacy and respect for the opposite sex at the family level which the children learnt by instinct
Parents used to monitor signs of growth and development in children and offered appropriate socialisation and teaching	Mothers were so keen on girls and the body changes for girls were received with lots of curiosity while for boys the changes were considered gradual, with less tension	The mothers were quick to inform the fathers about anybody changes and the parents discussed possible avenues to enable the girl child start courtship (allowing the girl child join courtship dances (<i>Larakaraka</i> - calabash dance), go to market places, visit the aunty (<i>Wayo</i>) And for the boys, the mother monitored closely the girl who came to <i>ot-otogo</i> (the boys' hut) and quickly reported to the father These arrangements promoted family hierarchy with defined command and communication channel. These meant that the mothers had to be close to the children to be in position to observe the changes and development in children
There were designated people to talk to children about sex for instance grandparents, uncles and aunties. The aunty was locally called "Wayo"	Due to cultural sensitivity about sex, talking about it was taken with precaution	Parent-child sex talk culturally had a lot of shame and so the designates were not the biological parents and therefore the sexual education did not carry a lot of shame Additionally, the designates were considered mature and had the experience and skills to talk about sex (use of some words which were selected carefully, less shameful and carried the same meaning of sex), however, such words were not documented
The purpose for sex was for marriage and procreation	Parents took active role in identifying marriage partners for their children	Marriage arrangement and approvals were done by both the parents of the boy and the girl and once the marriage was done, it earned the children the rights to start sex

4.5.3.1 The evening family class - 'wangoo'

The Acholi had a designated “family class” known as ‘wangoo’ or the evening fire place. Wangoo was a good family time for parents to teach children on different issues through stories and riddles and the teaching covered different aspects of life and to instil good morals in children. The teachings were passed through the word of mouth. The communicants (parents and designate family members for instance the grandparents) used their wisdom obtained through experience and what their parents told them. For example a story can depict a good family, the role of the father, mother and the children. The following except is from one of the interviews ...

“traditionally, parents and especially the fathers had a big task of ensuring that his family is seen to be a model in the community, the evening fire place was a must attend for all children and during the family class, the father prevailed over his family and taught children different aspects of life and growing up to become a responsible person...” a cultural leader

4.5.3.2 The Acholi had divided gender roles in grooming and teaching children

It was reported that mothers, aunts and grandmothers ‘moulded’ girls to become future “mothers” that the family wished them to be. The fathers, uncles and grandfathers concentrated on teaching the boys. The teachings for the girls were mainly done during gender defined activities (weeding, fetching water and firewood and for boys during grazing animals and hunting. In both instances the teachings were not necessarily documented and took the form of stories and direct or indirect self-referencing ...

“traditionally there were gender divided activities that parents and their children participated in together that made it very easy and gave opportunities for parents to talk to their children (the gender dimension of teaching)” a cultural leader

4.5.3.3 There were designated sleeping arrangements for children (boys and girls) and parents

During the discussions, it emerged that traditionally, Acholi homesteads had different huts meant for different purposes. The kitchen (the Mother’s territory- the cooking hut) and the

kitchen hut were the sleeping places for girls. The paternal grandmother would share the kitchen hut with the girls and during sleeping time the grandmothers took an opportunity to tell stories to the girls. Girl children were not allowed to sleep alone in the hut, an arrangement which ensured both security and protection from early initiation to sex meant to preserve girls as virgins until marriage.

The fathers' sleeping hut locally referred to as 'ot-otogo' was shared by both parents (father and mother). For men who had multiple wives, the women would visit the 'ot-otogo' in turns according to the timetable set by the man. Wives awaiting their turn joined the girls in the kitchen and slept there.

In equal measure, boys also had their separate sleeping areas. Boys either slept as boys alone or with the grandfathers. When the boys were considered to be mature, they were allowed to construct 'ot-otogo' (sleeping hut) an indication of boys' maturity for marriage. These different sleeping arrangements did not have to be explained to the children; rather the sex socialisation was learned by instinct.

Traditionally, the sleeping arrangements depicted the male dominance in the family setting. Fathers and boys were the ones who had the privilege to own a hut while the mothers and girls had kitchen to share and use as a sleeping space. Further, the sleeping arrangement created a sense of privacy and respect for the opposite sex at the family level.

Additionally, the sleeping arrangement depicted the patriarchal inheritance whereby the boys had the privilege to construct their own sleeping hut "ot-otogo" at home. On the contrary, girls used the kitchen for sleeping, as at some point they were expected to be married off and leave the parents' home.

4.5.3.4 Parents used to monitor signs of growth and development in children and offered appropriate socialisation and teaching

It was reported that mothers paid close attention to the girls and closely monitored the body changes in girls. When changes were noted, precautions were taken and the mothers also made a report to the father. The parents would then discuss the process of transition of the girl from childhood to womanhood. For instance the parents would allow

the girl to go to social places like markets; attend courtship dance *Larakraka* and also visit the paternal aunty (locally called 'wayo').

The transition to marriage was overseen by the aunty ('wayo') who pronounced to all other suitors that a girl had made her choice before the sharing the news with the parents who proceeded to carry out family background checks before their approval after which an official marriage arrangement could be done.

The socialisation process for boys was gradual and had less tension with boys allowed to explore and develop in order to become responsible for the home. The boys who were considered mature for marriage built their own huts and during this period, the boys participated in courtship activities similar to those of girls. When a boy finally settled the "would be wife", the girl then visited the boy's parents during the day time. During the courtship period, the parents performed thorough background check for both children and if they granted approved then official marriage arrangements commenced in similar fashion to that of the girls.

The mother was the first point of contact in this process and where everything was in order, a report was given to the father. These arrangements promoted family hierarchy with properly defined command and communication channels. This necessitated mothers to be close to their children to support and monitor their behaviours. The same hierarchy was followed in cases of lack of discipline whereby a mother who felt that the children were defiant, would still communicate to the father who would then instigate serious family measures were taken to correct such behaviours.

4.5.3.5 Designated people talked to children about sex and used appropriate words

Like most African communities, the Acholi were very conservative in talking about sex. Where such talks took place, a lot of precautions were put in place leaving only designated people like paternal aunties, uncles and grandparents to initiate. Parent-child sex talk was culturally considered to be taboo, as such children were forbidden to discuss sex with parents. Direct parent-child talk on sex was discouraged hence the other designated people supported the parents.

The designated people were not the biological parents and therefore the sexual education did not carry a lot of shame. The designated people were considered mature and had the experience and skills to talk about sex (use of some undocumented words which were selected carefully, less shameful and carried the same meaning of sex). For instance, during the FGDs with different study participants some words which were used to describe sex surfaced ...

“Butu ki awobi onyo anyaka” meaning sleeping with a boy or a girl

“Rwate ikin awobi ki anyaka” meaning joining between a boy and a girl

“Ribe ikin awobi ki anyaka” meaning coming together between a boy and a girl

“Toro ot ki awobi onyo anyaka” meaning sharing a hut with a man and a woman

The words to describe sex which emerged from the FGDs were merely descriptive and did not have any direct sex connotation. The indirect use of words to describe sex depicts a lot of respect that was attached to sex and the lack of openness on the subject.

Through the researcher’s experience in Acholi language, it is complex since one word can have different meanings. A case in point is the description of sex as used above where an of ‘*ribe, buto, rwate, toro*’ can mean sex thereby making it complex to teach or write as standard words for use.

4.5.3.6 Sex was for the purpose of marriage, procreation and multiplication

Referring to section 4.5.3.3 above, right from childhood, the sleeping arrangements precipitated learning of sex by instinct. Parents took an active role in modelling and preparing their children for marriage; the family ensured that the girl children were protected and kept their virginity until marriage through the sleeping arrangement.

At the ‘right time’ the parents took an active role in identifying marriage partners for their children and marriage arrangement were signs of approval that the children were grown and the marriage earned the children the right to start sexual relations as sex was meant for procreation and multiplication.

Later in life after marriage, traditionally, when parents ended procreation/multiplication for instance after menopause, the elders (grandparents) changed the sleeping arrangement which was an indication that sex was meant for procreation.

Also, sex for procreation was timed (the traditional family planning method), for instance lactating mothers either wilfully (by choice) or by force (male influenced) slept in the kitchen with the girls. In polygamous families, non-lactating wives would then visit the 'ot-otgo' more frequently and this practice continued until the wives had as many children as possible. Naturally, these practices promoted child spacing (traditional ways of family planning) whereby say every two years, the wife and the husband cautiously had sex for procreation purposes.

4.6 THE IMPACT OF THE LORD'S RESISTANCE ARMY (LRA) WAR

4.6.1 Background of the LRA war

Uganda has been ravaged by civil war and ethnic tensions (Beard 2011:4). In 1985, Northern Uganda experienced tensions when war broke out between the Ugandan government and the Lord's Resistance Army (LRA) which was led by Joseph Kony.

The LRA gained power through horrific massacres and killings as Kony advanced radical beliefs of Acholi military extremism rejection of trust in the Ugandan government. Kony's main objective was to cleanse Northern Uganda of the older generation of the Acholi people, and rebuild the culture according to his own ideologies. In order to accomplish this objective, Kony chose to enlist an army of children who, through violent force, helped him to exterminate the Acholi population (Cheney 2005:32).

4.6.2 The impact of the LRA war on Acholi traditions

The LRA war that lasted for two decades (1986-2006), greatly impacted Northern Uganda and it destroyed the physical, cultural, emotional, social, and economical lives of the Acholi community. The people were battered, bruised, tormented by grief, lived in a state of despair and fear. As noted, "the extent of suffering according to international benchmarks constituted an emergency out of control." The livelihood, the culture, the

children, the public health, and the family structure and life of the Acholi community were completely interrupted (Uganda Peace Foundation Initiative [UPFI] 2014:3; IRIN 2014:5).

The current study was carried out 10 years after the LRA war ended in 2006. The subsection below provides details on the study findings on the impact of the war on the Acholi traditions. Specifically the impact, which is documented in this study only depicted changes that the war caused in the socialisation of children on sexual matters as detailed in the emerging themes in Table 4.11 below:

Table 4.11: The emerging themes and sub-themes on the impact of LRA war on the Acholi socio-cultural norms of socialising young people on sexual matters

Emerging themes	Details of the impact (sub-themes)
IDPs camp life changed the economic gender roles for men and women and family life	The family teaching forum/class (the evening fire place- wangoo) concept was completely interrupted
	It brought changes in gender dimension of the family roles as women became more empowered and men became disempowered
	The IDP life changed the traditional sleeping arrangement of the Acholi family
	Some children took became independent and took up adult roles and responsibilities
	The IDP life led to high moral decadence among the community; some men resorted in to over drinking of alcohol that subsequently, led to a lot of gender based violence among households and in the community
Many children became orphans	Many children lost one or both parents and some lived in child headed households
Early marriage and early start of child bearing	Due to the war, social services including education system was interrupted, some children dropped out of school and ended up in to early marriage
Transactional and cross generational sex	Life in the camps was very difficult, since the parents did not have adequate means of supporting themselves. The children did not receive the basics for life and some girls ended up engaging in transactional sex and cross generational sex a means of survival
Weakened social capital and sense of belonging among families and communities	The camps brought people from different backgrounds and families with different ideologies and values. Lack of shared ideologies among the people in the camps weakened the social support to each other
The war created a state of helplessness among men as head of households	In Acholi parents especially the father was seen as the main source of protection as the head of the family. But during the war, children were abducted in the presence of their fathers. This created a state of helplessness among fathers

4.6.2.1 *The impact of the internally displaced persons (IDPs) camps on family life*

The family is the smallest unit of society and the family is of mainly two types, the nuclear and extended families. The nuclear family comprises father, mother and children whereas the extended family is typically multigenerational and may include three or more generations of parents, children and grandparents (Zonta 2016:7). According to Mabuza, Thwala and Okeke (2014:2252), the family is an important unit in the society. It is the first socialising agent the child interacts with and it has great influence on the child's physical, mental, moral and social development. The family's most outstanding responsibility is to train and bring up the child in the norms and values of the society.

4.6.2.2 *The family lost the family school domain "the wang-oo"*

The wang-oo, was a very important class in the Acholi family, but as a result of the LRA civil war, the family set up of the Acholi people was interrupted as people were forced in to IDPs and in the qualitative views of the participants, the following were reported ...

"The war brought different changes on the Acholi family life, when people were forced in to IDPs camps, the traditional approach of teaching children moral values were completely eroded ..." Cultural Leader

"Now we do not have the fire-place that was previously used by men (fathers) mostly to teach children different aspects of life, so nowadays father have less opportunity to talk to their children about life. This change started during the IDP camp life and it has continued up to day ... men have lost out on their role of teaching children different aspects of life ..." Parents FGD, Bwonagweno, Gulu District

4.6.2.3 *The IDP life changed the gender dimension of family roles*

As detailed in Section 4.5 of this chapter, the Acholi family had clear gender roles at family level which were disrupted due to life in the IDPs leading to, gender roles of the family being totally changed. During the different interviews, the community narrated a lot of changes that came up as a result of displacement.

Traditionally, the father was head of household and their source of livelihood used to be agriculture (cash crops like cotton) and cattle rearing to supplement the family income. However, when men came to the camps this was all lost. It was risky for men to leave to camps (due to fear of abduction) as such; women had to move out of the camp to fend for the family, something which impacted greatly on the psychology of both women and men. This state of affairs disempowered men who lost the original authority and became beggars leading the majority of men to resort to excessive alcohol consumption. This state of powerlessness further meant that the men lost the “**voices of teaching at home**” and the excessive alcohol consumption fuelled violence at home.

To the contrary, the women who went out to look for food for the family felt more powerful and had more authority in the family. Without the efforts of the women children would go without food. This state was totally paradoxical and was presented in a couple of views in the subsequent paragraphs.

“In the Acholi tradition, the man is the head of household, but because this position was threatened by women economic empowerment, men resorted in to over drinking alcohol and through the influence of over drinking a lot of gender based violence were experienced in homes ..., partly men wanted to use violence to retain their power ...” FGD with cultural leaders

“we men are doing badly, before the war we had herds of cattle, could grow cotton as cash crop but all these are no more nowadays ..., men used to sell the food ratio that were given as hand-out by World Food Programme(WFP) to get some little cash ... contrary to women the government has come out with different economic empowerment programs that target the women, and most women are now engaged in petty businesses (‘Awaro’) and as such women have little time at home to monitor, supervise and teach the children” FGD with Parents

“Women who have money are very difficult to control. Due to the war, more women became economically empowered compared to men. Naturally, the men’s self-esteem to direct home affairs is threatened. And some separated/divorced and other men decided to leave their responsibility to the mothers to bring up children single handed ...” FGD with cultural leaders

“Most men have neglected their homes. Women are the ones taking the family roles, even in school meetings and paying school fees, the war has affected men

mostly, even if you are to go anywhere here, you will not find men helping the women. Even the ones, who are employed, will not take care of their children. They are the worst. They come home late and the child calls anyone who comes home, daddy. Before the war in Northern Uganda, men were responsible, but due to the impact of the war, most men have gone insane everywhere” ... KII interviews with religious leader

The change in gender roles was paradoxical to the norms of patriarchal society. Men became redundant, helpless, and dependant on women. This was depicted as follows ...

“Life in the IDPs made men become “children”, they could not help themselves and their families, instead women were the ones who used to support in running the families ...” FGD with cultural leaders

Similar findings on the weakened position of men leading to economic vulnerability have been reported in war ravaged communities in Somaliland. . Families suffered severe economic distress due to loss of income and women were compelled to take on the role of the family breadwinner because many men were either involved in the war or unemployed and that as a result of displacement, the family underwent a fundamental social and cultural transformation, marked by a gradual erosion of societal norms and values; there was an abrupt change in the economic role of women, which represented significant departure from the tradition (Sucaad 2002:12).

4.6.2.4 *Camp life changed the traditional sleeping arrangements*

Again referring to section 4.5, the Acholi traditional sleeping arrangement depicted many teachings, which did not have to be verbal. Many aspects of sexual socialisation were learned by instinct through what was derived from the sleeping arrangements. The phrases below were picked during the discussions ...

“Parents used to share rooms with their children in the camps and children learned bedroom matters (sex) through what they saw/heard and witnessed while in the IDPs and the influence of alcohol and redundancy that men experienced made most people (men and women) resort in to casual intimate behaviours and children got exposed to sexual scenes and some children started practicing what they saw”
FGD with Parents, Lila Village, Pader District

“Some children were exposed to sexual matters when they were very young for instance at 6 years, a child could see what the father and mother did in bed”. Such exposure forced some children to engage in early sexual debut ...” KII with religious leader

For those who were not living in IDPs, the concept of night commuters emerged as some children opted to commute daily at night to look for safe abode. Sleeping in hospital verandas, bus parks, church grounds and in local factories, the children travelled wherever they could in order to feel a sense of safety and comfort. Although many of these children had yet to suffer the fate of becoming child soldiers, the night commuters were living in a horrible reality ..., and it did not only threaten the children’s stability, but it also deterred the advancement of education and increased the likelihood of children engaging in unprotected sex at early ages.

This was reported in one of the FGDs ...

“The war affected children in many ways, some children became sexually active for instance by eleven years some children had initiated sexual activity ...” Parents FGD, Lila Village

To help visualise the family life set-up in the camps, according to a report by Uganda Peace Foundation Initiative (UPFI) (2014) evidence shows that camps were massively over-congested; for example Pabbo (in Gulu) and Kalongo (in Pader), had a population of 72,000 and 55,000, respectively all condensed into a space of 1 square kilometre. This translates into a space of **16 m²** for each person, whereas the recommended minimum surface area for each person is **45 m²**. In addition, the same report shows that most of the camps had less than 1/4 of the area recommended in such emergencies. Families of 6–8 persons had to pack themselves, ‘sardine-like’, into a tiny hut of **1.5** meter radius. The minimum standard for such emergencies is **3.5** square meters per person.

During the camp time, three generation family shared the same sleeping arrangement for instance the children, parents and grandparents had to sleep in the same living space and this was totally contrary to the Acholi tradition of sleeping arrangement that carried a lot of privacy, respect and dignity. This was depicted ...

“Culturally, it is very sensitive to talk about sexual matters to children and yet with the camp housing arrangement, parents needed to have talked to their children about sexual matters ...” FGD with parents Omyanyima Village, Kitgum District

The lack of parental guidance on sexual matters therefore meant that some children had to explore sexual matters for themselves.

4.6.2.5 *The war made some children become independent from their parents*

From the discussions, it was noted that due to the war, some parents who had connections with relatives or friends sent their children to towns and cities to avoid the risks of child abduction. While in the cities and town, some children got involved in casual employment such as hawking foodstuff for business owners, house maids for girls, *bodaboda (motorcyclist)* transporters for boys among others. This state of affairs enabled some children to become independent financially, socially and physically. They had the freedom to decide on what they considered good for themselves and some of the children started sending cash hand-outs to the parents who were in the IDPs.

In the interviews, some views were captured ...

“Some children who got some casual work in town where able to send some support to the parents and parents became dependent on the children, some feared correcting the children even though the children did unacceptable things, due to the fear of losing the source of help from the children and some children got married since they had some source of income ...” FGD with cultural leaders

The community viewed the children’s work (labour) during the time of the war as the main source for independence among some children. These trends have continued to present day as was reported in one of the interviews ...

“Today we have many young people in town doing all sorts of jobs like ‘bodaboda’ and barmaids, these children are big headed, they can’t listen to parents, they feel they have money and free to do anything; others have indulged in over drinking alcohol and other substances like (Marijuana), and casual, transaction and irresponsible sexual activities ...” FGD with Cultural leaders

4.6.2.6 Many children became orphans

In Uganda, there are an estimated 2 million orphans and of these, northern Uganda (4%) ranks second to Karamoja (4.9%) that had the highest numbers of orphans (UBOS and ICF International Inc 2012:21). The war could have accounted for the high number of orphans in northern Uganda.

The focus group discussions and interviews with different study participants generated views on the source of orphan-hood in northern Uganda, different scenarios and explanations were given depicting death of parents especially the fathers as a result of the war; for instance ...

“Many women became widows during the war as the result of killing their husband in the presence of family members and /or the men died during captivity ...; some girls who gave birth during captivity returned (were rescued) with children and left the husbands in captivity or the husbands were killed in captivity ...” FGD with cultural leaders

During phase I study (the case study in sub-section 4.5), it was established that the majority (80%; n=12) of the teen mothers were orphans (lost one or both parents) and of these 75% were paternal orphans (had lost a father). The state of orphan-hood experiences among the adolescents prior to teen pregnancy had a direct link and provenance with teen pregnancy reported by teen mothers under sub-section 4.3.1.1 above.

4.6.2.7 LRA war led to sexual exploitation of girls and women

It's been reported that modern warfare has a devastating effect on the lives and dignity of women and girls, as well as on the health and educational services that are essential to family and community survival. Women suffer adverse sexual reproductive health complications when compared to men since deliberate gender-based violence and discrimination is rampant in war settings (UNFPA 2002:3; ICRC 2001:29). Conflicts tend to increase the incidence of sexual violence; rape; sexually transmitted infections (STIs) including HIV/AIDS and unwanted pregnancies. In addition, essential social services,

such as medical facilities, on which women heavily depend for their well-being, are greatly disrupted by armed conflicts (UNFPA 2007:2)

Lack of quality reproductive health services in conflict settings leads to negative health outcomes for women; increases in STIs including HIV/AIDS, increased rates of unsafe abortions, and increased morbidity due to high fertility rates and poor birth-spacing. These result in disproportionately high mortality rates among women and children (UNFPA 2002:7). A recent post-conflict study in Africa found that the HIV- infection rate of adolescent girls was four times that of adolescent boys. Rape, high-risk behaviours, the inability to negotiate safe sex, and sexual exploitation are risks that have disproportionately impacted women and girls (UNFPA 2002:3).

The current study, found that the girls and women were sexually exploited; the women participants with grief recalled how girls and women were affected sexually through exploitation which ranged from; rape, defilement, forced marriage, child mothering and transactional sex. In the qualitative reports, the following direct quotes were picked:

“Girls were targeted by LRA since they were taken (abducted) to go and work as servants or wives to the rebel leaders and commanders ..., so one of the ways of safeguarding the girls from abduction was to become a mother (early and forced) that led to early child bearing since the LRA would not abduct mothers” FGD with Cultural Leaders

4.6.2.8 *The LRA war weakened the social capital and sense of togetherness among family and community members*

Social capital remains an elusive concept as it is generally imbued with positive connotations; in particular the importance of social networks and trusts in promoting a sense of belonging and well-being. Social capital is an asset which has the potential to link and explain factors that influence both health and wellbeing. (Madeleine 2005:605; McPherson 2013:1). Putnam (1995:73) points out that ‘the most fundamental form of social capital is the family’. Whilst the family is the smallest unit of society and comprises of two types (nuclear and extended family), there are other different forms such as single parent families, post-divorce families, step parents families and cohabiting families. Social capital at family level is built on the strength of parents and the children. Certain family

characteristics determine the level of social capital for instance: two-parent families, small size families (with few children), and families where mothers are full time housewives, as opposed to single-parent families, with many children, and mothers working outside home. All these influence the time sufficiency that individuals (parents and children) have for successfully building a strong relationship (Rosalind, Franklin & Holland 2003:7).

At the community level, social capital is influence by the level of civic engagement and participation through different activities such as leisure, clubs and politics. The current study found out that the impact of the LRA insurgency weakened the kind of social support (capital) that the Acholi people used to enjoy both at family level and at community at large.

In one of the interviews, this was directly reported ...

“Acholi culture was such that everyone belonged to a wider community, there was a strong sense of togetherness, with a communal (clan) system of instilling sense of moral responsibility among children ... but the war completely destroyed this ...
KII with cultural leader

When people were forced into IDPs, the family structure completely changed, the family forum (the fire place) was eroded, the economic family gender roles of women changed, and the housing and sleeping arrangement were appalling.

Conclusively therefore, beyond the impact of LRA war on the social capital of the Acholi community, increasingly the intergenerational closure as termed by Coleman (1997:87) has led to the gradual weakening of the social capital among families.

4.7 THE INFLUENCE OF MASS MEDIA ON THE SOCIO-CULTURAL NORMS OF THE ACHOLI IN SOCIALISING YOUNG PEOPLE

It emerged in the findings that mass media had and continues to have great influence on young peoples' access to sexual reproductive health information. Key emerging themes that were generated through the focus group discussions and key informant interviews with different community stakeholders are shown in Table 4.12.

For this case, the term ‘adolescents’, has been used to mean children because throughout the interviews with different participants, the parents and local leaders in their respective capacities lamented that even a child of two-year-old child could now follow what was being aired on the radio and TV, and can also use a phone. For the purpose of getting a uniform understanding and not reflecting the finding on adolescents only, the researcher chose to use the word young people to mean all the three categories of children (children, adolescents and young people).

The emerging themes

Table 4.12: The emerging themes and sub-themes on the influence of mass media on the socio-cultural norms of socialising young people

Emerging theme	Details and observation made by the participants
Creation of new youth culture on sexual issues (The negative influence)	<ul style="list-style-type: none"> • Young people feel more knowledgeable than the parents • Young people can easily access information as they wish and which are not age appropriate • A lot of sexual sensation messages come through the media (radio and TV) and some young people have begun to explore different sexual practices. • Increasingly, due to the influence of mass media, there is over “sexualisation” talks and sex is no longer a private matter; this is contrary to the old way that the parents knew and parents look at this as serious abomination to the values that was attached to sex
Positive influence of the exposure to mass media	<ul style="list-style-type: none"> • Allows information to move so fast for instance for mobilisation • Exposure to good stuff that can encourage young people in career development • For people who are in school and doing research, the internet helps to search for needed information • The world is Connected and soon the world is becoming a global village
Recommendations and opportunities for improving the use of Mass Media	<ul style="list-style-type: none"> • Strengthen the regulatory systems • By laws by community leaders • Pronouncements by cultural and religious leaders • Ordinances by the district leadership • Enhancement of parents knowledge, skills and attitudes on information technology and at family level parents should take family control measures for the young children

According to the emerging themes, the mass media has led to the following:

- Mass media has created/is creating new and divergent youth cultures (what was considered negative influence on the young people).
- The positive influence of mass media (from the community perspectives).
- Key recommendations to improve the use of mass media in information dissemination, given the fact that young people are in the era of information and technological (IT) explosion.

4.7.1 Creation of new and divergent youth culture on sexual matters

From the discussions with different study participants, the general views on the new youth cultures on sexual matters among young people were that:

- Young people feel more knowledgeable than parents due to exposure to mass media information.
- Sexual sensations have exposed children to inappropriate sexual information.
- The issue of sexual diversity and rights was making children rebellious and the old way of communal disciplining of children has been affected by rights issues and thus brought a lot of divergent views to those of the Acholi tradition.
- There are overly “sexual” talks and sex is no longer a private matter; this is contrary to the old way that the parents knew and therefore most parents today look at this as a serious abomination to the values that previously were attached to sex.

In some of the interviews, different direct quotes were reported:

“I think we have lost the battle because children are a head of us, quite a head, so I see a challenge, the leaders in the community who should teach these young people are behind, they don’t know, it’s the young people now teaching them because they are reading on internet” key informant interview with a religious leader

“The media has destroyed our children, previously older children say those above 10 years some little talks on sexual clues could be hinted here and there to them, but today even a 4 years old child say something related to sex for example “if it’s not on, it’s not safe” a popular message on media promoting condom use ..., when a child asks questions related to such, it becomes very heard for parents to talk about that due to age inappropriateness” Parents FGD, Omiyayima Village, Kitgum District

“Right now there are different sources used to get information like radios, televisions, internet and others are through phones, all things are sent on phone, through Twitter, U-tube and Facebook, all those things are there right; some songs are of sensational and if a child listens to it, says aaah mummy what are they singing? All these things have come and have surrounded children; parents are in

dilemma on what to tell and teach the young ones. So I think teaching children have become hard for parents ...” KII with religious leader

Sensational sex messages passed through the media

For instance there is a song that is normally played on radio and says :

“if you want to find the sweetness raise your legs up” is that a good song? Those are bad things of which if children knew about Acholi culture they would not be singing such songs. That’s bad influence because when young people listen to such a song then can explore the sweetness being sung on the songs ...” Parents FGD Lila Village, Pader District

“when it comes to internet many times aaah parents have beaten children due to exposure to nudity for instance some young people are addicted to pornography and via internet they can Google and download anything...like people having sex; sometimes the messages that come through the social media is full of bad information and such information does not only come to old people, even young people access such...”

and

“... another case is off short message send on phones by people who market their products on media that if you want to have juicy sex send to this number and you get tips, and that doesn’t come to only old people but even to young people who have phones”....,

“when it comes to video halls, the video halls are all over even deep in villages with no electricity you find some people with small generators showing movies of people making love, kissing themselves and undressing themselves up and are in bed; all these are in the spirit of businesses ...” Parents FGD, Bwonagweno village, Gulu District

... “I recall some years back when I went to an internet café and I got some two boys of about 12 years they were on the internet do you know what they were watching? Different styles of sex, to me that was an abomination and brought a total shock to me ...” KII with a religious leader

Sexual diversity and orientation (homosexuality)

“On the issue of sexual diversity and rights, this is unacceptable, young people are being influence to this vice simply because of what they see and read through the media, but in our culture; when a man sleeps with a fellow man, it was an abomination. It requires cleansing. How can a woman sleep with a fellow woman? Even animal, at home doesn’t do that. How can you a human being do such a thing? In some countries, a whole Bishop has a man as a spouse, God created a man and a woman. This is abomination and God will punish ...” FGD with religious leaders

“The whites have exported their bad culture to us of a man sleeping with a man...unfortunately we as black people we look at ourselves as inferior and we tend to copy what the white man does or says...and yet to the whites, it is a trade/business ...” Parents FGD, Omiya-anyima Village, Kitgum District

In some ‘communities’, for example, prisons, or the army, men who spent a long time sailing on the water (seas and oceans) ... I recall due to the nature of their work and the long duration of time spent away in predominantly single sex, forced some men to sleep with fellow men, but this shouldn’t happen in a community such as ours, there are many women and men, moreover freely given by God ...” FGD with cultural leaders.

4.7.1.1 Opinion on what parents need to do about mass media and teaching young ones

Given the above recordings and sentiments from the community about the negative influence of mass media on the emergency of new youth cultures, some suggestions were made to improve the use of mass media at community level. Generally the participants were convinced that trends in information and technological advancement will continue and the community needed to appreciate the development and adapt amicably to catch up with the changes due to information technology.

One of the policy makers had this to say ...

“If parents are to get authority on sex education; they should get all the knowledge their children have got about sex education...and with the right skills to communicate sexual matters ...” “I recall a parent once told me that her 7 years old daughter came and told him that her friends were saying that sex was very nice..., that was an abomination to the parent since the parent did not know what information to communicate to the daughter ...” Kill with a policy maker.

However, in terms of effective communication, Owusu and Oforiwaa (2014:82) cite Devito (2002) that, unlike information dissemination (as the case of mass media which is one way in most situations), communication is a two-way traffic involving the sharing of ideas, knowledge and experience. Thus communication must be between adolescents and the agents of the messages and not only one group of persons like the case through the media which most often is used for dissemination of information rather than for effective communication where feedback is generated.

Interestingly, some probing questions were asked during the focus group discussions; “has the mass media taken over from parents, educators and other socialisation agents the roles of teaching children?” The participants in their views felt that whatever is being passed through the media, the ultimate goal for the media producers is to make profits, and always the information disseminated has to entice the audience. And in one of the FGD, this was said ...

“The people who work in media houses are working for money ..., it is the work of parents to guide their children and tell the young ones about the good and bad of the mass media ...” Parents FGD Lilla Village, Pader District

On the other hand, the participants brought out views on some positive influences of mass media as detailed in sub-section 4.7.1.2 below.

4.7.1.2 *The positive influence of Mass Media*

The general views on the influence of mass media on sexual reproductive health for young people depicted many negative aspects as seen above. The positive influence of mass media was on the other hand, assessed from the perspectives of general development including:

“Information through the mass media moves so fast; and it can be used to pass on vital Information to mobilise the masses ...; and for any current information that young people need to know, they just Google, the google engine is so powerful ...,
Parents FGD Lila Village Pader District

- Others reported that television helps some children to set their career goals. For instance, during national celebrations and other programs that are broadcast on TV; a child may watch and gets inspired to become like the role model of his/her choice.
- It promotes learning. Some people study online through the internet and it is relatively cheaper.
- It opens up communities to the global economy with a lot of trade and business opportunities on the globe.

4.7.2 Recommendations and opportunities for improving the use of Mass Media

The general observation was that the world is experiencing IT explosion and the trends of IT advancement were to continue growing to an even worse state than today. The participants then discussed and made some recommendations on the opportunities that mass media brings to the community. The older generation (parents, guardians and the adult community) need to be supported to appreciate the modern trends of development.

In the current study, quantitative study Phase II, sub-study III, presents results which show that the radio (27%) was the major source of ASRH information reported by respondents compared to print media (6%); TV (4%) and internet (0.3%) which were the least sources reported.

In the context of the current study, the adolescents advanced some reasons why the radio as a source of mass media was preferred:

Radio was more accessed by the community as compared to the other types of mass media. It was affordable (most households had radios), accessibility (each district has one or more radio stations), the convenience (small radio is movable, some phones connects to the radio) and that not so many households can afford the cost of television and others.

From the participants' discussions, some control measures were proposed. The participants were convinced that the government still had an important role to play by setting strict rules and regulations for the media houses and this was said:

"The Government should set strict laws for media houses since they are in business, they should abide by the law and the community should come out with by laws and pronouncements to censure some media programs..." Parents FDG, Bwonagweno Village, Gulu District

During the interviews at the national level, it was reported that ...

"Three years ago, the national broadcasting council of Uganda which is a body that unites all media owners and broadcasters for both radios and televisions stations came up with a minimum broadcasting standards under the flagship of Uganda communication commission (UCC) and this policy guideline can be used to monitor the work and ethical standards of media houses and the community level and as well use this as a reference to bring to books the media houses that are non-compliant in their communities..." KII with a Policy Maker

It was, however, noted that the challenge still remains with the use of World Wide Web (www) and the Google engine, which is very difficult to regulate or control as it is a direct connection. Also, people can use their smart phones and/ or go to public internet providers to access whatever information they may require.

"I still repeat, parents and other people taking care of young people need to control their children from visiting sites which are not age appropriate, the kind of control is family centred depending on the family values ..." KII with a Policy Maker

So if parents are to have control and be able to talk to the young people, they need accurate information and the parents should be supported to make them feel more comfortable and confident that they possess the necessary communication skills to communicate more effectively with their children on sexual issues (Owusu & Oforiwaa 2014:84-85).

Beyond the mass media, the current education system emerged as one key aspect that continues to influence the Acholi socio-cultural norms that were used to socialise young people on sexual matters as detailed below under sub-section 4.8.

4.8 THE INFLUENCE OF EDUCATION SYSTEM ON THE ACHOLI SOCIO-CULTURAL NORMS

According to Dewey (1944:1), education is a form of learning in which knowledge, skills and habits of a group of people are transferred from one generation to the next through teaching, training, or research. Education normally takes place under the guidance of others. Amone et al (2013:126), add that any experience that has an formative effect on the way one thinks, feels, or acts may be considered educational and that education is divided into two major components; formal and informal education.

Formal education is the hierarchically structured, chronologically graded 'education system', running from primary school through to the university. This includes in addition to general academic studies, a variety of specialised programs and institutions for full-time technical and professional training. Informal education is the truly lifelong process whereby every individual acquires attitudes, values, skills and knowledge daily (Amone et al 2013:126).

4.8.1 The traditional or informal education system (the pre-colonial era)

In Uganda, the traditional education system existed informally unlike the formal school like setting of today. People were nonetheless educated and trained through informal systems. In almost all African societies, the system of instruction tended to be similar; only the subject matter or syllabus differed according to the particular needs and social values of a given society (Muhangi, 2008:16).

Muhangi (2008:16) cites Fallers (1968) and Apter (1967) that in most African societies, the informal teaching emphasised discipline and respect. The instruction normally took place round the fireplace after the evening meal or whenever a child committed an offence. The teaching was in the form of stories, tales and riddles. The mother or grandmother would tell the children what society expected of them as they grew up. The

fathers would, through proverbs; stories and direct instruction teach the young boys their expected roles in society (Ibid).

Similarly, as outlined in sub-section 4.5, the Acholi taught children the traditions and norms from childhood. This was done at the fire place ('wang-oo'), children were told riddles, proverbs ('caroo-lok'). Boys were taught by the fathers and uncles during activities such as digging, looking after cattle. The girls were taught by the elderly women feminine roles like cooking, fetching water, fetching firewood and how to look after themselves.

To enforce sexual discipline and respect, some societies used capital punishments to alert the young generations to the gravity of particular cases of indiscipline and immorality. Muhangi (2008:17) citing Cunningham (1969) says that in Bakiga culture, a girl child who got pregnant before marriage was killed by throwing her down a cliff to serve as a bitter lesson to other girls who contemplated having sex before marriage. The Banyankole also cursed and disowned the girl who became pregnant before marriage. The Langi and the Acholi would fine the boy heavily for such misconduct. These were done to discourage young people from engaging in undesirable sexual relationships before marriage.

It was a moral obligation of the adults for the young to be taught their cultural values, norms, taboos and totems. The young were taught the dos and donts of the society in which they were born (Muhangi 2008:17). Besides, they were also taught about their clan relations and their boundaries in order to avoid incest (Ibid). Further, the boys among the Bakonjo, Bamba, Bagishu and also girls among the Sabinu were initiated into manhood and womanhood by undergoing the ritual of circumcision (Ibid). Accordingly, the fathers would train the boys in methods of herding, fighting, hunting, agriculture and trade. The mothers would instruct the young girls in the proper ways of cooking, basketry, pottery, childcare, dressing and other functions related to housekeeping.

During the pre-colonial era, education was mainly traditional, as such the Acholi educated young ones through playing, practical work, dance, rites and ceremonies. Formal education sessions were also conducted, in instances where people wanted to be black smiths, herbalists, craftsmen etc. These people would undergo formal training at an expert's place of work (Ocitti 1973:31). Folktales/oral literature ('Ododo') was also used to educate youngsters on virtues such as communal unity, hard work; conformity, respect and honesty. The folktales were based primarily on day to day happenings and bore a

very close relationship to life. Through folktales, children learned a lot about human follies, faults and weaknesses (Amone et al 2013:132).

4.8.2 Education in the post-colonial era

Modern education comes from the human rights perspectives where education is a right for all children and those children who are not in school are being denied that right. The international treaties and declarations, in particular the Convention on the Rights of the Child (CRC 1989), the World Declaration on Education for All (EFA 2000) and the Millennium Development Goals (MDG 2000) gratify compulsory primary education of good quality for all children, free of costs (Mbabazi, Awich, Olowo & Lubaale-Yovani 2014:1). Uganda as a country is a signatory to the convention and a lot is being done to promote education within the legal mandate stipulated in the convention. In Uganda all education activities are within the mandate of the Ministry of Education and Sports (MoES) (Amone et al 2013:127). The current system of education in Uganda has a structure of 7 years of primary education, 6 years of secondary divided into 4 years of lower secondary and 2 years of upper secondary school, and 3 to 5 years of post-secondary education (Amone et al 2013:129).

4.8.3 The influence of the modern education system on the traditional norms of socialisation

During the discussions, the participants often compared modern education with the traditional education system. The participants recalled how traditional and indigenous methods of teaching children were carried out and how this had totally changed in the modern time. From the discussions, the following were major themes:

Table 4.13: Emerging themes

Theme	Sub-theme
School has taken over parental role of training children	Children stay away from parents most of the time and spend more time at school with teachers
Children have become more knowledgeable than parents	Education exposes children to read, and most often they are able search for information they need
Relationship between parents and children have been weakened (social capital)	Parents focus more to look for money to pay school fees and have children at school and have less time to relate with children

4.8.3.1 *Children spend more time in school than with parents*

In the discussions, the participants tended to compare the education system between pre-colonial and post-colonial era. In the post-colonial era, young people spent more time in school and parents had very limited contact time with the children. Whether in boarding or day schools, children spend more productive time in schools and most parents have delegated their parental responsibility of teaching and grooming their children to teachers, as articulated below ...

“Parents today do not have time with children for instance with the boarding school system, a child of 5 or 6 years can be taken to boarding and forever such child will never bond with the parents ...” FGD with Parents Bwonagweno, Gulu District

4.8.3.2 *Some children feel more knowledgeable than parents*

Some parents felt that the current education system focuses more on teaching young people skills and knowledge to compete in the modern and development world, and little on morals and values. The young people therefore project themselves as more knowledgeable and exposed compared to their parents thus making it very difficult to offer guidance to the children ...

“Some children feel that they are more knowledgeable than their parents and that makes it very difficult to support and teach them” FGD with Parents, Lila, Pader District

“Some parents think schools in Kampala (capital city) are better and they end up sending children in boarding schools in Kampala making it very difficult to even see the children, during holiday, some children stay with relatives and don't go see their parents...” KII with religious leader

4.8.3.3 *Weakened relationship (social capital) between parents and children*

It was also observed that the current education system takes away children from the parents during the critical stage of child and adolescent development from primary to senior secondary level which is from between 6-19 years age. During this stage, teachers

take up parenting roles since children spend more time in schools. The children may bond more with teachers than parents thus affecting the social capital that parents previously enjoyed with their children.

Other aspects which were discussed included the issue of language that tends to be foreign and in some homes; the local language is becoming extinct. As said ...

“The way young people communicate with parents today, one may fail to understand.”

Amone *et al* (2013:131), indicates that many new foreign languages (English, French, Swahili and German) were introduced in Uganda through the modern education system. These foreign languages have gained the status of official languages in Uganda and English is used as both the official and national language. Because of the introduction of foreign languages, local languages are nearing extinction. Children of today are taught in foreign languages and some cannot speak their mother tongue fluently. Influx of foreign languages has also led to the emergence of slang among the Acholi youth such as “zeyi” meaning father, “sisto” meaning sister, “ziki” meaning music and many others. This means young people and the parents communicate using different “wavelength”.

As noted earlier, communication is a vital medium of passing on messages and once communication is tampered with as in the case of language barriers between parents and children, then the message is not understood (Ola 2012:93; Botchway 2004:16). In the current study, the parents intimidated there was a big language barrier between themselves and the children and this was picked as a direct quote ...

“... the language used by the modern children can't be understood by us parents; the teachers have a lot of work to do since the parents have failed to catch up with the level knowledge of the children ...” KII with religious leader

Confounded by mass media, the education system has enabled young people to access information through the mass media such as newspapers, magazines, and movies. In some instances this negatively impacts on young people who are often exposed to pornography which leads to moral decay as the young people watch and practice what they see. For example, young people tend to dress like the people they see on television

hence end up dressing indecently which may expose them to sexual risk such as rape, defilement, transactional sex (Amone et al 2013:130).

The education system has also brought about changes in the marriage institution. Amone et al (2013:131) state the emergence of same sex marriage (between men and also between women among the traditionally accepted monogamous (nuclear families) marriages. This is with the exception of Muslims who allow polygamous marriages. The period of courtship has shortened unlike before the introduction of formal education where courtship would take between one to five years. Today courtship is less than a year, making it difficult to know the real character of the potential partner hence divorce is a common occurrence. Before the advent of formal education, virginity was highly valued but with the advent of formal education where young people want to copy the western lifestyle, valuing virginity is thought of as an outdated and conservative mind-set.

In the olden days, parents played a key role in selecting marriage partners for their children but after the advent of formal education, marriage only concerns the two and it is only their choices that matter. The quality of Acholi marriage partners before the advent of formal education, centred on hard work and good body-build. Nowadays, education, beauty and wealth are considered more important (Ibid 132). According to Muhangi (2008:15), the education system in Uganda has evolved over time and during each era the method of teaching, the goals and the expected outcomes have adapted as outlined in Table 4.14.

Table 4.14: The evolution of the education system in Uganda

Themes	The teachers	The ultimate goal	The outcome
The traditional, indigenous and pre-colonial education	Parents, grandparents, uncles, aunties and clan members	Train children in all life supporting skills, morals, norms, values, taboos as defined by the culture of the community and clans	Properly brought up children with behaviours which are socially acceptable (respectful, disciplined and obedient children)
The colonial education system (Missionaries period)	Missionaries, men and women working with the missionaries	To preach the word of God, teach people how to write and read	God fearing people who are obedient and faithful servants
The modern and developed education system (post-colonial era)	Trained teachers who have obtained skills from formal education	To impart various social, political, economic, technical skills for modernisation and development and therefore more emphasis is put on education and the community feel that without education, there is no future	Education became number one priority for most parents and it has made children to spend more time at school than with the parents Children have become more knowledgeable and some parents feel disempowered to teach their children thinking the children now know it all

(Source: Muhangi 2008:15)

4.8.4 The importance of education evolution over time

From the findings, it has been difficult for education to evolve properly in accordance with the process and stages of child development. The traditional norms of teaching children may not be ideal in present day, and during the discussions, the participants were cognisant of the changes and discussed some of the benefits that the current education has brought and among others; this was said ...

“Education has made our children so knowledgeable and the children can be employed to work in different offices” KII with local leader in Pader District

Since the world has become a global village; educated children will get opportunities to work in any part of the world if they get the right education, knowledge and skills. According to Amone et al (2013:131), because of formal education, communication systems also improved due to technological advancement, e.g. phones, internet and email, fax, e-trade, e-learning among others. These systems enable easy flow of communication and also promote e-learning (learning where students receive lectures and learning materials online) which overcomes some barriers to education. The communication system has improved considerably due to formal education.

4.8.5 Highlights of education challenges in Uganda

Much as the contemporary education system is viewed and believed to be the engine for delivering development; the education system in Uganda is still characterised by a number of challenges. According to the Uganda Education Management Information System (EMIS) report of 2009, the average primary school completion rate was reported to be 52%; retention rate in primary school was 53% for boys and 42% for girls. However, during the release of the primary seven national exams results in February 2013, it was reported that over one million pupils or about 71% who enrolled in Primary one under the Universal Primary Education (UPE) in 2006, were no longer in school (Mbabazi et al 2014:3).

When compared with other East African countries, Uganda still has a very low primary survival rate of 33% compared to Kenya (84%), in Tanzania (78%) and Rwanda (81%)

(Ibid page 4). The survival rate is the number of children starting together in primary 1, progressing through the cycle with their peers until finishing the primary cycle in primary 7 together. Uganda therefore needs to learn from other neighbouring countries on how to improve retention and survival rate.

The results under Phase I and phase II sub-study III of the current study concurs with the above findings. The quantitative results (Phase II sub-study III presented under sub-section 4.9 below) shows that 98 % (n=600) of the adolescents were in school and only 2% had dropped out of school by the time of the study. While in Phase I of the current study (the case study sub-section 4.3.1) found that of the 15 teen mothers who took part in the study, 73% of the teen mothers had dropped out of school prior to their pregnancy (before or during adolescent stage).

4.9 PHASE III STUDY RESULTS

4.9.1 Introduction

Phase III study was purely qualitative and the objective was to identify health systems factors that influence the community role in supporting adolescents sexual reproductive health. The question the phase III study attempted to answer was how health systems have influenced community roles in supporting ASRH and taking in to account the findings of the study, what strategies would best address the issue of community involvement in ASRH?. In answering the question, the following were achieved:

- i. The study explored the community responsiveness to the national adolescents' health policy
- ii. Established the challenges that influence community role in supporting the implementation of adolescents' sexual reproductive health policy guidelines and service standards
- iii. Generated recommendations from the different study participants through triangulation of information obtained from the policy makers, implementers, parents, adolescents, local, cultural and religious leaders on how to improve community participation on ASRH matters

Before looking at the community's responsiveness to adolescents' health policy guidelines and service standards mandate, the sub-section below provides a brief understanding of the adolescent health (ADH) policy.

4.9.1.1 National adolescent health policy

By definition, a policy is a deliberate system of principles to guide decisions and achieve rational outcomes and policies can assist in both subjective and objective decisions making. Subjective decision-making would consider the relative merits of a number of factors before making decisions and the results of subjective decisions are very hard to objectively test. Objective decision-making is usually operational in nature and can be objectively tested. The national adolescent health (MoH 2011) is therefore a policy document that was objectively developed and as detailed under sub-section 2.5 of the literature review, the current study explored the community responsiveness in the implementation of the policy.

The National adolescent health policy guideline and service standard is therefore a reference document that guides all key players in the field of adolescents health including ASRH. According to the policy (MoH 2011:10), adolescents face many health challenges, especially those related to reproductive health which include early/unwanted pregnancies, unsafe abortions, STI including HIV/AIDS, female genital mutilation, psychosocial problems such as substance abuse, delinquency, truancy and sexual abuse. As a result of these problems, many adolescents drop out of school or lead a compromised and vulnerable life that extends through to adulthood. For adolescents to achieve their full potential they need to be provided with opportunities to:

- Live in a safe and supportive environment
- Acquire accurate information and values about health and development needs
- Build life skills they need to protect and safe guard their health
- Obtain counselling services
- Have access to wide range of services addressing their health needs

For the adolescents to achieve the above, it calls for a multi-pronged approach by different community players including policy makers, implementers, community leaders, parents and adolescents themselves. During the study, data was collected from key

players to establish how the community was fulfilling their mandate as stipulated in the adolescents' health policy (MoH 2011:21). For the purpose of this study, the term used to explore community participation in adolescent health as per ADH policy is community responsiveness.

4.9.1.2 Responsiveness

From the health systems perspectives, according to Darby, Valentine, Murray and De Silva (2000:1-2), responsiveness in the context of a system can be defined as the outcome that can be achieved when institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals. Responsiveness can be viewed from two angles; firstly, the user of the health care system often portrayed as a consumer; with greater responsiveness being perceived as means of attracting consumers (client orientation). Secondly, responsiveness is related to the safeguarding of rights of patients to adequately and timely care (respect for persons). In other words, responsiveness is how well the health system meets the legitimate expectations of the population and considers the non- health enhancing aspects which are seven in number such as:

- Dignity
- Confidentiality
- Autonomy
- Prompt attention
- Social support
- Basic amenities
- Choice of provider

Health systems responsiveness is based on consumers' reports on those factors (respect for persons and client orientation) that they care about (or matter to them) and about which they are the best source of information (De Silva 1999:3).

4.9.1.3 **Community systems responsiveness**

Community systems are used by communities through which members, community-based organisations, and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities (The Global Fund Community Systems Strengthening Framework 2014:1). To understand the term community systems responsiveness, the researcher referred to the work by Dowerik, Power, Manz, Block, Leff, and Rupnow (2001:71-73) to elucidate community responsiveness from the community systems perspectives and he states ...

“The ability for university/school based programme to be responsive to the community takes more than good will and topical expertise; the needs are more pressing... but how can exemplary programs be implemented in communities with such pressing needs? And how can community be made to work, the community needs an effective and economic solution for sustainable development work ...”

Most often the needs of the community are enormous and more pressing than what the outsiders see. As for the case of adolescents' health including sexual reproductive health needs, many issues that affect adolescents' health have been reported; unplanned pregnancy, early start of childbearing age, unsafe abortion, non-use of contraceptives and STIs including HIV and AIDS, child abuse, substance abuse and negative norms and practices among others (MoH 2011:7). The mandate for the community systems is to contribute to achieving better health outcomes for adolescents by being responsive to the health needs of the adolescents.

According to Dowerik *et al* (2001:74), the community responsive model has six elements that include:

- 1) **Identification of needs and strength of the community by the community** i.e., communities have heterogeneous needs and as well as strength, helping the community to identify their needs and strength help to rationalise their response).
- 2) **Established a place in the system:** Having a defined place, location and venue in the community where the community can perform their work and activities.

- 3) **Improving the working relationship:** Supporting the intergroup, inter sector and networks collaboration to leverage on the community resource for community responsiveness.
- 4) **Building capacity of the community:** In terms of training to empower them to be able to fulfil their responsibility.
- 5) **Envisioning positive images** by creating images of future success as compared to the current situation that the community may be experiencing.
- 6) **Carrying out data based evaluation** especially through participatory action research and this allows for adjustments within the programme for better outcomes.

The above six elements of community responsiveness were used to appraise the work of the community basing on the adolescent health policy mandate for the community and relating it to the emerging issues presented on Table 4.15 below.

Table 4.15: Emerging themes and sub-themes

Themes	Sub-theme	Observation and comments
The general understanding of the ADH policy and its usage to promote community participation and involvement	Multi-sectorial approach to promoting adolescent health	At institutional level for e.g. health and education, the policy presents a clear and well defined package and standards for implementation of ADH policy
		For the local, cultural and religious community, the package and standards and structures are not well streamlined to support active community participation and sustainability
	Integrated approaches	ASRH is being promoted but seemingly under the flagship of HIV and AIDS as if though before HIV&AIDS adolescent sexual reproductive health wasn't a problem
	Advocacy issues	The policy highlights key advocacy issues such child abuse, substance abuse, traditional practices etc. which have deep rooted causes in the community and thus require more action oriented advocacy by community stakeholders
	Co-ordination structures	There is no exist clear co-ordination structures for the implementation of ADH policy beyond the district level to support community responsiveness on ADH implementation
	Alternative approaches to promoting ASRH	The traditional approaches of using interpersonal and peer led have been emphasised but increasingly, the new youth cultural explodes require re-thinking of alternative channels such as electronic media
Challenges affecting	Controversial and opposing views	The religious and cultural institutions sensitivity to discussing some aspects such family planning, condom

Themes	Sub-theme	Observation and comments
community responsiveness to ADH policy		use and sex education affects the common position of the community stakeholders on what to tell adolescents
	Weak community mobilisation for ASRH	Negative attitudes and disapproved of sexuality matters affecting young people affect community mobilisation for support of ASRH
	No co-ordination structures at community	Sub-county, parish and village structures are non-existent making it very difficult to generate lower level community response
	Lack of knowledge and skills and as well limited IEC for messaging	Lack of knowledge and skills coupled with limited IEC makes it very difficult for community participation on ASRH
	Limited resources (Finances)	Most of the ASRH activities being implemented are donor driven for e.g. support from the UN family structures and once such donation end, the community cannot sustain their activities
Recommendations for improving community response to ADH policy	Training and capacity building	To enhance knowledge and skills for different community players to effectively reach adolescents and young people with sexual and life skills education. There is need to develop appropriate IEC materials for use by community
	Need to acknowledge cultural dynamism in the contemporary society	The community especially the religious and cultural institutions need to proactively develop strategies to touch the 'hearts' of young people in order for the institutions to remain relevant in the contemporary society
	Integration of community programs for sustainability beyond donor funding	Need to build capacity of existing community structures especially through schools, religious and other community structures to integrated ASRH in their routine activities
	Instituting community co-ordination mechanism for better networking, advocacy and community mobilisation	instituting lower community co-ordination mechanism with clear terms and reference and one of which should monitoring community factors that support and predispose children and young people in to risky behaviours then come up with appropriate steps such as by-laws, pronouncements and ordinances
	Planning, monitoring and evaluation of community response	Need to develop action oriented monitoring plans for instance through monitoring the outcomes of community by-laws, pronouncements and ordinances which are set periodically

The issues generated from the community understanding of adolescent health policy and the current approaches being used to promote community participation in adolescent health, the challenges affecting community responsiveness to ADH policy and the recommendations for improving community response to ADH policy as detailed above (Table 4.14) guided the development of a community strategy for enhancing community responsiveness to adolescent health as detailed in chapter 5.

4.10 SUMMARIES OF KEY THEMES FROM THE QUALITATIVE STUDIES

The following key theme emerged from the results under the qualitative study phases:

Phase I (Case study)

On the demographic characteristics of the participants, the majority (80%; n=12) of the teen mothers were orphans, who were raised in predominately single female headed households with a relatively large family size. Due to various factors, the majority (73%) of the participants had dropped out of school prior to their pregnancy. The majority attributed being out of school as a major risk factor that exposed them to teen pregnancy since they were not productively engaged.

4.10.1 Level of knowledge on adolescence among participants

The results showed that the teen mothers had limited knowledge about adolescence as a stage of transition and also lacked comprehensive information on adolescents' sexual reproductive health as depicted vividly in some of the participant quotes. Equally, the parents and guardians had limited knowledge and skills on what information to offer regarding adolescence and/or puberty, ASRH and lacked skill and expertise of how such information could be delivered.

In addition, the unsupportive home environment which was characterised by domestic and gender based violence coupled with lack of life skills and late information received by teens from untrusted sources such as peers were key hindrances and risks to teen mothers and further explains the circumstances that surrounded the teens before they fell pregnant.

4.10.2 Support by community stakeholders to the teen mothers

The results revealed that the support that community stakeholders offered to the teen mothers came from family members, peers, health workers, teachers, and community leaders. Embedded in the socio-ecological model, the support depicted the interactive nature of individual adolescents with their immediate family members and friends and as well at institutional level and the broader societal context. The support that enabled the

teen mothers to cope ranged from being physical, material and psychosocial. Nonetheless, issues of stigma which arose from both self, family and community spheres hindered the coping ability of the teen mothers with teen pregnancy.

Phase II: The socio-cultural influence community support of ASRH

In line with the socio-cultural issues that influence the community support and participation on ASRH, numerous issues were identified ranging from: the Acholi traditions and norms, the effects of the LRA, the influence of mass media and the current education system on the Acholi traditions as detailed below.

4.10.3 The Acholi traditions and norms on sexual socialisation

Traditionally, the Acholi like any other African community attached a lot of respect to sex, and sex was not a subject to be discussed openly. The socialisation of the Acholi enhanced the learning of sexual matters by instinct. The children did not have to be taught sexual education but learned through the socialisation processes.

4.10.4 The effects of LRA on the socio-cultural traditions of Acholi

The LRA had a direct effect on the Acholi traditions; as the results of displacement of people from their homes to the internally displaced persons camps, the Acholi lost their traditions which hitherto was protective in grooming children to become morally responsible adults and it emerged that the IDPs life led to the following:

- The family lost the family school domain “the wang-oo”
- Changed the gender dimension of family roles
- Changed the traditional sleeping arrangements
- The war made some children became independent from their parents
- Many children became orphans
- Led to sexual exploitation of girls and women
- Weakened the social capital and sense of togetherness among family and community members

4.10.5 The influence of mass media on the Acholi traditions

On the influence of the mass media, the following emerged:

Increasingly, the mass media is leading to a creation of new youth culture on sexual issues. Young people feel more knowledgeable than the parents and can easily access information as they wish and there are overly sexual sensation messages that come through the media (radio and TV). Some young people have begun to explore different sexual practices and increasingly, sex is no longer a private matter contrary to the old way that the parents knew and parents look at this as a serious abomination to the values that were attached to sex. Nonetheless, there are some positive aspects of the use of mass media as detailed in the above sections. Parents and other community stakeholders need to come up with clear recommendations and monitor the standard codes (as defined by the UCC) of mass media houses performance and as well advocate for appropriate programs that enhance family relationship building and better parent-adolescent communication.

4.10.6 The influence of the education system on the Acholi tradition

On the influence of education systems, it emerged that:

- **Schools have taken over parental role of training children.** Children stay away from parents most of the time and spend more time at school with teachers than with parents.
- **Some children have become more knowledgeable than some parents.** Education exposes children to reading, and most often they are able search for information they need as opposed to the old tradition in which the parents were the most valuable and trusted source of information to their children
- **The relationships between parents and children have been weakened (social capital).** Parents focus more on looking for money to pay school fees and have children at school most of the time and have less time to relate with children. With the boarding system, some parents take their children as early as pre-primary school (say from 4 years) and such a child is completely detached from the parents.

However, from the human rights and development perspectives, education is a right for all children and it offer opportunities for growth and development for people and to the community. Parents and other community stakeholders need to work through the education system and support the system to effectively deliver a holistic learning to children including issues of adolescents' sexual reproductive health.

Phase III: health systems factor that influence community participation in ASRH

4.10.7 Community responsiveness to the national adolescent health

Under phase III, the results revealed that the national adolescent health policy which is the policy framework that guides the implementation of all community responses to adolescent health is responsive; though there are calls for more integrated and well co-ordinated efforts based on the existing community systems (ranging from family, schools, health facility, religious institutions, recreational facilities and cultural institutions). However, in terms of community systems strengthening to support community responsiveness to adolescent health, the community requires both logistical and human capacity development to enhance effective community response.

4.11 QUANTITATIVE RESULTS

Phase II sub-study III were the quantitative strands of this study

Quantitative data was collected from adolescents aged 10-19 years. A total of 600 adolescents were targeted under this phase with the aim of collecting quantitative results to be presented as numbers, percentages and frequencies in a bid to measure the magnitude of the phenomena documented under the qualitative study phase.

This phase achieved the following results:

- Established knowledge on adolescents' sexual reproductive health among the respondents by determining the level of awareness about growth and development stage during adolescence.
- Established sexual activity and safe sex practices among the respondents.

- Established the sources of information pertaining adolescents' sexual reproductive health reported among the respondents.

4.11.1 Social demographic characteristics of the respondents

The social demographic data covered the respondents' gender, age, residence, school attendance, level of education, orphan-hood status and the type of orphan-hood and occupational status.

Of the 600 adolescents; 300 were interviewed from the community setting and 300 were interviewed from school setting. Gulu contributed 270 (45%) respondents, Kitgum 170 (28.3%) respondents and Pader 160 (26.7%) respondents. In each district 50% of the total respondents from the community setting interviewed were during school holiday and the other 50% were interviewed from the school setting during school term. The response rate was 100%; Figure 4.1 gives the gender of the respondents.

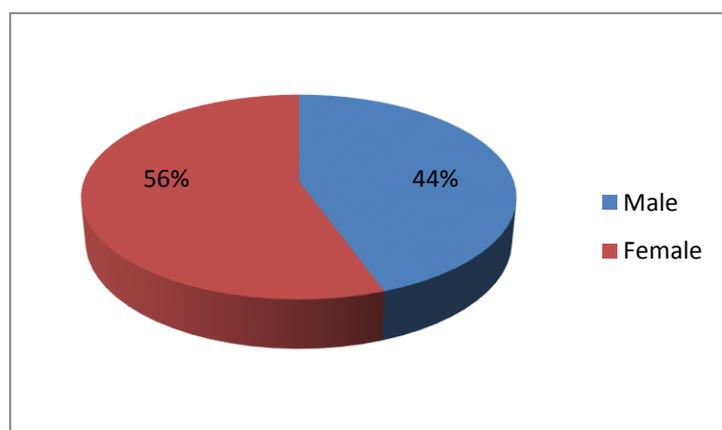


Figure 4.1: Numbers of respondents by sex (N=600)

4.11.1.1 Respondents' age

The respondents' age considered is that of adolescents as defined by UNICEF (2009:5), to be 10-19 years. The respondents were asked to state their absolute age in years and for those who could not remember their age, a probing question was asked to ascertain the respondent's previous/last birthday. The responses were generated and summarised under two age categories of young adolescents; 10-14 years (31.5%) and middle and older adolescents; 15-19 years (68.5%).

4.11.1.2 Respondents' religion

The respondents were predominantly Catholics with 58%, followed by Protestants with 29%, Pentecostal were 12% and Muslims were 1%.

4.11.1.3 Respondents' school attendance and level of education

Overall, 98% (n=589) of the respondents were still schooling and only 2% had already dropped out of school at the time of the interviews. Of the 589 who were still schooling, the majority (59.2%) were in upper primary (P5-P7), followed by O' Level with 29.4%, lower primary (P1-P4) with 9.7%, A' level with 1.4% and tertiary level with 0.3%.

4.11.1.4 Respondents' orphan-hood status and type of orphan-hood for those orphaned

The study found that 31% (n=183) of the respondents were orphans who had lost one or both parents and 69% had both their parents alive. Of the orphans (n=189), the majority (80%) were paternal orphans and 20% were maternal orphans. According to UBOS and ICF International Inc (2012:21), the estimated numbers of orphans in Uganda was two million children; of which, northern Uganda had 4.0% of the total estimated numbers of orphans. Under the case study (sub-section 4.3.1.1), the results shows that 80% (12 out of 15) participants were orphans.

4.11.2 Knowledge about adolescence among the respondents

4.11.2.1 Understanding adolescence

This section of the study examined the respondents' knowledge about adolescence as a stage of growth and development. According to WHO (2002:5) and Neema et al (2004:6); adolescence is a transition stage from childhood to adulthood, it's a time of physical, emotional biological and psychological changes as the body matures and the mind becomes more questioning and independent.

During adolescence some of the key developmental traits include: desire for self-autonomy and independence; start to establish intimate relationships, self-identity and

attraction to the opposite sex as well as becoming adventurous (Petersen et al 2012:413). However, it has been reported that during this phase adolescents are faced with life threatening health risks which are attributed to sexual and reproductive issues such as unwanted pregnancies and sexually transmitted infections including HIV and AIDS.

4.11.2.2 The respondents understanding of who is an adolescent is

The researcher established the respondents' understanding of adolescence by age definition, major characteristics of adolescence and using the respondents' answers or responses to the question, the researcher established the respondents' ability to identify some of the changes that have occurred on their bodies.

4.11.2.3 The respondents' definition of who is an adolescent

Using a multi choice question for the definition of adolescence by age, the respondents were asked to choose one option; which among others included: those under the age 10 years, those aged between 10-19 years and those above 20 years. From the responses, 95.6% (n=576) correctly identified who an adolescent is, that is between 10-19 years of age (UNICEF 2009:5). Only 4.4% (n=24) could not correctly identify who an adolescent is. Figure 4.2 summarises the responses.

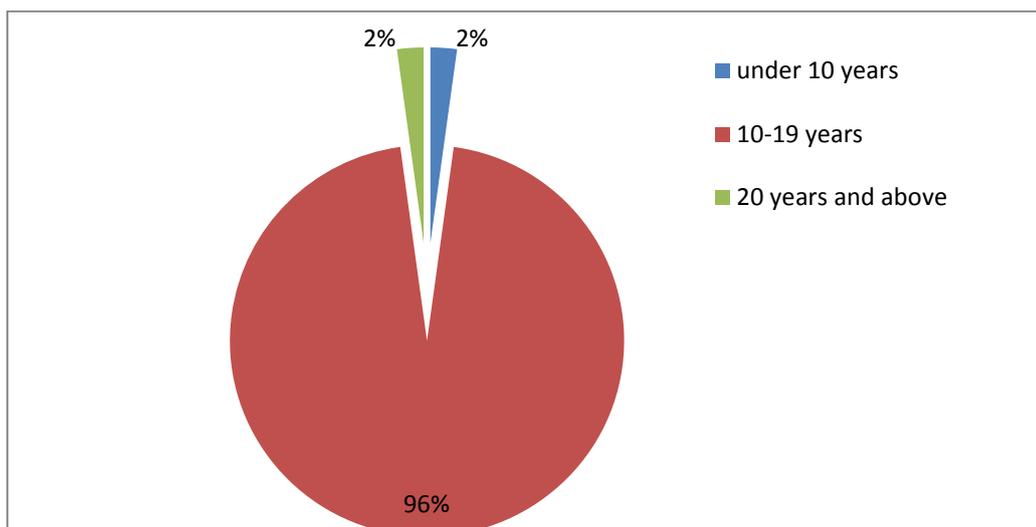


Figure 4.2: Percentage of respondents who defined who an adolescent is by age (N=600)

4.11.2.4 The respondents understanding of key characteristic of adolescence

A multi-choice question was asked and respondents were required to state all that applied and the researcher ticked the responses as stated. The figure below presents the responses generated from the in school and out of school interview settings with the respondents.

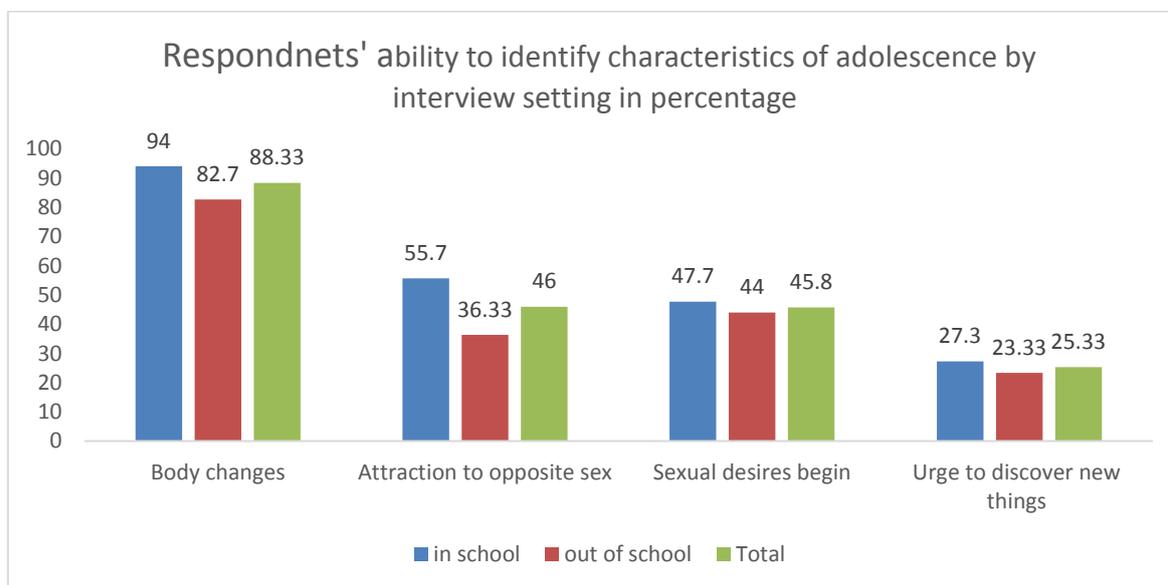


Figure 4.3: Respondents' ability to identify characteristics of adolescence by interview setting in percentage (N=600)

The characteristics were grouped under physical, emotional and social; body changes, attraction to the opposite sex, sexual desires and urges to discover and explore new things as shown Figure 4.3 above. In all the four areas of changes listed above, respondents who were interviewed from the school setting had a better understanding of characteristics of adolescence with the majority (94%) stating body changes as compared to 82.7% in the out of school interview setting; attraction to the opposite sex was 55.7% for the in school setting and 36.3% for the out of school setting. Sexual desire and urge to discover new things rated at below 50% for respondents in both interview settings.

These results resonated with the results for the case study on the knowledge about adolescence and ASRH among teen mothers where there was exhibition of limited knowledge about adolescence as a stage of transition and also lack comprehensive information on adolescents' sexual reproductive health.

4.11.2.5 Physical, social and emotional changes reported by respondents

The researcher asked the respondents to share their personal experience of the physical, social and emotional changes; and according to the respondent's gender or sex (boy or girl). Multiple-choice responses were generated on the changes that have occurred on respondent's bodies. The researcher read out the multiple-choice questions and recorded the respondents' answers.

The characteristics looked at included; physical, social and emotional changes by sex as detailed in Table 4.16 below.

Table 4.16: Major characteristics (physical, social & emotional) changes during adolescence

<p>Box 4.12a: three major characteristics of body changes for girls and boys during adolescence</p> <p><u>Girls</u></p> <ul style="list-style-type: none">• Development of breasts• Menstruation• Soft voice <p><u>Boys</u></p> <ul style="list-style-type: none">• Deepening of the voice• Enlargement of private parts• Wet dreams	<p>Box 4.12b: Characteristics of social and emotional changes during adolescence for both boys & girls</p> <p><u>Girls</u></p> <ul style="list-style-type: none">• Mood swings• Attraction of the opposite sex• Smartness <p><u>Boys</u></p> <ul style="list-style-type: none">• Attraction of the opposite sex• Independent• Discovering new things
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For the physical changes in boys and girls, the question required the respondents to state the kind of physical changes that they have experienced as detailed on the Figure 4.4 for girls and 4.5 for boys below respectively.

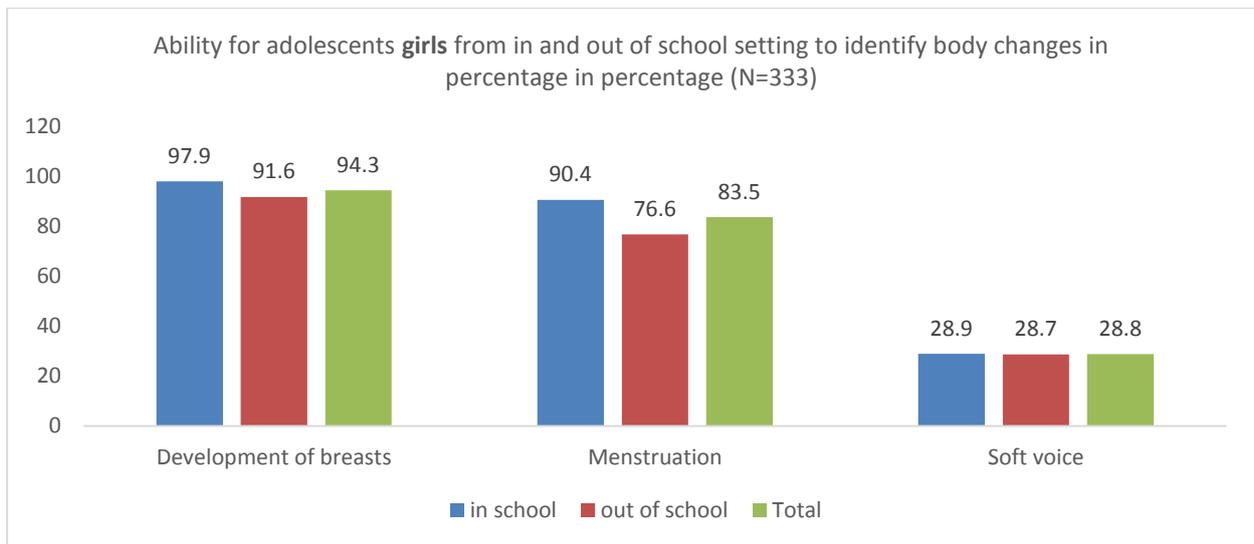


Figure 4.4: Percentage of adolescent girls by interview setting who could identify three major body changes (N=333)

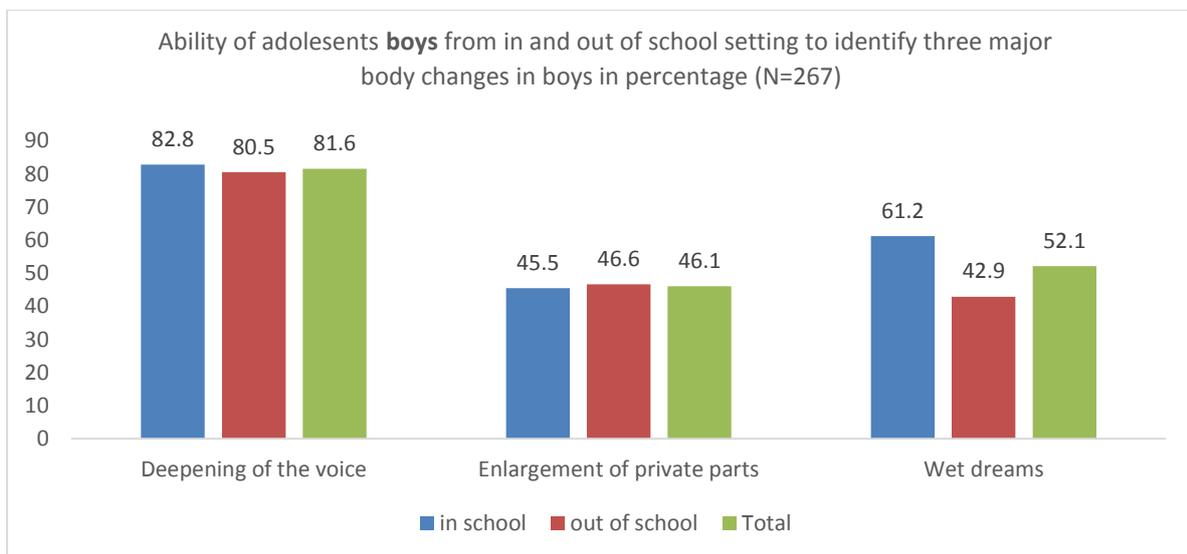


Figure 4.5: Percentage of adolescent boys by interview setting who could identify three major body changes (N=267)

From the results, girls had better understanding of body changes compared to boys in both the interview settings. Majority of girls (94%) were able to identify development of breasts as compared to boys (82%) who could identify deepening of the voice. In the area of menstruation for girls and wet dreams for boys; 84% of girls identified menstruation as a sign of adolescence as compared to just 52% of the boys who could identify wet dreams as a sign of adolescence. On the enlargement of the private parts, only 46% boys could identify and associate it to adolescence as compared to only 29% girls who identified soft voice as a change that occurred during adolescence.

Previous studies show similar knowledge gaps on adolescence as a transitional stage in adolescents growing up. World Bank (2014:1) shows that adolescents and young people (10-24 years of age) around the world face tremendous challenges in meeting their sexual and reproductive health needs partly due to inadequate access to health information and services, as well as inequitable gender norms that contribute to a lack of knowledge and awareness about puberty and sexuality (African Union 2013:5-6; Neema et al 2004:21; Amanda 2014:5).

4.11.3 Sexual activity among the respondents

This section explored respondents' sexual activity and safe sex options. It began by establishing those who were in a relationship, the duration of relationship, the age of boy/girlfriend and if at all the respondents had experienced sexual intimacy; then what was the age at first sex for those who reported to have had sex, and as well if they had other sexual partners; or if had ever been attracted to same sex relationship given the fact that the issue of sexual orientation and rights has become a global movement. The last part of the section looks at safe sex practices that basically looked at knowledge on condoms and its utilisation.

4.11.3.1 Respondents who were in a boy/girl-friend relationship

A total of 600 respondents answered this question, of which the majority 62.5% (n=375) were not in a relationship and 37.5% (n=225) reported that they were in a boyfriend /girlfriend relationship. By research setting, more respondents (41.3% n=124) of those interviewed from the community setting were in a relationship (58.7%; n=176) from the same setting were not in a relationship as compared to (33.7%;n=101) in the school interview setting who were in a relationship against 66.3% (n=199) who were not in a relationship (see Figure 4.6 below for details).

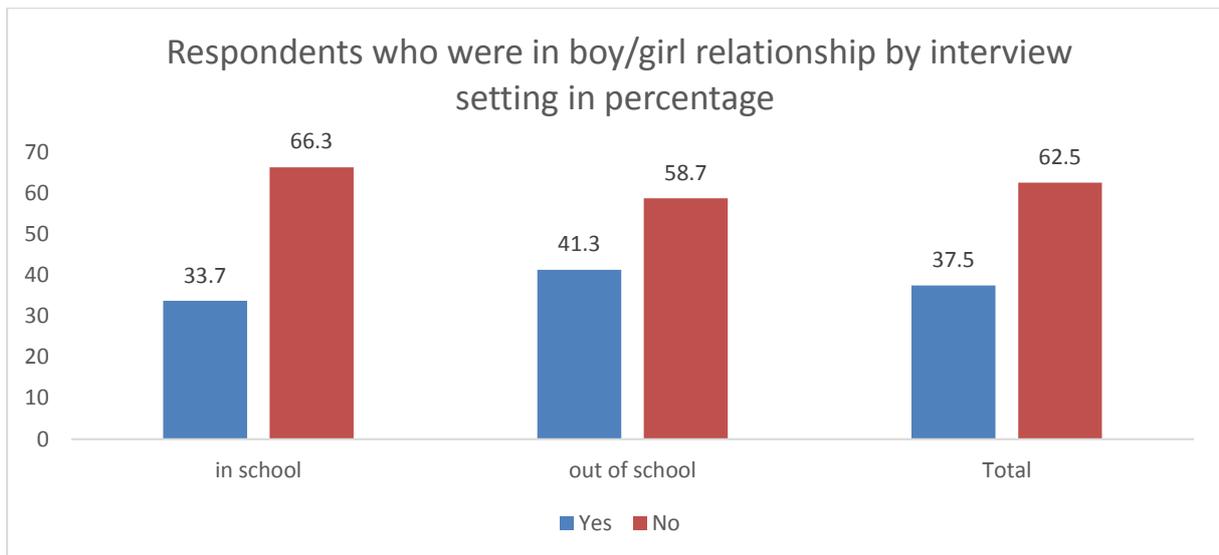


Figure 4.6: Percentage of respondents who are in a relationship by interview setting (in or out of school) (N=600)

4.11.3.2 The average duration and length of time the respondents have been in a relationship

The results found that a total of 225 (37.5%) respondents were in a relationship. The respondents were asked to state the duration and the average length of time they had spent in the relationship. The average length of time ranged between 1-5 months, 6-12 months and above 12 months (see Figure 4.7 below).

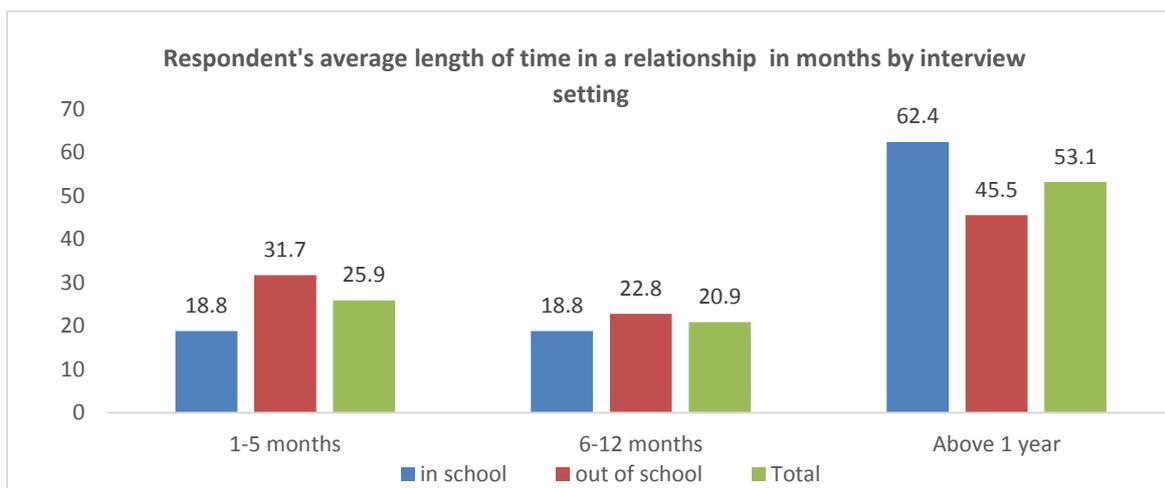


Figure 4.7: Percentage and duration of period of respondents who are in a relationship by interview setting and months (N=225)

Overall, 53% (n=119) of the respondents had been in a boyfriend /girlfriend relationship for over a year. Of these, 26% (n=59) had stayed in a relationship for period of 1-5 months, and just about 21% (n=47) had stayed for between 6-12 months. The results show that for respondents who were in a relationship for more than 12 months, a bigger percentage 62.4% (n=xx) were from the school interview setting as compared to 45.5% (n=xx) from the community interview setting.

4.11.3.3 The age of the sexual partners of the respondents

The study established the age of the sexual partners of the respondents. The ages of the sexual partners were categorised as 10-19 years (adolescents); 20-24 years (as young people) and above 25 as adults. The results, shows that the majority (67.7%; n=153) were in adolescents’ relationship (aged 10-19 years), followed by 27.7% (n=62) respondents were in a relationship with young people (20-24 years) and 4.6% (=10) were in a relationship with adults 25 years and above.

The study went further to establish that the relationships peaked during holiday period as compared to school time. Overall, 67.7% (n=152) respondents were in adolescent to adolescents relationship, 27.7% (n=63) were in relationship with young person 20-24 years and 4.6% (n=10) were in relationship with adults aged 25 years and above (see Figure 4.8 below).

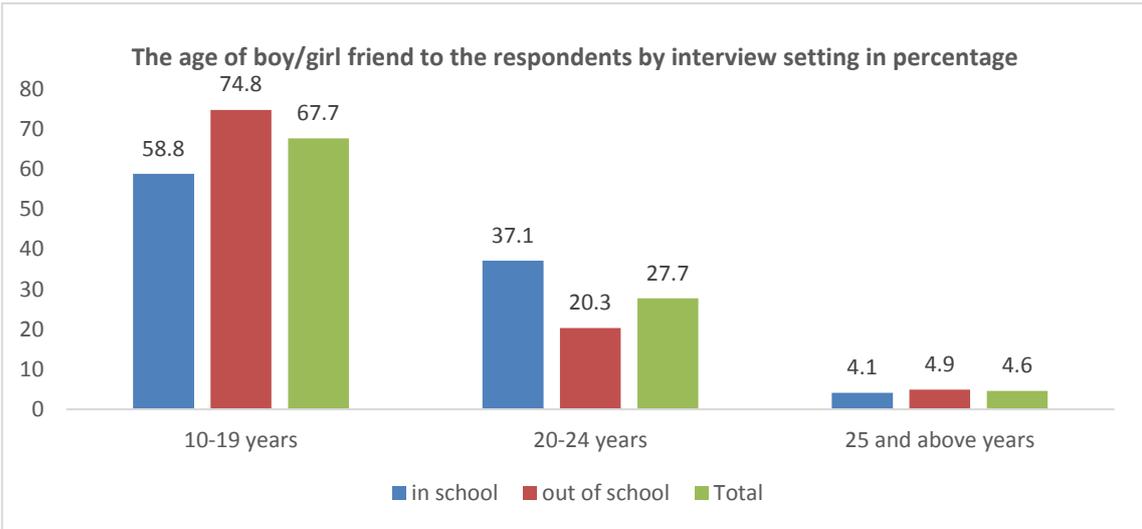


Figure 4.8: Age of boy/girl friend of the respondents by interview setting in percentage (N=225)

4.11.3.4 The duration in a relationship by sex of the respondents

Under section 4.9.3.1 above, a total of 225 (37.5%; n=84) adolescents were in a relationship. Of these, it was found that 121 (54%) were girls compared to 104 boys (46%). Regarding the duration in relationship, more boys 64% (n=37) as compared to girls 36% (n=21) had been in a relationship for between 1-5 months; while for the duration between 6-12 months, there was no difference between boys and girls at 57% for both.. However, for the longer duration more girls 61% (n=72) compared to 39% boys (n=47) had been in a relationship for more than 12 months ($p=0.008$) implying that girls were more likely to stay longer (over 12 months) in a relationship compared to boys.

The findings established that adolescent to adolescent relationship were common with about 68% (see Figure 4.8 above) which is similar to findings under the case study where (75%) of teen mothers were impregnated by fellow school mates (adolescents) who were in upper primary (P5-P7), indicating child-to child sex.

4.11.3.5 Respondents who had ever had sex

Of the 225 respondents to this question, a total of 129 respondents (57%) reported to have ever had sex. The majority of these (27%) came from the respondents who had been interviewed from the community setting as compared to 16% respondents from the school setting (p -value of 0.001), which indicates that the adolescents were more likely to have sex during the school holiday compared to during school time. Regarding the gender of the respondents who have ever had sex, 57% (n=73) were male and 43 % (n=56) were female. For sex by gender, the ($p=0.002$) value indicated that boys were more likely to have sex during school holiday.

4.11.3.6 Respondents who had sex with the current boy/girl friend

Of the 225 respondents to this question, a total of 77 (34%) respondents reported to have had sex with the current boy/girl-friend while 66% had not had sex (see Figure 4.9 below). Of the 77 respondents who had sex, 41 (53%) were female and 36 (47%) were male.

In terms of interview setting, the majority (40.3%) of respondents interviewed from the community reported to have had sex with their current boyfriend or girlfriend compared to 26.7% respondents interviewed from school settings.

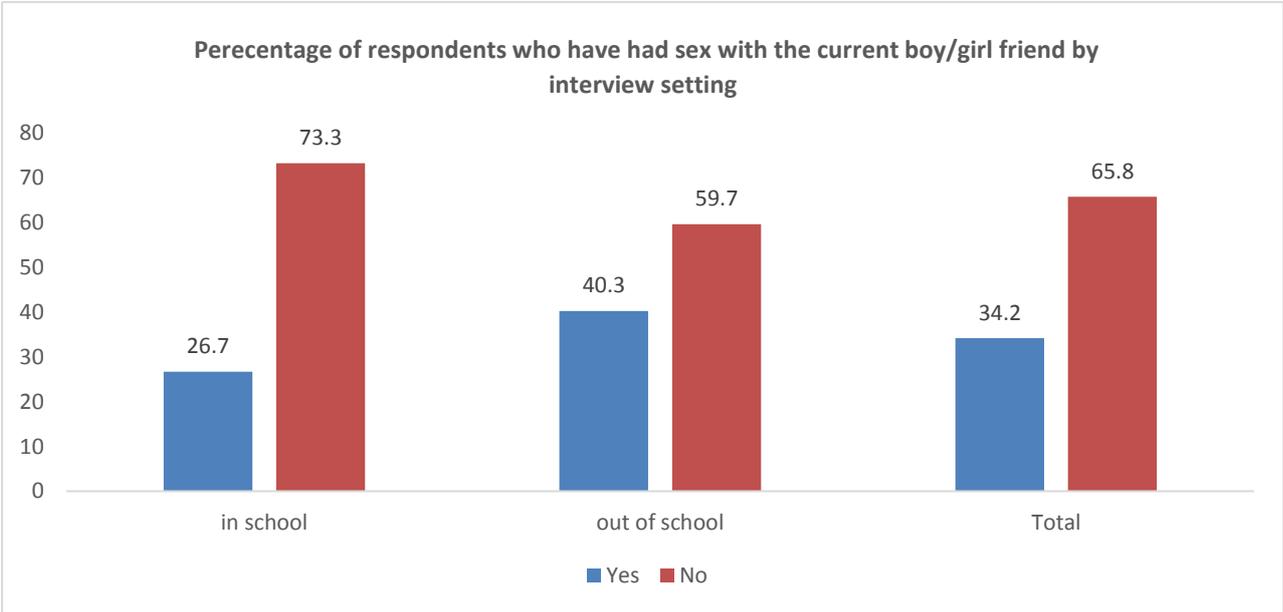


Figure 4.9: Percentage of respondents who have had sex with the current boyfriend/girlfriend by interview setting (N=225)

4.11.3.7 Respondents who had other sexual partner(s) apart from the current boyfriend/girlfriend

Multiple and concurrent sexual practice is one major sexual risk factor that exposes people to the risk of HIV and AIDS and other sexually transmitted infections. The respondents who reported to have a current boyfriend/girlfriend relationship were asked if they had any other sexual partner(s). Of the 225 respondents who were in a boyfriend/girlfriend relationship, 7.1% (n=16) were in a multiple and concurrent relationship. Slightly more respondents (8.9%) who were interviewed from school setting compared to 5.7% from the community setting were in a multiple relationship. Of the 16 respondents who had a multiple relationship, 11 (69%) were boys as compared to 5 (31%) reported to be female.

4.11.3.8 Respondents who were attracted to same sex and reported to have had a sexual relationship

The modern trends in development coupled with information technological advancement is gradually creating a global village where young people are increasingly beginning to explore new ideas and are developing new youth cultures. One of such new trend is sexual orientation, whereby from the human rights perspectives and the advancement of the rights and freedom to choice of sexual partner, aspects such as same sex relationship have emerged. The study explored if the respondents had ever been attracted or desired to have an intimate sexual relationship with peers of the same sex. Of the 597 respondents who answered this question, 1% (n=5) reported to have been attracted to the same sex. Of the 5 respondents, 4 were from the school setting and only one (01) was drawn from the community setting. Of these 5 respondents, three (03) were male and two (02) were female.

4.11.3.9 Respondents who had heard about condoms and the source of information on condoms

Respondents were asked using close-ended questions if they have heard about condoms. From the respondents' answers, the majority (95%) had heard about condoms and only 5% had not heard about condoms. The level of awareness and knowledge on condoms were more or less the same for the in school (95.3%; n=286) and community (94.9%; n=285) interview settings.

Regarding the sources of information on condoms, a multiple choice question was asked and the respondents stated all responses that applied to them. Table 4.17 below shows the different channels through which the respondents got information on condoms.

Table 4.17: Places where respondents got information on condom by interview setting in numbers

Places where respondents got information on condom	Number of respondents by Interview setting			
	In school (N=300)	Ranking	Out of school (N=300)	Ranking
Health center	165	2 nd	167	1 st
School	212	1 st	147	2 nd
Peers	125	3 rd	131	3 rd
Radio	77	4 th	95	4 th
Parents	38	5 th	41	5 th
Print media	18	6 th	11	6 th
Religious institution	9	7 th	5	7 th

Since it was a multiple choice responses, total number of responses were summed up. The results show that for the community interview settings, health centres were ranked number one followed in sequence by the school, peers, radio, and parents (5th ranking), print media and lastly the religious institutions. For the in-school interview setting, the school was ranked first as a source of information on condoms then followed by the health centre and the sequence was then similar as for the community setting.

In the context of the health centre (which included the hospital, lower health centres and clinics) as a source from where information on condoms was obtained, the results show that more respondents got information on condoms from lower health facilities, then hospital as the second ranked and then clinics which ranked third as detailed in Figure 4.10 below.

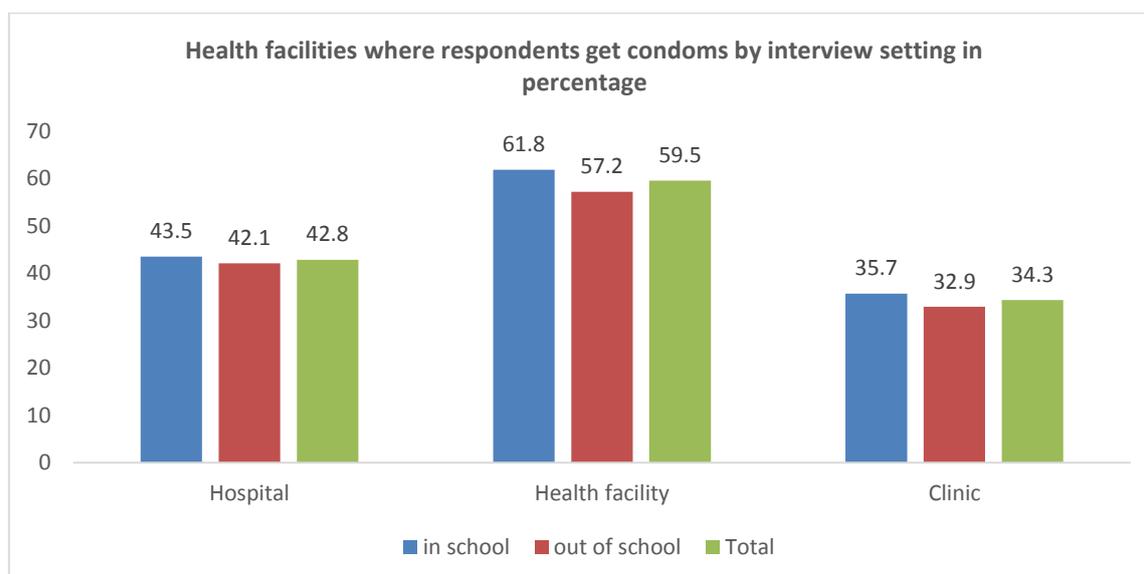


Figure 4.10: Health facilities where respondents get condoms in case of need

4.11.3.10 Respondents who had ever used a condom

Using a close-ended question, respondents were asked to state if they had ever used a condom. A total of 124 respondents answered this question which gives a response rate of 22% (out of the 600 total respondents). Of the 124, the majority 71.8% (n=89) reported they had ever used a condom. By interview setting, close to 76% (=94) response on condom use came from the community setting while about 64% response on condom use came from the school interview setting (see Figure 4.11 below). Among the respondents who reported to having ever used a condom, 46 (52%) were boys compared to 43 (48%) girls.

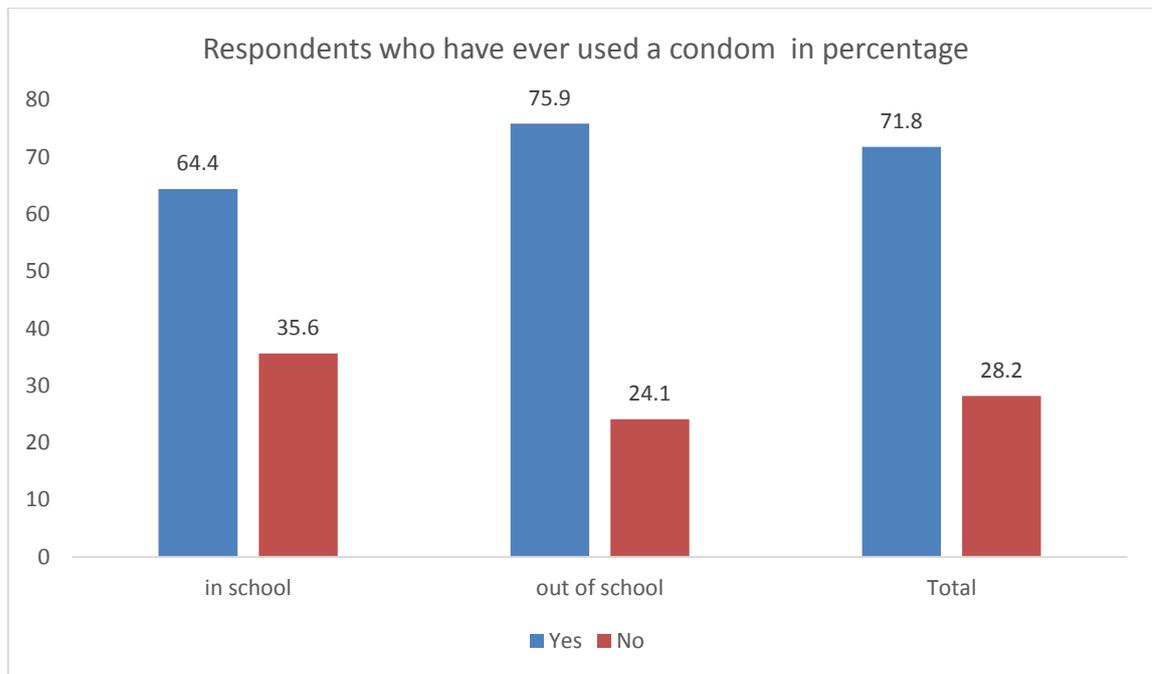


Figure 4.11: Percentage of respondents who have ever used a condom by interview setting (N=89)

4.11.3.11 Consistency of condom use among respondents who ever used a condom

The respondents (n=89) who reported to having ever used a condom were asked how often they used a condom whenever they had sex. Overall 53% (n=47) reported to have always used a condom compared to 47% (n=42) who reported that sometimes they used a condom. The consistency of condom use was higher (54%; n=48) among the respondents interviewed from the community compared to 46% (n=41) respondents interviewed from school setting.

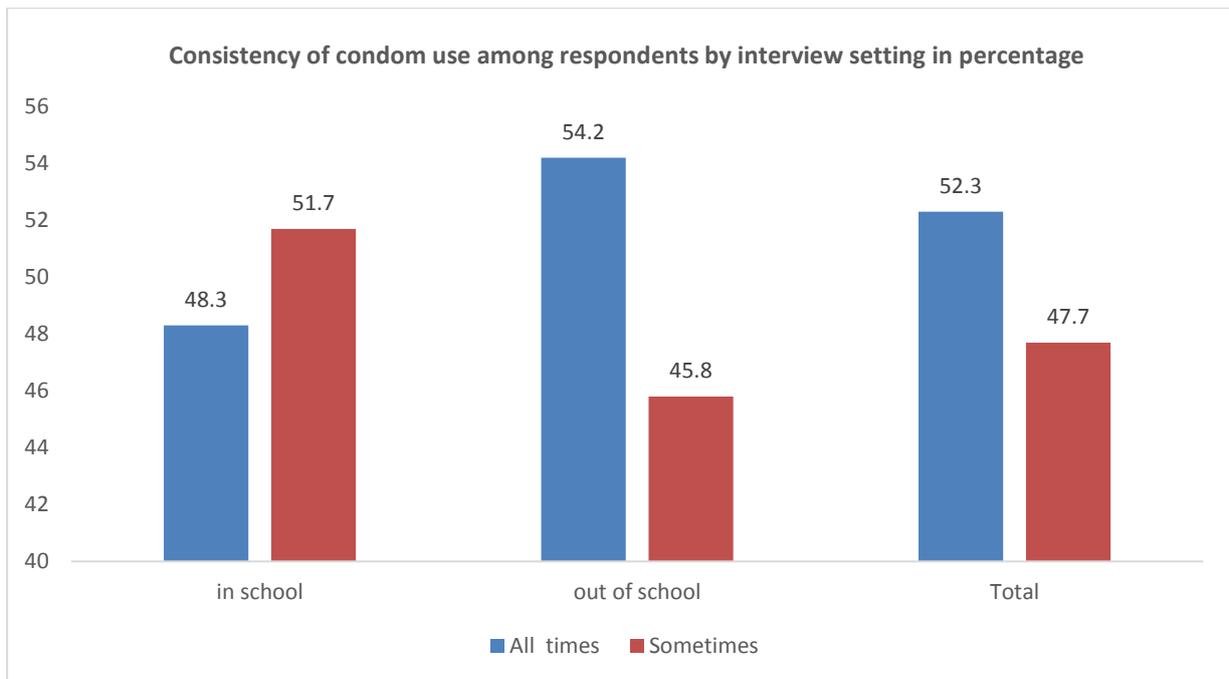


Figure 4.12: Consistency of condom use among respondents by interview setting in percentage (N=89)

4.11.3.12 Respondents who used a condom during the last sex

Using a close-ended question, the respondents were asked to state if a condom was used during their last sex encounter. Referring to the sub-section 4.9.3.5, where 22% (n=129) reported to having ever had sex, 56.6% (n=73) reported to having used a condom during the last sex encounter. There were more respondents (n=50) from the community interview setting compared to just 23 respondents from the school interview setting. By gender, there were 58% males and 42% females who reported to have used a condom during the last sex encounter.

4.11.3.13 Places where to get a condom in case of need

Using a multiple-choice question, respondents were asked to state where from their community they would get a condom in case they needed one. From the table, health facilities that included hospital, health centre (lower level facilities in the community) and clinics were ranked number one (44%), followed by shops (31%), peers and the boyfriend or girlfriend (25%).

4.11.3.14 Awareness about the dangers of unsafe sex

The respondents were asked using close ended question to state whether they were aware of the dangers of not using a condom (unsafe sex) and all (100%) indicated that they were aware of the dangers of unsafe sex. And in a follow on question, the respondents were asked of the dangers of unsafe sex using a multiple choice question and the responses show that some respondents were able to identify at least one of the dangers or all the three dangers that included:

- (a) Unplanned pregnancy
- (b) HIV and AIDS
- (c) Other Sexually transmitted infections (STIs)

The results showed that the majority (94.7%) could only identify any one danger and only 37.3% identified all the three major dangers listed above. Of the three, HIV and AIDS was the most popularly known danger of unsafe sex. The level of knowledge (ability to identify all the three major dangers) was higher among the in school interview setting (41%) when compared to the community interview setting with 33.7% as shown in Figure 4.13 below.

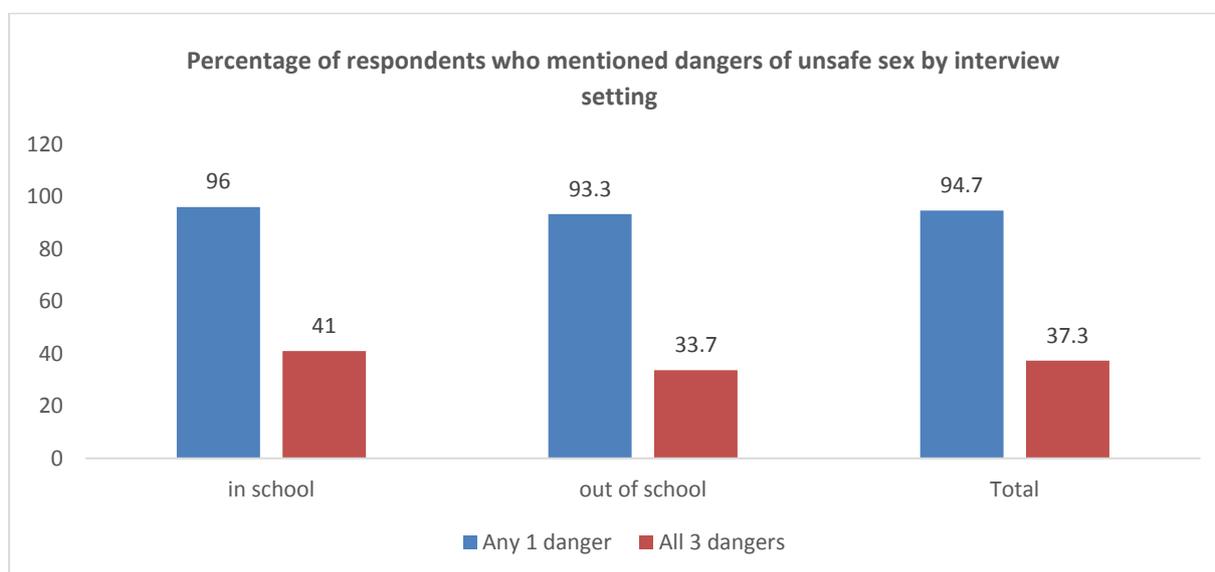


Figure 4.13: Percentage of respondents who mentioned any one or all the three danger signs of unsafe sex (N=600)

4.11.4 SOURCES OF ASRH INFORMATION AMONG RESPONDENTS

Under this section, the researcher explored the respondents’ level of knowledge on adolescents’ sexual reproductive health; including the sources of information that the respondents used to get sexual reproductive health information, the respondents’ preferred sources of ASRH information and reason for the preference of the source and finally whether the respondents were satisfied with their preferred source.

The researcher asked respondents using a multiple choice question to state all answers that apply. Among the sexual reproductive health issues discussed were early sexual activity and pregnancy prevention. This also included respondents’ knowledge of abstinence (primary prevention), condoms and other modern methods of family planning or birth control. The outcomes of early sexual activity included: unintended pregnancy, abortion, HIV and AIDS and other sexually transmitted infections. The results generated from the respondents are presented as follows:

4.11.4.1 Respondents’ knowledge on pregnancy prevention

The respondents from both interview settings knew condoms as the major way of preventing pregnancy (77.8%), followed by abstinence (55.5%) and use of family planning (40.5%) outlined in Figure 4.14 below.

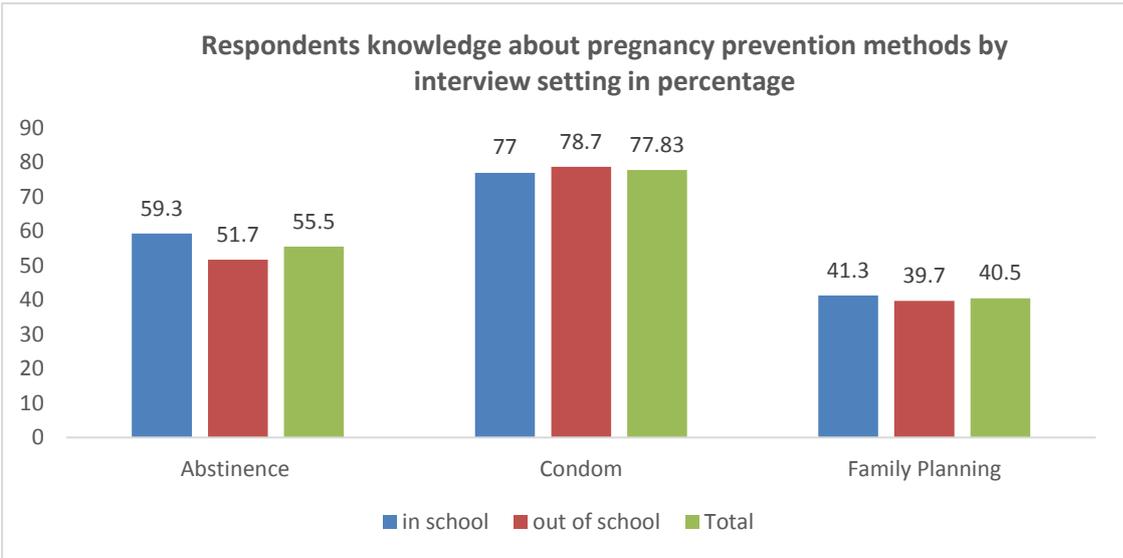


Figure 4.14: Respondents knowledge about pregnancy prevention by interview setting (N=600)

4.11.4.2 Respondents' knowledge on the dangers of early sexual activity

The results on the dangers of early sexual debut among the respondents show that the majority (83.7%) were more knowledgeable about HIV and AIDS, then followed by unplanned pregnancy (64.3%) and then abortion (48.3%).

4.11.4.3 Source of adolescents sexual reproductive health information among respondents

The respondents were asked to state the source where they received information on ASRH. Using a multiple-choice question, the respondents were asked to state all that applied to them. The sources of information were grouped under two sub-categories (a) and (b) below:

- (a) Interpersonal sources (peers, parents, teachers, health workers and local leaders)
- (b) Mass media including print, radio, television and internet

The information generated from the respondents is detailed below.

4.11.4.4(a) Interpersonal sources of information on ASRH

Among the interpersonal sources of ASRH information, the most popular were teachers (28%) followed by health workers (21%), parents and guardians (18%), peers (16%), religious leaders (12%) and the least, cultural leaders (5%).

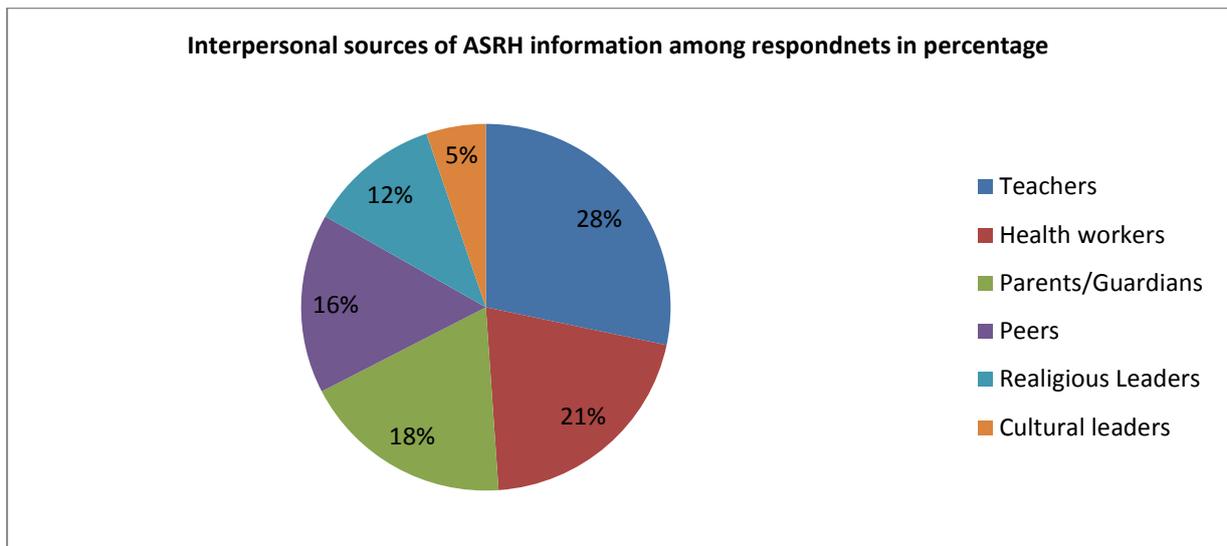


Figure 4.15: The interpersonal sources of ASRH information among respondents in percentage (N=600)

The results further showed that more respondents (54%; n=324) accessed ASRH through interpersonal sources during school term time compared to holiday time (46%; n=276)).

4.11.4.4(b) Mass media as source of ASRH information among respondents

Use of mass media is increasingly becoming a major source of information for young people (Owusu & Oforiwaa 2014:81-82; Crown 2010:42). The results from the current study show that the radio was the major source (27%), in the use of mass media as the source of ASRH information. This was followed by print media (6%), television (4%) and then the internet (0.3%).

4.11.4.4(c) The proportion of respondents who used mass media to access ASRH

Considering the 300 respondents interviewed from both interview settings 33% in-school respondents used any form of media to access ASRH and 46% from the community setting used any of the four media sources including print media, television, radio and internet.

4.11.4.5 Respondents' preferred source of information on adolescents' sexual reproductive health

Referring to both the interpersonal and mass media sources presented under items 4.9.4.4 (a-c) above, the respondents were asked to state one of their preferred sources. Figure 4.16 below shows the results with teachers (38.3%; n=230) being the most preferred, followed by health workers (31%; n=186), parents and guardian (18%; n=108)), peers (6.5%; n=39), radio (5%; n=30) and both print media and TV with 1.2%.(n=7).

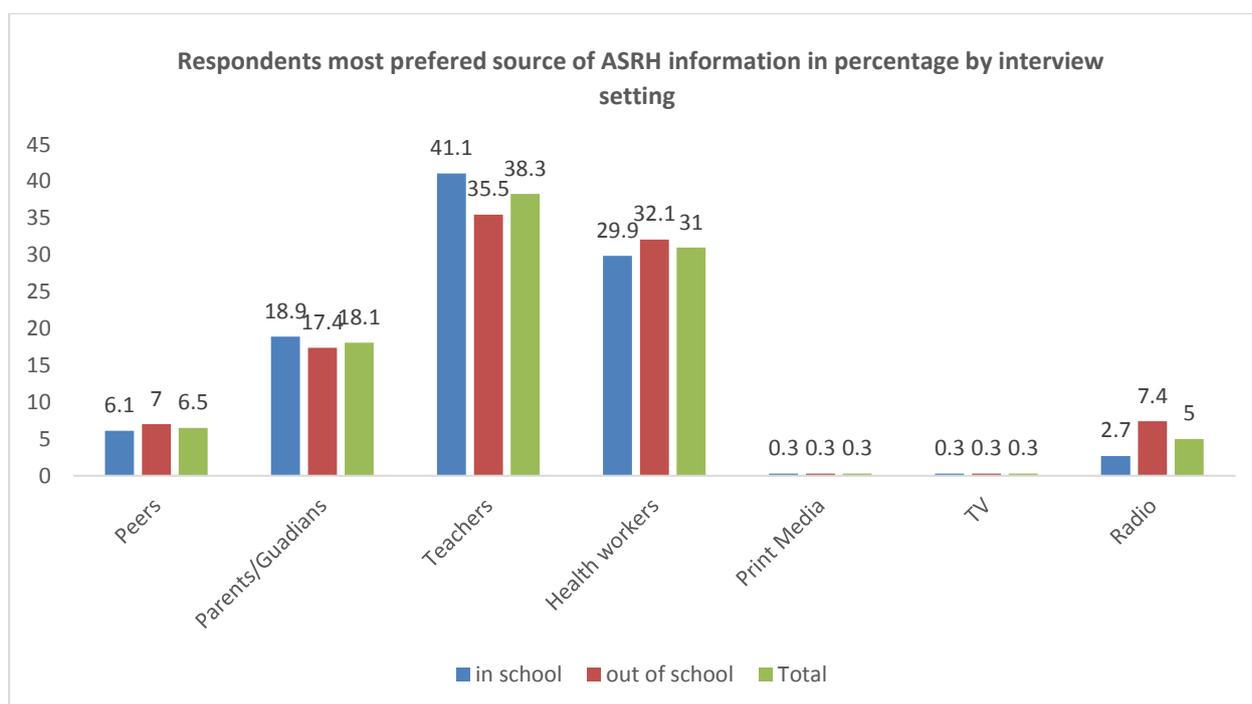


Figure 4.16: Respondents preferred source of ASRH by interview setting in percentage (N=600)

4.11.4.6 Respondents' reason for the preferred source of ASRH information

The respondents were asked to state the reason for their preferred the source of information as reflected in Figure 4.16 above. Using a multiple choice question in which the respondent was required to indicate only one reason for the preference, the result shows that, trust and reliability were rated highly with an average of 62%, followed by accessibility (38.2%), confidentiality (17.3%) and lastly privacy (11%) as shown Figure 4.17 below. The trends for preference for in school and out of school interview settings were the same with more number reported among the in school in all the four indicators

(ranging from 66.3%, to 40.3%, 22.7% and 13.3%) as compared to the out of school which ranged from 57.7%, to 36%, 12% and 8.7%) respectively as shown on Figure 4.17 below.

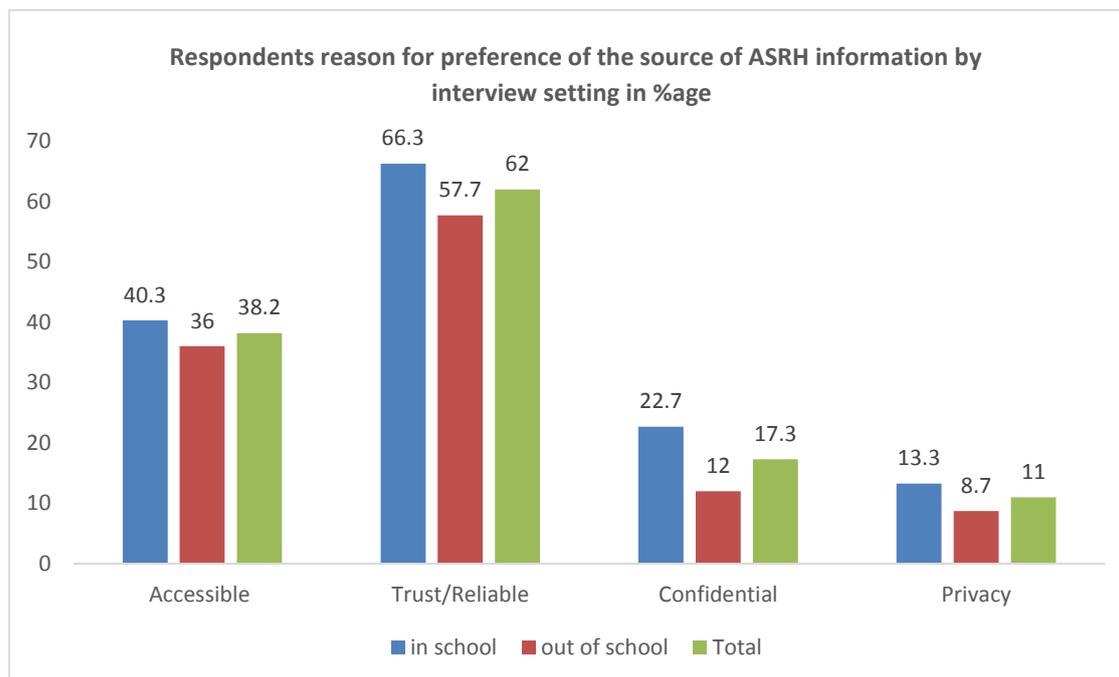


Figure 4.17: Respondents' reason for the preferred source of information on adolescents' sexual reproductive health (N=600)

4.11.4.7 The usefulness of the source of ASRH information

The respondents were asked if they were helped by the various sources of information on ASRH reported under sub-section 4.9.4.3 above. Overall for both interview settings, over 96% (n=576) indicated that the sources were helpful and just about 4% (n=24) felt that the sources of ASRH indicated didn't help them. Figure 4.18 below shows the details.

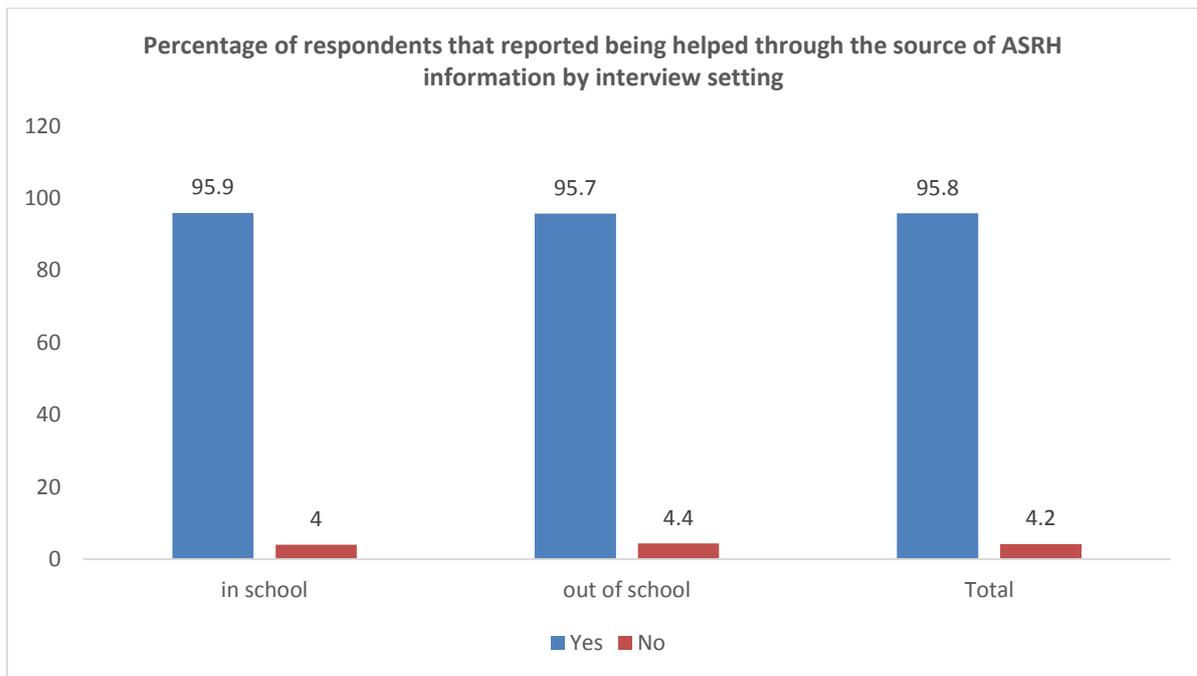


Figure 4.18: Helpfulness of the source of ASRH information in percentage by interview setting (N=600)

4.11.4.8 The rating of the usefulness of the ASRH information obtained from the above sources

The results on the rating of the usefulness of the ASRH information obtained from the different sources shows that 44.6% (n=268) were very satisfied with the information, 46% (n=276) were satisfied, 7.9% (n=47) were somewhat satisfied whilst 1.5% (n=09) were not satisfied with the ASRH information they obtained (see Figure 4.19 for details).

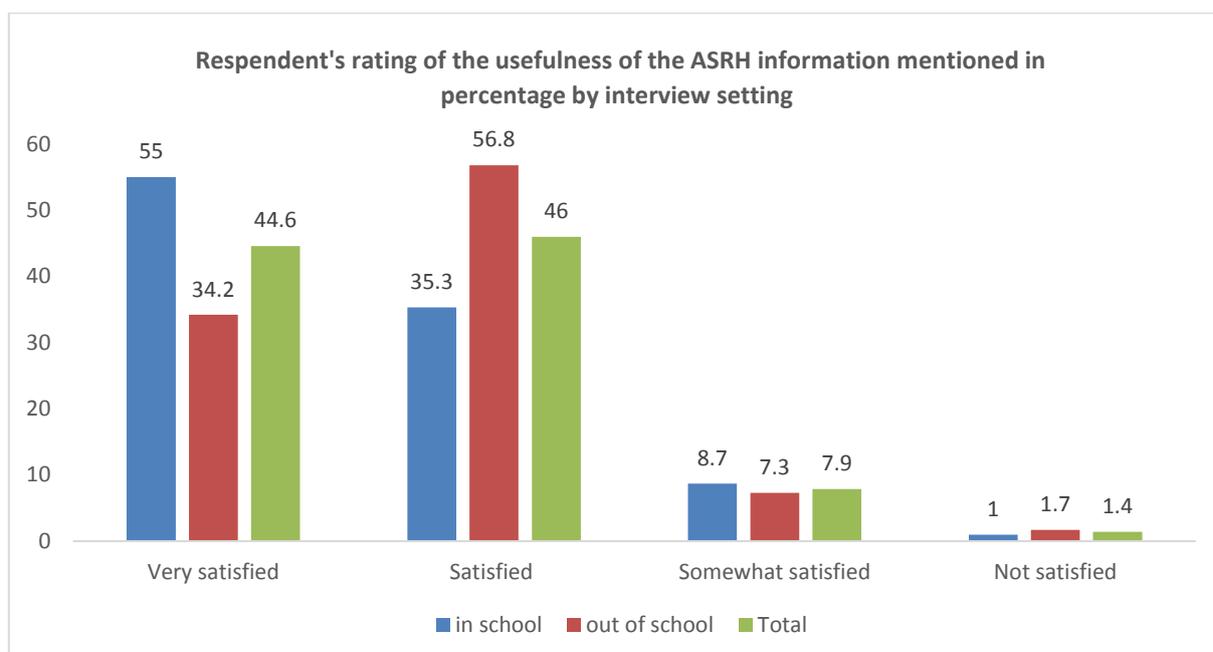


Figure 4.19: Respondents rating of the usefulness of the ASRH information in percentage by interview setting (N=600)

4.12 KEY FINDINGS FROM THE QUANTITATIVE STUDY

The quantitative study results revealed the following as key findings:

Demographic characteristics of the respondents

On the demographic characteristics of the respondents, 56% (n=336) were female and 44% (n=264) male. The majority (98%; n=588) were still schooling and only 2% (n=12) had dropped out. The majority of those schooling were in upper primary (P5-P7). The orphan-hood status among the respondents stood at 31% (n=186).

Respondents level of knowledge on adolescence

Regarding the level of knowledge of adolescence as a transitional stage, the majority (96%; n=576) could correctly identify an adolescent as one aged between 10-19 years. On the major characteristics of adolescence including physical, emotional and social changes, the physical changes were easily identified by the majority as compared to the other characteristics. By interview setting, the in school group were more knowledgeable (95%) on stating physical changes compared to by the out of school group (82.7%).

As for gender distribution, the results revealed that girls had better understanding of physical changes compared to boys in both interview settings. The majority of girls (94%) were able to identify development of breasts compared to boys (82%) who were could identify deepening of their voice. In the area of menstruation for girls and wet dreams for boys; 84% of girls identified menstruation as a sign of adolescence compared to 52% of the boys who identified wet dreams as a sign of adolescence. On the enlargement of the private parts, only 46% boys could identify and associate it to adolescence compared to about 29% girls who identified soft voice as a change that occurred during adolescence.

Sexual activity reported among respondents

On sexual activity among respondents and specifically on the issue of boyfriend/girlfriend relationships, 32.5% reported to be in boyfriend/girlfriend relationships but the majority (62.5%), was not engaged in any sexual relationship.

Of those who were in a relationship, 67.7% were in adolescent-to-adolescent relationships as their partners were aged 10-19 years. Close to 28% were in a relationship with young people 20-24 years and less than 5% had relations with adults aged 25 years and above. Regarding the duration of relationships, more than 50% had spent at least 12 months (one year) or more in a relationship. More girls 61% (n=72) compared to 39% boys (n=47) had been in a relationship for more than 12 months ($p=0.008$) implying that girls were more likely to stay longer (over 12 months) in relationships than boys.

The majority (57%) of those in a relationship reported to have had sex already, and by interview setting, 27% were interviewed from the community setting compared to 16% respondents from the school setting ($p=0.001$) which indicates that adolescents were more likely to have sex during school holiday time compared to school term time.

Regarding the sex of the respondents who had ever had sexual intercourse reported above as 57% (n=129); more were male 57% (n=73) compared to 43 % (n=56) who were female. Gender wise, boys were more likely to have sex during school holiday than girls ($p=0.002$). About 7% of the respondents who reported to have had sex were in a multiple concurrent sexual relationships.

Safe sex practice

On safe sex practice, out of 124 respondents, the majority 71.8% (n=89) reported to having ever used a condom. Among those who reported to have ever used a condom, the consistency of condom use was 52% (n=64).

The dangers of unsafe sex (non-use of condom), that were listed included among others:

- (a) Unplanned pregnancy
- (b) HIV and AIDS
- (c) Other sexually transmitted infections (STIs)

The majority (94.7%) could identify at least one danger and only 37.3% identified all the three major dangers listed above. Of the three major dangers, HIV and AIDS was the most popularly known danger of unsafe sex. The level of knowledge (ability to identify all the three major dangers) were higher among the in school interview group (41%) compared to the community setting group (33.7%).

On pregnancy prevention, the majority knew condoms as the best way of preventing pregnancy (77.8%), followed by abstinence (55.5%) and also use of family planning methods (40.5%).

Sources of information on ASRH

The source of information on ASRH included both interpersonal (peers, parents, teachers, health workers and local leaders) and mass media (print, radio, television and internet). Of the interpersonal sources of ASRH information, the majority reported teachers (28%) as their main source of ASRH, followed by health workers (21%), parents and guardians (18%), peers (16%), religious leaders (12%) and the least popular cultural leaders at 5%. While for mass media, the radio was the major source (27%), followed by print media (6%), and TV and internet were the least popular sources with 4% and 0.3% respectively.

4.13 CONCLUSION

Chapter 4 presented results of the study findings from both the qualitative and quantitative strands of the current study. The results revealed many key findings which informed the key recommendations which were fused with expert views and opinions to guide the development of a community model and strategies for enhancing community responsiveness to adolescents' sexual reproductive health as presented in Chapter 5.

CHAPTER 5

INTERGRATION OF FINDINGS AND DISCUSSION

5.1 INTRODUCTION

Chapter 5 discusses the integration of findings with the discussion, with the aim of situating this study within other research studies done. In integrating the findings five themes emerged with sub-themes as shown in Table 5.1

Table 5.1: Themes and sub-themes

	Themes	Sub-themes
1.	Experiences of teen mothers	<ul style="list-style-type: none">• School dropout• Orphanhood• Parenting• Knowledge deficit
2.	Community support	<ul style="list-style-type: none">• Communication• Disintegration in informal education
3.	Early parent separation	
4.	Stigma and discrimination	<ul style="list-style-type: none">•
5.	Sexual exploitation	

5.1.1 Experiences of teen mothers

One major finding of the study under experiences of teen mothers was dropping out of school where the majority of adolescents (73%) dropped out of school prior to getting pregnant. This finding contradicts what has already been reported in literature where it was adolescents who fell pregnant who dropped out of school (Sebola 2014:45). According to Namukwaya and Kibrige (2014:423-425), factors that influence school drop-out include among others: low socio-economic status of the household, parents' level of education and mobility. According to the International Center for Research on Women (ICRW) (2007:5), while dropout rates rise with age and are often greater for girls than boys among older adolescents, girls are more likely to drop out for reasons other than pregnancy and early marriage; pregnancy and early marriage tend to occur shortly after dropout. Pregnancy and early marriage are more likely to be consequences rather than

causes of early school leaving. It is therefore difficult to conclusively associate teenage pregnancy with school dropout.

The current study found that 73% (n=15) of the teen mothers had dropped out of school prior to their pregnancy. It is therefore of paramount importance to look at preventative measures against unplanned pregnancy for adolescents on the background of increased “sexualisation” of society due to information and technological advancements (Crown 2010:42). Adolescents and young people are increasingly becoming more aware and exposed to sexual and intimacy information at an early age and this can influence their sexual urges at a tender age. However, little information exists on family planning (FP) or birth control among adolescents and in addition, which FP methods can be age appropriate for adolescents.

A previous study by (Chae 2013: 2) alluded to the fact that the majority of orphaned adolescents become pregnant early in their teens due to their family circumstances. Guarcello, Lyon, Rosati and Valdiva (2014:4), supported this view that family living arrangements for adolescents change drastically after the death of one or both parents. The death of both parents (double orphans) can drastically lead to family fragmentation either through fostering and redistribution. In many Sub-Saharan Africa countries, fostering is a common practice in particular where extended families including grandmothers, aunts and uncles play a more important role of caring for children who have lost both parents (Guarcello et al 2014:4). The current study found that 20% of the teen mothers were double orphans and they were supported by either grandmothers and aunts or both.

According to Guarcello *et al* (2014:5), when the father dies, children will most likely stay with their mothers to avoid changes in the living arrangements. The current study found that 60% of the teen mothers were paternal orphans and had lived with their mothers either in single female headed households or in newly created families due to remarriage of the mothers. The new living arrangements significantly impacted on the lives of some children living in such households due to step parenthood relationship where preferential treatment in some instances were extended such as denial of school fees, who should attend school and who shouldn't

Studies have shown that in almost every country in the Sub-Saharan Region, female-headed households assume care of more orphans than male-headed households. As a result, female-headed households with orphans have the highest dependency ratios (Guarcello et al 2014:5). The current study established a high dependency burden among the households in which the teen mothers lived with an average of seven (7) dependants per household. In such instances providing the basics for the family becomes a hurdle and in the qualitative interviews, some single mothers reported their experiences ...

“I am 46 years, a widow with 7 children (5 girls and 2 boys) and a peasant farmer; it’s very difficult for me to provide for my children all the basics they need ...” A guardian of a teen mother from Pader H/C III, Pader District.

Equally, life in the newly established families had affected some dependants as depicted in responses to some qualitative interviews ...

“... Children who stay under the care of guardians need to be supported equally; sometimes such children lack love and end up seeking love in the hands of strangers... I lived with my step parent (father) and I did not like the way I used to be treated, my father denied me schooling and that I should help with domestic work and yet other children in the household were schooling ... I ended up loving a boy in our neighborhood ...” a 15 years old teen mother from Lalogi H/C IV Gulu District

According to Akinlabi, Olatunji and Ayodele (2012:159), almost half of all families headed by women were living below the poverty datum line. Many single mothers are under acute stress, and it affects the behaviour of their children. Most often some of the stress is attributed to work overload because a single mother has to deal with all the tasks, responsibilities and demands that would ordinarily be shared by two and some of the stress may come from social isolation. The single mother may be overwhelmed by responsibilities and poverty that she becomes a lonely captive in “a child-centered world”.

In addition, parents’ mental disruption and living as a single-parent have been found to be associated with early onset of adolescent’s sexual behaviour. This is reflected among a number of other factors such as lower family income, disadvantaged neighbourhood, lesser supervision and parental modelling, influence of sexually active friends, religion, and family structure. All these factors may all determine adolescent’s sexual behaviour

that may lead to adolescents' pregnancies and other sexually transmitted infections including HIV and AIDS (Akinlabi et al 2012:158).

Originally, the family as the smallest unit of society was an important socialising agent for the child, with both the father and mother having complementary roles to support the child's upbringing; which in turn influences the child's physical, mental, moral and social development. Any disruption that destabilises the parental role of both parents and the family systems and structures, impacts negatively on the lives of children and this impact goes through to adult life (Mabuza et al 2014:2252). In the current study, the findings on the orphan-hood status of the teen mothers revealed that 80% were orphaned, and of these, 20% were total orphans and 60% were paternal orphans and close to 54% were living in single female-headed households. The absence of a father or father figure among the teen mothers could therefore have instigated the early sexual activities during early adolescence among the teen mothers which further exposed them to the risk of early pregnancy and teen motherhood.

Parenting for adolescents is problematic, as adolescents are not yet emotionally mature to take care of themselves, let alone others (Baumrind, Larzelere & Owens 2011:468). The current study established that 93.3% of the teen mothers were children (less than 18 years). A total of 11 out of 15 (73.3%) were teen mothers living as single adolescents or child parents under the care of other guardians other than the man who was responsible for the pregnancy. This was largely due to either child-to-child sex that ended in pregnancy and the community could not allow the children to live together as wife and husband or denial of the pregnancy by the males.

Studies show how adolescent (child) parenting affects children, families, and communities with countless challenges (The Urban Child Institute 2014:2). Even for the most prepared of parents, raising a healthy and happy child is one of life's major challenges. Having the ability to check off commonly accepted parenting prerequisites including a quality education, a good job, mental and emotional stability, and a safe home can make the challenge easier to tackle; but unfortunately, adolescents who become parents often lack key life skills and other resources that are vital to the parenting process. This sad reality is supported by Bloclin, Crouter, Updegraff and McHale (2011:35) who observed that on average, children who are born to teen parents are less likely to ever

reach their full potential. The effects of teenage pregnancy on parent, baby, and community can undoubtedly be devastating.

According to Hoskins (2014:2), adolescent parenting is one of the major risk factors associated with early childhood development. In addition to its other effects, teen parenting is likely to hinder a child's social and emotional wellbeing. When a baby is born to a teenage mother, she/he is likely to have more difficulty acquiring cognitive and language skills as well as social and emotional skills like self-control and self-confidence. These abilities develop in infancy, and they are essential for school readiness. Studies on early childhood development found that adolescent mothers (19 years of age and younger) are less likely than older mothers to engage in emotionally supportive and responsive parenting. They tend to have less knowledge about child development and effective parenting, and often misjudge their infant or toddler's ability to adapt and learn.

In the qualitative interviews, some teen mothers reported challenges relating to baby care:

"I wondered how I would give birth, I am so much worried since the health worker told me that since I was young I could go for C-section ... I also wondered how I would care for the baby, breast feeding the baby and how to get requirements for the baby and other things they need for delivery" a 15 year old teen mother, Lalogi H/C IV Gulu District.

Teen parents are more likely to engage in harsh parenting practices like yelling and spanking as a result of having fewer life experiences and coping skills, compared to older parents and that makes them irritable. Depressive symptoms or persistent stress from other sources can increase these feelings of anger and resentment among teen mothers (The Urban Child Institute 2014:4).

In one of the qualitative interviews a guardian had this to say ...

"My daughter is not attached to her baby, she does not like her baby...; I do not know why. She leaves the baby for so long without breast feeding, bathing the child and showing love to her baby" a guardian to a 15 years old teen mother, Cwero H/CIII, Gulu District

It has been reported that children born to adolescent mothers are more inclined to repeat their parents' behaviour and that the children are more likely to drop out of school, have more health problems, face unemployment and become teen parents themselves. The cycle of teen parenting can only be reduced through promoting sex education and teaching on the benefits of abstinence and pregnancy prevention. Parents and educators can share in this responsibility by ensuring that teens (adolescents) gain this knowledge at home and at school. Avoiding discussions on the issue of sex and safe practices only heightens the potential for teen pregnancy to occur (The Urban Child Institute 2014:6). This was also espoused by one of the guardian participants in interviews ...

“Early guidance is important; adolescents should receive early support about what they expect during adolescence ... including changes on their bodies. At least by the age of 9 years, adolescents should begin to learn about adolescence” a guardian at Okidi H/CIII Kitgum District

According to Pogoy *et al.* (2014:161) teen pregnancy and childbirth impose difficult long term outcomes and has adverse effects on the young mother and her child. In addition, the challenge of limited knowledge and skills among adolescents to enable them to experience healthy relationships and good sexual health without the risk of unplanned pregnancy and myths surrounding sex and sex education in some societies still remains elusive. According to Crown (2010:6), myths about sex, fertility and abortion still exist and awareness of the full range of contraception options is low; a significant number of parents lack the knowledge and/or confidence to talk to their children about sex and relationships.

With the inadequacy in the level of knowledge on adolescence and sexual reproductive health matters, the teen mothers were ill-prepared to manoeuvre through adolescence and other life challenges beyond adolescence. According to WHO (2010:6), younger and older adolescents were not well informed about sexual and reproductive matters, including the processes of puberty, in part because their major sources of information tended to be friends and they acquired this information from other informal sources other than schools, health-care providers and parents. In the same study, parents (who were also interviewed) were themselves often uninformed and preferred that their children learn from teachers or health-care workers, who in turn believed that parents should have the primary responsibility for providing this information.

The World Bank (2014:1), shows that adolescents and young people (10-24 years of age) around the world face tremendous challenges in meeting their sexual and reproductive health needs partly due to inadequate access to health information and services, as well as inequitable gender norms that contribute to a lack of knowledge and awareness about puberty, sexuality, and basic human rights. Subsequently, these challenges can have serious implications on health, welfare and economic development. According to African Union (2013:5-6); Neema et al (2004:21) and Amanda (2014:5), the inadequacy of ASRH information among adolescents and young people has been attributed to the following:

- Sensitivity in discussing sexuality matters especially in African communities in which such talks are considered taboo.
- Authoritarian adults- children (adolescents) relationships that discourage open communication between adults and children; and many parents avoiding sex education conversations due to uncertainty, or lack of confidence on how to best educate their children on topics such as sexual health and relationships.

Studies have shown that community involvement and participation is an important element in health promotion and other development programs (FHI 2006:5). One key component of community participation is the community sense which is the feeling of bonding, togetherness and belongingness; strong sense of belongingness by community members creates social capital/wealth/asset (McMillan & Charis 1986:4; Petty et al 2006:3).

Out of the studies carried out at Glasgow Caledonian University on the role and impact of social capital on the health and wellbeing of children and adolescents; three reported on evidence on family structure that suggested that living with at least one biological parent was protective and the presence or absence of the father for adolescents was very important especially for young adolescents (10-14 years), who were less likely to be sexually active if they lived with a father figure (Glasgow Caledonian University 2013:22).

Studies have reported the sensitivity to sex education in most African communities (African Union 2013:5-6). Most often the challenge is the timing and what age is considered appropriate for sexual information and education for adolescents and young people. According to WHO (2010:5), the international recommendations relating to sexuality education, health services, legal protections and other programmes and policies

for adolescents typically refer to “age-appropriate” interventions in recognition of young people’s “evolving capacity” to understand and protect their own interests. However, evidence on the chronological timing of events such as peak growth periods, first menstruation for girls (menarche) and first ejaculation for boys (semenarche), brain development (growth of the frontal lobe, in particular), and social maturation reveals extensive variations across and within populations and between girls and boys in the timing, sequencing and nature of each of these processes. This therefore remains a critical challenge in terms of offering age-appropriate sex education.

WHO 2010:6 further observed and raised the question of what could constitute a “basic package” of information and services to which all young adolescents should be entitled by, say, 12 years of age, and again at 15 years of age, when many young people are on the verge of initiating sexual activity if they have not already done so. The report also raised the question of what types of interventions would be feasible for improving parenting skills so that adolescents could have their needs for information and emotional and social support met more effectively within their own families, which too often relies on threats and physical or emotional punishment.

5.1.2 Community support

A measure of community support was eminent from the study findings. The findings highlight how community stakeholders supported the teen mothers links to the socio ecological model (SEM), which describes the interactive characteristics of individuals and their environment that underlie health outcomes. The model recognises individuals as embedded within the larger social systems that include the family, peers and friends (basically these are relationships), institutions and the broader society at large. These systems interact and their interactions influence health outcomes (CDC 2013:4). The teen mothers stated that the family, which included the mother, father, sibling, husbands and relatives like aunties plus their peers, helped them to understand issues relating to ASRH. At the institutional level, health workers and teachers were listed as part of community stakeholders that played a role in supporting the teens to meet their sexual reproductive health needs.

Studies have shown that community involvement and participation is an important element in health promotion and other development programs (Family Health

International [FHI] 2006:5). One key component of community participation is the community sense which is the feeling of bonding, togetherness and belongingness; strong sense of belongingness by community members which creates social capital, social wealth and social asset (McMillan & Charis 1986:4; Petty et al 2006:3).

Support for teen mothers was through communication with adolescents which was either formal or informal. Rommetveit's and Blakar's communication model (1984:37) provides the dialogical perspective on communication where the communication process is seen as an interaction between two parties who each have the ability to influence the other. There are six interconnected processes in communication which include: production of messages, encoding of messages, decoding of messages, processing and memory of received messages, sender's anticipation of receiver's decoding, and receiver's listening to the premises of the sender (Ola 2012:92).

In the communication process, conceptualisation is very critical, and it can influence the way a message is perceived and interpreted to create meaning. Considering the above modes under which communication on ASRH was passed to teen mothers, and in a community where parents and adolescents consider communication on sexuality as a taboo subject (as is the case with many African communities and Acholi community inclusive), interaction is unlikely to occur (Zhohua 2009:14). In such a social context of regarding sex talks as cultural taboo, parents may employ less direct communication to transmit their message largely due to the embarrassment associated with parent and child communication about sexuality (Ola 2012:93; Botchway 2004:16).

Secondly, the ability to relay messages while communicating is very vital and it requires knowledge of the subject. In some situations the knowledge may be absent, such as when parents are unable to present facts on ASRH due to their lack of knowledge (Population Council 2015:3; Zhohua 2009:15). In the current study, the teen mothers reported that self-referencing (that is telling stories about oneself) was used by some parents and guardians when relaying ASRH especially during one-on-one sessions.

However, it should be noted that the use of self-referencing communication especially among non peers (parent/adult-children), may be affected by time and age difference, because communicants must have a shared worldview. Intergenerational differences

between parents and children can cause misunderstanding and this may impact negatively on the way the message is perceived (Zhohua 2009:16).

Employing certain skills in self-referencing (telling stories about one-self or about the family) can enhance effective communication. According to Amanda (2014:31-32), family stories that contained themes of stress were much less satisfying than family stories whose themes revolved around accomplishment. The current study did not examine the content of self-referencing stories told by parents/guardians of the teen mothers. Depending on what the teen perceived about the story whether stressful or satisfactory impacted the understanding of ASRH among the teens.

According to Botchway (2004:18), communicants must have the mutual trust and confidence in each other for communication to be more effective. In the parent-adolescent sex communication process, most often adolescents regard their parents as being judgmental, overly protective, and disrespectful of their privacy and autonomy. Such factors undermine the perceived trustworthiness of the parent as an information source, and communication may not be effective. Nonverbal cues may also affect the communication. For example, parents who speak in high or low tones (in this study, in the cases of communication through warning after a perceived situation of defiance), eye contact with the child/adolescent and use body gestures could all affect the child/adolescent when they answer their questions.

Jokes and casual chats with peers were reported by teen mothers and this often occurred during leisure time. Similarly, previous studies have shown that adolescents learn to communicate about sex through conversations with their friends and that friends become increasingly important sources of information and serve as critical social references for adolescents as they develop especially during early adolescence. Youth disclose more to their friends than to their parents about many sex-related topics (Widman, Choukas-Bradley, Helms, Golin, & Prinstein 2014:732). However, what remains unclear is the content of sex communication when peers discuss with each other to help determine the effectiveness of their communication in promoting ASRH.

From the results, the support that the teen mothers received from the family members (especially their own mothers and other mother figures like grandmothers) and the

community support system especially from the health institution (health workers) contributed tremendously in helping the teen mothers cope with teen motherhood.

Similarly, other studies have shown that parental support helps many young people develop knowledge and skills for healthy adulthood. However, when parents are not available, other adults including teachers, nurses, youth leaders, other family members and neighbours can provide support (Barbara 2010:9). Families, in particular, can be protective against depression. Protecting young mothers from depression improves the mothers' abilities to form and maintain social and intimate relationships, perform effectively in education and employment, and effectively care for her baby (Clemmens 2002:555-562; Turner, Sorenson & Turner 2000:780-793).

The study found that the mothers of the teen mothers (among the other family members in the households) in which the teen mothers lived, supported the teen mothers more and this support greatly helped the teen mothers to cope with teen motherhood. According to Resnick (2000:158), "resilient people have a close relationship with at least one caring, competent and reliable adult who recognises, values and rewards pro-social behaviour" in which case, the caring and reliable adult to the teen mothers were their mothers.

The material support that the teen mother received supported them to cope and according to Ungar, Brown, Liebenberg, Othman, Kwong, Armstrong and Gilgun, (2007:289) social support that facilitates access to material resources such as food, clothing and shelter, medical and employment assistance is also important.

Teenage mothers also parent better when they have strong social and emotional support from their child's father (Cox & Bithoney 1995:964; Samuels, Stockdale & Crase 1994:429). The length and stability of the relationship, the father's involvement in planning for the child's arrival are deemed important (Elsters, Lamb & Kimmerly 1989:760). In the current study, the teen mothers who reported that they were living together as wife and husband showed great zeal in their narration of the lived experiences and were optimistic about their future parenting.

Informal education was also a means of support for adolescents (Muhangi 2008:16). The current study established that informal education has been replaced by mass media which often-times are not culturally relevant (Dioka 2016:3). Muhangi (2008:16; Amone

et al 2013:126) reported that informal teachings emphasise discipline and respect and further argue that informal teachings bring togetherness and unity among families allowing adolescents to verbalise their insecurities and anxieties.

5.1.3 Early parent-adolescent

The other significant finding of this study was that some adolescents left home early and lived independent lives without the control of parents. The study found that adolescents attained a form of independence through food rations given by United Nations organisations or after abduction during the LRA war. This independence was influenced by the war, where adolescent boys were forcefully removed from their homes. Previous studies have also shown similar views on independence, where according to Sucaad (2002:15), dependence on refugee food and material rations paradoxically gave each member of the family greater independence with respect to access to food, undermining the close-knit family relationship and parental control over adolescent children. As a result of the economic independence associated with life in the camps, many youths adopted unconventional behaviour such as early marriage (which was often short-lived) and indulged in drug and alcohol consumption.

The freedom and independence that the children obtained as a result of the war situation created a dilemma for parents (who were already impoverished). As a result, the economic support that came from the children threatened and weakened the parents' original authority and power over the children and made it very difficult for parents to teach and offer guidance to the children due to the fear of losing the economic support.

According to Omoni and Ijeh (2010:31), many children are increasingly being engaged in child work and there are various reasons why children work including; poverty, craze for wealth, lack of education/ignorance, indebtedness or bonded child labour, traditional practices, broken homes/divorce. But in the case of the Acholi community, the war forced children out of school and most of the children ended up in the informal sector, and the parents did not have much control over the situation as the children had to work.

However, child labour *per se* is not bad. According to Omoni and Ijeh (2010:32), worldwide, millions of children have to work to support themselves and families and as such child work is unavoidable. The controversy, however, is on child labour which is

exploitative and dangerous for the child. Children need to work with dignity and protection to help their families. Children who engage in work have the opportunity of acquiring skills in various trades.

It is further pointed out that in the rural areas, children engage in farming, fishing and trading to help their immediate families. In the process, the children are also preparing themselves to be responsible citizens of tomorrow (Omoni & Ijeh 2010:35). In preparation for tomorrow, the children and parents (and the community at large) need to support and counsel children about different work that children can engage in so they protect the children from exploitation, promote the children's rights, dignity and responsibility for self-reliance and self-sufficiency in this contemporary society (Omoni & Ijeh 2010:36).

5.1.4 Stigma and discrimination

Teen pregnancy is still abhorred to in many societies (Chambers & Erausquin,2015:2), and is also totally unacceptable in most African countries (Agunbiade Ojo et al 2009:8). In Acholi culture, pregnancy before marriage is locally known as "*nywal luk*" for a woman irrespective of age and these women are given derogatory nick-names like "*carama*" (meaning *second hand*), "*ogek*"/ "*gekere*" (meaning *already used*) and "*okalocwan*" (meaning *not a marriage material*), which are negative and devalue the women. A child born before marriage is labelled as "*latin luk*" meaning a child born before marriage (the mother's family) and such children belong to the family of the mother unless the father responsible for the pregnancy pays a monetary fine (locally known as "*culu-luk*") for impregnating the girl before marriage. By patriarchy, children belong to the man's lineage, so in a situation where an adolescent mother and her child live at the mother's family, such negative labels which most often are expressed verbally or non-verbally to the teen mother and her child, negatively impact on the both the teen mother and her child (Agunbiade Ojo et al 2009:9).

According to Lewis, Scarborough, Rose and Quirin (2007:304), such negative labels on teen parenthood were functional in society's wisdom as a deterrent to unintended adolescent pregnancy, but dysfunctional to adolescent parents and their offspring as the negative messages may affect the self-perceptions, outlook of already pregnant and parenting adolescents, and set them on the path to failure. Children born in such a context may also grow to believe the negative meanings and start acting them out in their

future interactions since they have been tagged 'failure' right from their mothers' womb. However, little is known about the adult life of such labelled children.

5.1.5 Sexual exploitation

Sexual exploitation among adolescents is well researched in literature (Holger-Ambrose, Langmade, Edinburgh & Saewyc 2013:330). According to the Okunola, Ojo and Olufemi (2012:70) close to 70% of adolescents who become pregnant have a history of childhood sexual or physical abuse. Adverse childhood experiences such as physical abuse, verbal abuse, and witnessing intimate partner violence are linked with having sex at an early age. For example, women who experienced frequent verbal or physical abuse during childhood were three times more likely than those who rarely experienced verbal or physical abuse during childhood to have had sex before the age of 15 years (Okunola et al 2012:71).

According to Hillis, Anda, Felitti and Marchbanks (2001:208), women who report that their mother was physical abused during their childhood were two and a half times more likely to have had sex before age 15 years compared to those who reported rarely witnessed their r mothers being physically abused during childhood. Women who are sexually abused during their childhood tend to feel guilty about the abuse, they develop negative feelings about themselves and lose self-esteem and these bad feelings about themselves often cause them to engage in high risk behaviours and practices such as risky sex that can lead to them contracting STIs including HIV & AIDS and unplanned pregnancy.

Previous studies have reported on the sexual exploitation of girls and women during the LRA insurgence. According to Beard (2011:11-12), the LRA abducted both boys and girls, and while boys were trained to become fighters, the majority of girls abducted by the LRA served as slaves for the LRA commanders. The LRA utilised a hierarchical, family-like structure in the bush, in which the commanders' wives acted as the heads of family in which all abductees were placed as "siblings". Younger girls assumed the position of servants to the commanders they were assigned to. The roles consisted cooking, cleaning, fetching firewood, and attending to the whims of the commanders. Once a girl has reached puberty, they typically assumed the role of "wife" to the commander. According to Leibig (2005:6), girls comprised 20 to 30 percent of the child soldiers

recruited and abducted in Northern Uganda. Of the estimated 7,500 girls abducted by the LRA, some 1,000 conceived and gave birth while in LRA captivity (Beard 2011:12).

According to the Uganda Peace Foundation (UPFI) (2014:7), rampant rape and sexual abuse were documented. Rape and generalised sexual exploitation, especially by government soldiers (both those stationed in the camps and the mobile units) have had become “entirely normal.” The soldiers feel entitled to take any woman or girl and do anything they want with her, with complete impunity. As noted in a recent report by Human Rights Watch, “Women in a number of camps told how they had been raped by soldiers from the Ugandan army. It is exceptionally difficult for women to find protection from sexual abuse by government soldiers.” “And subsequently, HIV and AIDS is too high, severe impoverishment forced some girls and women to exchange sex for survival and the powerlessness among women led to rape and sexual violence ... and generally rape was used as weapon of war by the fighting forces”.

The above state of sexual exploitation among girls and women during the LRA insurgency could for instance explain the disparities on key sexual reproductive health indicators. The national average of teenage pregnancy was 19.2% compared to that of Northern Uganda that stood at 23.6%. The percentage of adolescents who had had their first child between the ages of 15-19 was 30.3% in northern Uganda as compared to 24.9% national average. Unsafe abortion was 70% in northern Uganda as compared to 54% national average (UBOS and ICF International Inc 2012:67; UNFPA 2008:41-54).

It is therefore justifiable to state that the LRA war either directly or indirectly impacted negatively on sexual exploitation of girls and women directly as thousands of women and girls were abducted and became sex slaves to the rebel commanders or indirectly due to horrific life experience while in the IDPs or in towns where the girls sought safety through night commuting and some engaged in transactional sex.

Previous studies also report similar opinions, that the conflict greatly affected Acholi culture and society (Davenport 2011:7). The impact of the conflict has been a catastrophe socially, culturally, economically, and personally for the Acholi. Not only did the conflict cause the displacement of thousands, it caused the breakdown on family life, the breakdown of social roles, and the breakdown of Acholi culture. For example, within the family, “children blame[d] their parents for failing to provide for and protect them (their

rights as children), and parents complain[ed] that children no longer respect[ed] them and are disobedient, respect and obedience being two significant markers of an ideal African childhood identity” (Davenport 2011:7)

In another direct quote according to Davenport (2011:24), “there has been a big deterioration on the Acholi culture, the way life that was before the conflict is no longer there. People no longer share or do things in groups. People are only concerned with themselves..., you can’t even get help from your clan anymore...”

5.2 CONCLUSION

This chapter integrated major findings of this study within the context of already existing literature. The discussion centered on community support for adolescents within the context of the war. Erosion of culture and the emergence of modern technologies resulted in part in school dropout, early parent separation. Stigma and discrimination for teen mothers, and their guardians as well as sexual exploitation were discussed as remnants of the LRA war and as societal ills that need urgent intervention.

CHAPTER 6

STRATEGIES FOR ENHANCING COMMUNITY RESPONSE AND PARTICIPATION IN ADOLESCENTS' SEXUAL REPRODUCTIVE HEALTH (ASRH)

6.1 INTRODUCTION

This chapter presents strategies for enhancing community response and participation in adolescent health and specifically on adolescent sexual reproductive health. The strategies design was based on the study findings, the literature review and input from a selected team of experts who reviewed and advised on the strategies. The ultimate aim of the study was to formulate strategies for enhancing participation and involvement in promoting ASRH information and service by the community which are responsive. There are six key components of community responsiveness (Dowerik et al 2001:74) that the study used to build on the community strategy to enhance community responsiveness to adolescent sexual reproductive health.

6.2 COMMUNITY STRATEGY TO ENHANCE COMMUNITY RESPONSIVENESS TO ADOLESCENT SEXUAL REPRODUCTIVE HEALTH

6.2.1 Supporting the identification of needs and strength of the community by the community

To effectively respond to the needs of adolescents, there is a need to consider the fact that adolescents have varying needs. Identification of strengths of the different communities helps in assigning a particular community response to adolescent health basing on the community strength.

6.2.2 Supporting the establishment of a place within the community system to enhance community response

The community needs a defined place, location and venue in the community where the community can perform their work and activities for effective response to adolescent health.

6.2.3 Improving the working relationship among community actors

In the community, there are different players that need to be supported through building community systems for intergroup, inter sector and networks collaboration to leverage on the community resources and strengths for community responsiveness. The co-ordination structure within the current national ADH policy goes down to the district, however, below the district structures, the policy is very silent about the co-ordination structures, it recommended that there should be a co-ordination mechanism at sub-county level for all communities in a given community to network, share experience and support each other in responding to adolescent health.

6.2.4 Building capacity of the community

Community members need to be empowered through training and capacity building in order to fulfill their responsiveness to the needs of adolescents in SRH. Community requires knowledge and skills that are well aligned to their expected deliverables and activities.

6.2.5 Helping the community envision a positive image

There is need of creating images of future success as compared to the current situation that the community may be experiencing. In line with adolescent health, there are numerous issues that do impact adolescents' sexual reproductive health and the community needs support to enable them envision the good health of adolescents (for instance the community may wish to end teenage pregnancy in their community and all their efforts would be geared to advocate for prevention of teenage pregnancies).

6.2.6 Supporting evaluation of community response

In order to support evaluation of community response, all stakeholders should be involved in the evaluation using different participatory approaches. This will allow for adjustments within the programme for better outcomes on adolescent sexual reproductive health.

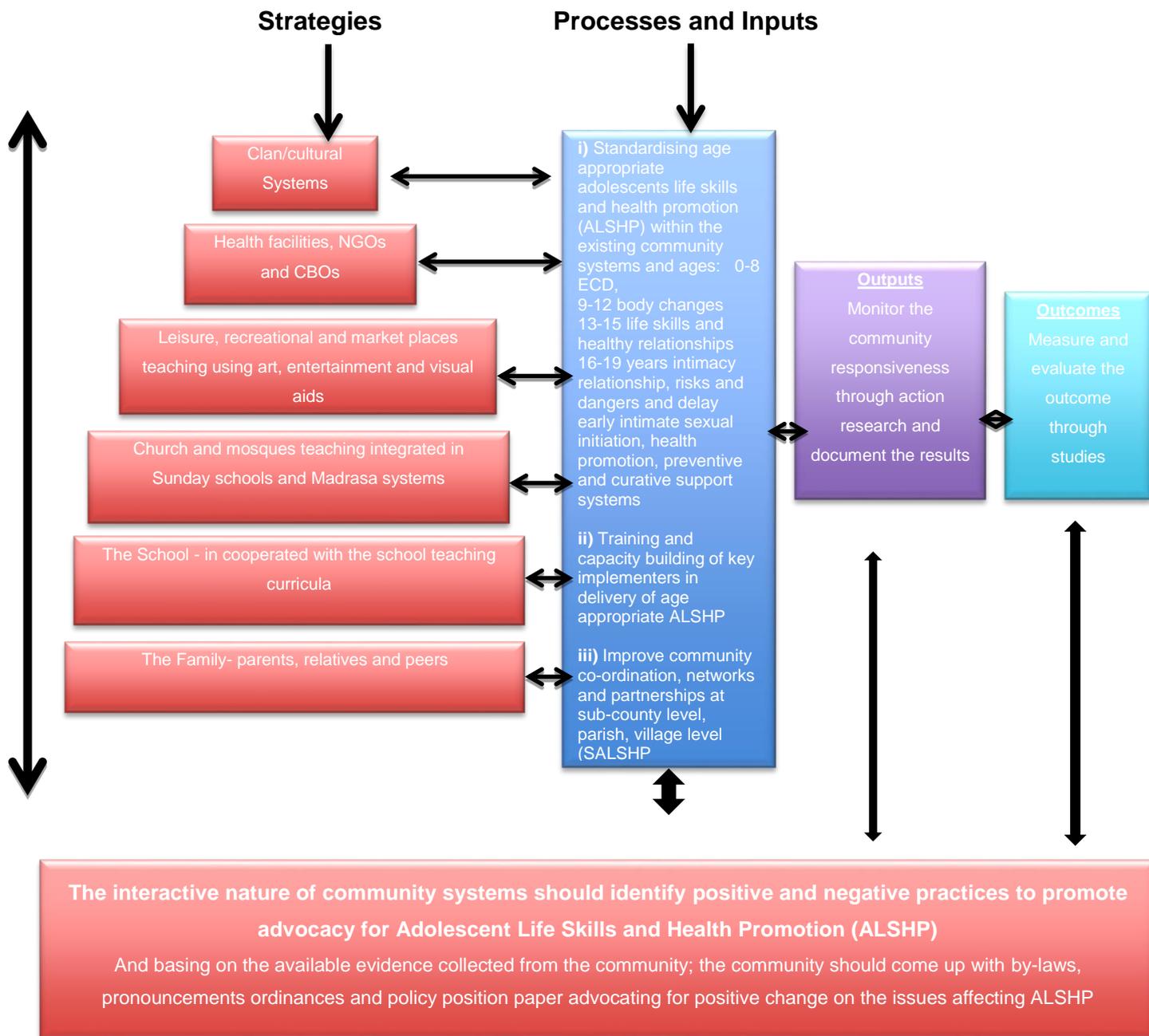
6.3 AN INTEGRATED ADOLESCENT LIFE SKILLS AND HEALTH PROMOTION (ALSHP)

Currently, there is an uncoordinated community support that has not been fully effective. The current strategy has been besieged with issues such as:

- Limited resources and capacity for the community
- Weak community networks, linkages, partnerships and coordination
- Community activities and service delivery systems not so well defined for some communities
- Organisational and leadership abilities gaps
- Monitoring and evaluation and planning gaps
- Lack of enabling environments and advocacy especially on certain aspects like family planning, condoms and sexual education especially among the unmarried as opposed by some sector of the community

In view of the listed issues that prevented the effectiveness of the current system the researcher developed the model in Figure 6.1.

Integrated community model for Adolescents Life Skills and Health Promotion (ALSHP)



**Figure 6.1: Schematic presentation of the proposed model:
Developed from findings and experts views**

To be able to achieve the above proposed model of integrated ALSHP, the following strategies have been proposed.

There is need to institutionalise the proposed model; and from the critical assessment of how to deliver the strategy, Ministry of Education Sport, Science and Technology is better positioned to co-ordinate with and work hand in hand with the other Ministries including Health, Gender, communication, local government and other relevant NGOs to promote the implementation of the proposed model.

Basing on the available teaching curricula/ manuals (for instance under Ministry of Education and Health), the contents of the teaching materials need to be reviewed, amended and or revised to suit the age appropriate topics as proposed above.

Thirdly, after the revision of the training materials, it's recommended that training and capacity building for people (human resources) to deliver the package for ALSHP should be carried out. Among the target human resources are:

- Senior woman and male teachers (matron/patron)
- The midwives/ nurses at health facility level
- Counsellors and social workers for NGOs and CBOs
- Sunday school teachers
- Madrasa instructors
- The cultural institutional arm for the 'first lady' or to wife to the chief (for the case of Acholi is the '*Dak-Ker*' community initiatives

The fourth stage is piloting the proposed model and monitoring the community responsiveness through community action research and then reporting for evidence based advocacy

The last stage would be to carry out in-depth studies on the community systems model for ALSHP to document outcomes observed over time and disseminate and replicate the model.

6.4 CONCLUSION

This chapter discussed the developed strategy based of the findings presented in chapter 4 and inputs from experts in the area of sexual and reproductive health. It proposes an

integrated model where all stakeholders come together for a common cause. The model strongly envisages that when all players come and work together to support adolescents, adolescent health in general and specifically adolescents' sexual reproductive health will be realised.

CHAPTER 7

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

This chapter presents the major conclusions and key findings of the study, briefly discusses its limitations, and makes recommendations for practice, policy and further research.

7.2 AIM AND OBJECTIVES OF THE STUDY

The aim of the current study was to investigate the role played by the community stakeholders in the Acholi community in supporting adolescents' sexual reproductive health during and after the war era. The ultimate aim was to develop strategies that would enhance further community involvement in the adolescents' sexual reproductive health.

In order to achieve the overall aim of the research, the objectives of the study were to:

- i. study the effect of the roles played by community stakeholders on adolescent's (teen parents) handling of SRH experiences
- ii. establish how socio-cultural factors influence adolescents' sexual reproductive health (ASRH)
- iii. To identify health systems factors that influences the community role in support of ASRH

7.3 RESEARCH DESIGN AND METHODOLOGY

The study was exploratory, descriptive and a case study which had three phases with 5 sub-studies and collected data from the sampled participants and respondents including teen mothers, their guardians, midwives, parents, adolescents, local, cultural and religious leaders as well as policy maker, technocrats and implementers at the community and district level. The study was implemented in Gulu, Kitgum and Pader districts of Northern Uganda.

7.3.1 Phase I

Phase I was a case study and the target participants consisted of teen mothers, their guardians and midwives. Through the midwives working in the selected facilities, the teen mothers were selected and invited to come with someone the teen considered a guardian. The interviews were conducted from the health facilities from a private and convenient location/room within the health facility.

7.3.2 Phase II

This phase generated information through FGDs and key informant interviews with different community stakeholders including adolescents, parents, local, religious and cultural leaders. Most of the participants under this phase were purposely selected. The interviews took place within the communities in convenient location chosen by the respective community leaders. Phase II sub-study III was quantitative and it targeted 600 adolescents from the three districts of Gulu (270), Kitgum (170) and Pader (160) respondents. The respondents were randomly selected and a questionnaire was administered among the respondents.

7.3.3 Phase III

Phase III study was purely qualitative. The study objective of this phase was to identify health systems factors that influences the community role in supporting adolescents sexual reproductive health and the question that Phase III study attempted to answer how the health systems influenced community role in supporting ASRH and taking in to account the findings of the study, what strategies would best address the issue of community involvement in ASRH. The participants were purposively selected and the target participants included: policy makers, technocrats and implementers. Key informant interviews were used to generate information from the participants in line with the objectives of the study phase.

7.4 SUMMARY OF THE FINDINGS

Of the 15 participants, the majority (93%) of the teen mothers were children (hadn't attained the age of consent), three were young adolescents aged 14 years and the 11 were middle age adolescents 15-17 years.

The majority (73%) had dropped out of school prior to pregnancy only 27% dropped out due to the pregnancy. Various risk factors have been reported as the cause for school dropout. The teen mothers attributed being out of school as a great risk factor that contributed to their teen pregnancy since they were not productively engaged.

The socio-economic conditions in the households in which the teens lived prior to their pregnancy were very critical and impacted on the lives of the teens and explain the circumstances that could have led to the teens' pregnancy.

Teen mothers had limited knowledge about adolescence as a stage of transition and also lacked comprehensive knowledge and information on adolescents' sexual reproductive health. Similarly, the parents and guardians also had limited knowledge and skills on what information to offer with regard to adolescence (puberty), ASRH and lacked the 'how' (skills) to deliver such information to adolescents. Lack of communication of sexuality matters have, however, been attributed to sensitivity to cultural norms, lack of ASRH knowledge and information and limited skills to relay ASRH messages.

The family plays a critical role in protecting children and adolescents and any disruption in family life greatly impacts the future of children. Parents should endeavor to resolve family conflicts in more harmonious ways to enable adolescents live in a supportive family environment for enhancement of better adolescents' transition period.

Among the three major sources of adolescents sexual reproductive health information were teachers ranked first, followed by health workers and parents as third. Among the different forms of media, the radio was the most preferred. And this was due to the good coverage of the radio stations; almost in every district in northern Uganda has a radio station (s).

The LRA war greatly impacted on the Acholi tradition of socialising children. The war destroyed the socio-cultural, economic and family protection mechanism, this coupled with the influence of the mass media and the education system, the socio-cultural norms which were moreover not documented are at verge of extinction and the society is experiencing what the study called 'intergenerational cultural shock' in which the old and the young generations are shocked and amazed with the cultural difference.

The study documented the community responsiveness to the ADH policy through the findings from the different phases. A community model and strategy for enhancing community response to ASRH was proposed (see Chapter 5).

7.5 LIMITATIONS OF THE STUDY

The study was conducted in three districts of Acholi sub-region including Gulu, Kitgum and Pader. This was out of the seven districts that form part of the Acholi sub-region. The conflict affected the entire Acholi sub-region and other neighbouring districts. The findings documented in this report may not represent the experiences of those from the other districts due to socio-cultural and structural difference.

Due to post conflict setting and the experiences that the community had as part of rehabilitation and resettlement program, some study participants especially the teen parents had false expectations on tangible benefits for the baby and as well for themselves including sponsorship to do vocational skills development to enhance their economic prospects. The researcher clearly explained the purpose of the research; made no promises of assistance, but stressed that the findings would be presented to policy makers for policy change or programme design.

Most of the data were collected retrospectively with regard to the community experiences and how the war impacted the life of the Acholi community. Retrospective data brings in recall bias. The researcher used data triangulation to control for the bias.

7.6 RECOMMENDATIONS

Based on the findings of this study, the researcher makes the following recommendations for practice by all those working in the field of adolescent sexual and reproductive health, future research areas and policy recommendations.

7.6.1 Practice

The results found that 54%, guardians of the teen were living as single parents and for the teen mothers, results found that 73.3% were not living with the man responsible for the pregnancy and in such instances, the vicious circle of single female parenting may continue. It is therefore recommended that single parents especially mothers require both livelihood, social and psychosocial support services to enable them minimise the negative consequences brought about by single parenting.

It is recommended that programs and models that aim at promoting community participation and involvement (responsiveness) to ASRH should focus on: dispelling the cultural myths on sex and sexuality education; and need to develop skills to enhance parent-adolescent communication and as well empower community with knowledge and information on ASRH and specifically defining what key ASRH information (basic package which is age appropriate) that can best be handled by parents/community and how such information can be delivered. (the current study has proposed a strategy see Chapter 5).

Due to the physiological appearance like protruded bellies, it created a feeling of shame among the teen mother and as a result the teen mothers reported to have avoided public places including health facilities as a way of coping and this could provide an explanation and a factor that impede uptake of antenatal care attendance by teens mothers. It is therefore recommended that programs, including health facilities, should offer information and sensitise the teen mothers holistically. This should include medical, social, emotional and physiological counselling to enable the teens understand each stage of pregnancy.

It was found in Uganda that the UPE performance in government schools was affected by retention challenges and poor survival rates as compared to the neighboring countries, Uganda therefore needs to learn from the neighboring countries to be able to improve retention and survival rate.

Sexual reproductive health is not a stand-alone service. Its delivery system can be integrated within the existing systems. From the community mapping of where young people spend time, it was clear that children at any one time, are at home, in school, at the health facility, at worship places (church or mosque), in the community, at leisure and recreational facilities or in the market or shopping malls. The delivery systems can then be integrated but with appropriate strategies that build on the existing services delivery systems.

In an African setting, different factors have been “blamed” for hindering effective communication on sexual matters to adolescents and increasingly young people are using different avenues to get information on sexual matters. Basing on the old tradition of ‘treating’ sex talks with respect the community may take a longer time to change their attitudes on sex talk. Across most African communities, the term sex still carries a lot of shame up to today, and therefore, the questions that come to mind are:

- Does adolescent health education only look at sex?
- What additional information do young people require to be healthy holistically?
- If the health needs of young people go beyond sexual needs, can there be another name instead of using it as sexual education?

With justifications and from the findings of the current and others studies, the appropriate name, which the current study proposes is: **Adolescent Life Skills and Health Promotion (ALSHP)**.

Lack of clearly defined age appropriate ASRH was reported to be a serious issue in promoting community response to ASRH. It is also known that adolescence is a transitional stage and the process of this transition is gradual but varies from child to child, the age period of adolescence has been defined as 10-19 years (UNICEF 2009:5), does this age brackets still hold with a lot of rapid development that are impacting on child growth and development? Some children start to experience early puberty and therefore the question of at what age should children be introduced to sexual education? What should be the package or the content of the information? Do adolescents only need sexual information?

The study proposes the following to guide the package and content of ALSHP:

By 9-11 years, children need to have been informed and made aware about the basic facts about growth and human development and what elements are good for healthy growth and development such as personal hygiene, good nutrition, play and safety.

By 12-14 years, children need to have been informed about adolescence including changes associated with physical, emotional, psychological and social characteristics of the life stage and as well they should have been equipped with skills to enable them develop a positive and healthy relationship including life skills of knowing oneself, living with others, decision making, problem solving, assertiveness and negotiation.

In the the third stage, that is 15 years and above, the topics could cover intimate relationships, the risks and dangers, and how to delay early intimate sexual initiation, health promotion through preventive and curative measures and as well as supporting adolescents to know the locations in the community where young people can seek medical and emotional/psychological help in case of need. In other words that means developing and or updating community referral pathway.

7.6.2 Further research

According to Sucaad (2002:16), early child rearing and care were traditionally the responsibility of mothers, and many women feel guilty about not having enough time to attend to their children. The current study established that there has been gradual change in the family gender roles; and increasingly, mothers are becoming breadwinners in their families and this is paradoxical. Today, many parenting challenges have been reported that majorly have been attributed to “absenteeism mothers”. Further research is recommended to explore more on how the absence of mothers from performing their expected roles impacts on child growth and development and the future potentials for the child.

With increasing “sexualisation” of society due to information and technological advancement (Crown 2010:42), adolescents and young people are increasingly becoming more aware and exposed to sexual and intimacy information at an early age and this could influence their sexual urge at tender age. However, little information exists

on the use of family planning (FP) or birth control among adolescents and in addition, which FP methods can be age appropriate for adolescents. According to Crown (2010:6), myths about sex, fertility and abortion still exist and awareness of the full range of contraception is low. A significant number of parents lacks the knowledge and/or confidence to talk to their children about sex and relationships.

Little evidence could be found to specifically point out what makes the father or father figure for especially on young adolescents to be protected from early sexual debut. It is therefore recommended that a more in-depth study be done to explore the protective effects of the father figure on the sexual behaviour of adolescents (young adolescents) Limited literature could be found on how teen mothers' skills and knowledge on pregnancy and baby care were enhanced apart from the experiential sharing that female relatives offer to support teen parenthood. It is therefore desirable to establish more structured guidelines on teen parenthood both for individuals, careers to improve knowledge and skills to enhance positive adolescent parenthood.

Further research is needed to explore the implications of changes in the economic role of woman and its impact on family life and parenting beyond communities affected by war.

In addition, a more exploratory study on the needs of men ought to be done to establish what the men feel needs to be done to normalise the gradual changes in family gender roles to harmonise shared responsibility at family level for concerted child upbringing.

There is need to do more research to promote understanding and documentation of t different Acholi traditions as opposed to the old ways of use of mouth to tell stories in form of riddles and tales in a bid to preserve the positive cultural norms and values. Documented evidence would be used to advocate for the abolishment of such dangerous traditions.

Research on how to work through the SMC and PTA to enhance parent-children communication is therefore recommended.

It is also recommended that more research be done to inform how religion and development harmoniously impact the life of young people.

7.6.3 Policy

Considering the findings of the current study, and other studies plus the actual changes on child growth and development among children, some start experiencing adolescence as early as 9 years. The study proposes that the age definition of adolescence be adjusted to cover early start of puberty in some children. This would then be properly harmonized with the existing programs. The adolescence stage should comprise the ages of 9-19 years.

The Uganda Education (Pre-Primary, Primary and Post-Primary) Act, (2008) does not recognise the PTA structure within the education management system. The study recommends that schools need to lobby through relevant authorities for inclusion of the PTA as a legal entity within the school structure since it's an organ that can strengthen parents-teachers collaboration on matters pertaining to child growth and development.

The impact of the LRA war, the mass media and the current education system have been found to negatively impact on the family (weakened the social capital) that hitherto was enjoyed among family members, lots of societal problems (for this case the adolescents health problems) that are due to the weakening of the family system. It is recommended that the concept of family togetherness and its strengthening be promoted to support family relationship building and some deliberate recommendations are hereby proposed.

Families are encouraged to use family meal time for relationship building and to forge togetherness so therefore family meal time should be a must unless under unavoidable circumstances.

Secondly, setting aside a family day is desirable and presently, it is recommended to have such day at different levels, say at the level of family, school, religious institutions, the district level and as well at the national level that the country marks a family day to revive the diminishing role that family plays to promote development.

7.7 CONCLUSION

The socio-demographic characteristics of the family and household status in which the teen mothers lived were critical and that included: growing up as orphans, living in a predominately single female headed households that had relatively large numbers of dependants and siblings which survived on subsistence farming among others, influenced the factors that surrounded the live experiences of the teens before and after teen pregnancy.

Culture is dynamic and unless it is documented, it is difficult to believe and practice. When culture is documented, it can be used for reference purposes, for teaching and used to reflect the process of community development, while reserving the good practices and abolishing those which seems dangerous for the community.

The issue of treating sex with sensitivity did not only happen to the Acholi, but generally in most African societies, the same respect was accorded to sex. Presently the old generation are shocked by the new youth cultures and it therefore calls for intergenerational dialogues to try and minimise the 'intergenerational cultural shock'.

Considering the findings of the current study, and other studies plus the actual changes on child growth and development among children, some start experiencing adolescence as early as 9 years. The study proposes that the age definition of adolescence be adjusted to cover early start of puberty in some children. And for proper harmonisation with the existing programs; adolescence stage should comprise the ages of 9-19 years.

The age between 0-8 to be defined as early childhood development (ECD) and ideally, in terms of programming, no child will be left behind. In summary, therefore, the age brackets for the different children and adolescents could clearly be marked with a clear package of information and services. In this case therefore:

Ages 0-8 falls under ECD and already there is standard information and services for this group of children.

Adolescents (9-19 years) should further be divided, with 9-12 years as early adolescence (the age appropriate information should cover body changes- growth and development),

13-15 years middle adolescence and the age appropriate information should cover life skills and health relationships and 16-19 years is old adolescence stage and the package of information need to cover intimacy relationship, risks and dangers; delay of early intimate relationship, adolescent health promotion, prevention, curative and support systems of adolescents.

The proposed age differentiation for adolescents will be used as guidance with community members working with young people.

Originally, the family as the smallest unit of society was an important socialising agent for the child, with both the father and mother having complementing roles to support the child's upbringing that influences the child's physical, mental, moral and social development. Any disruption that destabilises the parental role of both parents and the family systems and structures, impacts negatively on the lives of children and the impact goes through to adult life (Mabuza et al 2014:2252). As the case of the Acholi sub-region which was affected by over 2 decades of civil war.

The disruption in the Acholi family life greatly impacted on the sexual life of the adolescents as the found out that 93.3% of the teen mothers were children (less than 18 years); an indication of early sexual debut among the adolescents.

Teen mothers had limited knowledge about adolescence as a stage of transition, and also lacked comprehensive information on adolescents' sexual reproductive health. The study revealed that the parents and guardians had limited knowledge and skills on what information to offer with regard to adolescence and/or puberty.

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ANNEXURES

ANNEXURE 1

Assent form

Informed Assent form for adolescents less than 18 years participating in the study, the adolescents will be interviewed from the health facility/clinic and or from their school or any other place of their choices in the community

The time duration for the different sub-studies will range from 45 minutes -2 hours

Introduction

My name is -----and will be collecting your views on issues that affect reproductive health of young people living in Acholi sub-region with an aim of understanding how the communities support adolescents on matters pertaining to their sexual reproductive health.

I am going to give you information and invite you to be part of a research study. You can choose whether or not you want to participate. We have discussed this research with your parent(s)/guardian and they know that we are also asking you for your agreement. If you are going to participate in the research, your parent(s)/guardian also have to agree. But if you do not wish to take part in the research, you do not have to, even if your parents have agreed.

You may discuss anything in this form with your parents or friends or anyone else you feel comfortable talking to. You can decide whether to participate or not after you have talked it over. You do not have to decide immediately.

There may be some words you don't understand or things that you want me to explain more about because you are interested or concerned. Please ask me to stop at anytime and I will take time to explain.

Purpose of the study:

The purpose of the study is help understand how the community in Acholi sub-region is supporting adolescents sexual reproductive health with a view of developing strategies that could improve community support to adolescents in meeting their sexual reproductive health.

Voluntary participation:

You don't have to be in this research if you don't want to be. It's up to you. If you decide not to be in the research, its okay and nothing changes. This is still your clinic or school everything stays the same as before. Even if you say "yes" now, you can change your mind later and it's still okay.

**I have checked the understanding of the child about voluntary participation
__ (initial)**

Procedures:

The procedures will involve asking you some questions and you will be required to answer the questions. You may not answer what you do not know. The duration of the interview will take some 45 minutes to one and half hour and you will be done.

I have to checked with the child the understanding of the procedures _____ (initial))

Risks:

Your participation in the study does not in any case put you at risk. You will only be asked some questions and you will be expected to answer those that you are able to answer.

Discomforts:

The question time may vary between 45 minutes to one and half an hour and during this time you may feel tired and or you may need to go to the latrine. Just let me know so that you can ease yourself before resuming the session.

**I have checked with the child and they understand the risks and discomforts _____
(initial)**

Benefits: There shall be no direct benefit that you will get from participating in this study, however, the indirect benefit could come later if the study results make recommendations that could improve community support of adolescents' reproductive health so that you and other adolescents in your community live a healthier lives. And this is important since as an adolescent you need to live a healthy life.

I have checked with the child and they understand the benefits_____ (initial)

Reimbursements: Because the time we may spend will be close to one and half an hour, during the interviews you may feel thirsty and you will need some refreshments. You will have some refreshments in form of water and soda after the interview.

Confidentiality: We will not tell other people that you are in this research and we won't share information about you to anyone who does not work in the research study. Information about you that will be collected from the research will be put away and no-one but the researchers will be able to see it. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key.

Sharing the Findings: When we are finished with the research, I will sit down with you and your parent and I will briefly tell you about what we learnt. Afterwards, we will be telling more people, scientists and others, about the research and what we found. We will do this by writing and sharing reports and by going to meetings with people who are interested the study conducted.

Right to Refuse or Withdraw: You do not have to be in this research. No one will be made or disappointed with you if you say no. It's your choice. You can think about it and tell us later if you want. You can say "yes" now and change your mind later and it will still be okay.)

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Certificate of Assent

I understand the research is to help get my views on issues that affect the reproductive health of young people (adolescents) in my community and I being one of the young people I understand that I will make a contribution by voluntarily participating and will give information by answering question that will be asked to me. Where I do not understand the questions I will be free to seek clarifications.

I have read this information (or had the information read to me) I have had my questions answered and know that I can ask questions later if I have them.

I agree to take part in the research.

Print name of child _____

Signature of child: _____

Date: _____

Day/Month/Year

ANNEXURE 2

Informed consent/assent form

Introduction:

Good morning/ afternoon. My name is

Thank you for taking the time to talk with me. I am a researcher working for Ajok Florence who is currently pursuing her PhD with the University of South Africa. The overall goal is to improve adolescent sexual reproductive health in Acholi sub-region. We are conducting a study to assess the young people's knowledge, attitudes and skills on issues related to Adolescent Sexual Reproductive Health (ASRH)

Purpose: You are invited to take part in a research study. As a part of this research, we will seek to interview 600 Adolescents in this region (300 in school and 300 out of school) and selected parents, local, cultural and religious leaders as well as policy makers and implementers.

Procedures: You are being asked to take part in this study because you are one of those who have been selected/ identified to participate in this study. Your community was picked purposively and/or by chance and if you agree to participate, i will interview you and the duration of the interview will vary between 45 minutes to about 2 hours.

Confidentiality: To protect your privacy, your name will not appear on any study materials. The answers we collect from you will not be shown to anyone outside of this study team since some questions that will be asked are very sensitive and or personal. All precaution will be taken not to include names or share the answers with anyone.

Right to refuse or withdraw: You do not have to be in this research. No one will be disappointed with you if you say no. It's your choice, you can say "yes" now and change your mind later and it will still be okay.

Certificate of Assent:

I have read this information (or had the information read to me), I have had my questions answered and know that I can ask questions later if I have them. I agree to take part in the research.

For any further questions while we are gone or if you wish to find more about the study, contact Ajok Florence 0784468310/0701272757, email: ajokodoch@yahoo.com or Suzan Kiwanuka –Chairperson IRB from School of Public Health Makerere University 0701888163, email: skiwauka@musph.ac.ug

Print Name of Participant.....signature of participant

Date:.....

ANNEXURE 3

In-depth interview guide- for teen mothers

Time duration: 1 hour & 30 minutes

Procedures:

- This will be done one on one or face to face interviews with teen parents at the facility level in a private room.
- Ask individual teen parent for their consent by going through the consent form help them make an informed decision by signing the consent form

Section one-information on Bio-data of the teen parents

Tell me more about yourself (name, age, what you do and your family status)

- Name
- Age (ablest age-10-19 years)
- Education background (out of school and what is the highest level of education)
- Parenthood status (orphan hood status) and presence of siblings
- Sexual activity (married/ single mother/secondary abstinence/ sexually active with other partners)

Section two: information regarding access to information on SRH by teen parents

- How did you get information on ASRH (source)
- What ASRH information did you get (range of information)
- Who offered SRH? Services (community stakeholders)
- How was the information passed?
- How useful was the information in helping postpone your first pregnancy until the time you got this pregnancy (empowering adolescents with life skills)
- How best would you have wished to be supported with information on ASRH to be able to delay early sexual debut until after adolescence?

Section three: information regarding access to ANC services by teen parents

- What was your experience when you realized that you have conceived (teen mother)/ when you girlfriend conceived- fear, stigma, depressed, wondered what would happen
- How were you referred to the health center for ANC after realizing that you were pregnant (teen mother)/or when your wife realized she was pregnant?
- What information on ANC were you given? (package of information on ANC)- refer to check list)
- How useful was the ANC information in helping you cope with teen parenthood?
- Are there any challenges relating to you accessing maternal and child health care? (stigma, cost, knowledge and skills as teen parents)
- How best would you wish to be supported as a teen parent?/address challenges

Section four: information regarding teen parenthood (both teen mother and father)

As teen mother share with me any unique challenges in regards to the gender roles? – Parenting and child nurturing for proper growth. (Child health, nutrition and social protection)

Is there any additional information that you would like to share with me in line with what we have discussed?

Closing remarks and assurance on confidentiality issues and how the results will be disseminated

ANNEXURE 4

In-depth interview guide for parents/guardians of teen mothers

Time duration: 1 hour

Procedures:

- This will be done on one on one (face to face) interview with the parents/guardians of the teen parents who have been invited to the facility for the interviews in a private room.
- Ask individual parents/guardian of teen parent for their consent by going through the consent form and help them make informed decisions by signing the consent form

Section one- information on Bio-data

- Name
- Age
- Gender
- Occupation and household economic status
- Number of children/siblings to the teen parent in the household

Section two: What are/were the experiences of parents/guardians in supporting their children who are teen parents?

Parental guidance on ASRH

- What ASRH information did you give your child as they were growing up in to adolescence?- Knowledge of ASRH
- How did you give such information? Check list on the traditional channel of teaching children good morals. Was it easy to talk to your child about ASRH?
- Did you experience any difficulty in supporting your child (adolescent) in matters of sexual reproductive health?
- What suggestion do you make to enable parents of adolescents provide proper guidance to adolescents on matters pertaining to their SRH

Parental support to adolescents seeking ANC/PNC

- How did you know that your child had conceived? And what was your reaction
- With whom did she live when she became pregnant?
- What support did you give to your child when she became pregnant? (health care, Psychosocial, emotional, care, nutrition and financial)
- What were your expectations about the future of your child
- Now that your child is a parent, what future plan do you have for her?

Family/community expectations/influence on teen parents

- What are some of the gender related expectations do you have for your children?- forced marriage/ child bearing
- i) Is there any additional information that you would like to share with me in line with what we have discussed?
- ii) Closing remarks and assurance on confidentiality issues and how the results will be disseminated

ANNEXURE 5

Key informant interviews (KIIs) with midwife who support teen parents

Time duration – 45 minutes

Procedures:

- This will be done one on one or face to face interviews with midwife at the facility level in a private room.
- Ask individual midwife for their consent by going through the consent form to help them make an informed decision by signing the consent form

Section one-information on Bio-data of the midwife

Name.....

Age.....

Sex.....

Marital status.....

Name of health facility.....

Sexual reproductive health care for teen parents presenting at health facility

1. How long have you worked as a midwife? (**experience in ANC**)
2. How are teen parents received at the facility? (**friendly space**)
3. From your experience what kind of reactions have you observed among health workers in supporting teen parents on their first ANC visit? (**attitudes**)
 - a. (Shall we conduct observation of ANC for teen mothers at the facility)
4. What ANC package are offered to teen parents (**policy related – is it defined**)
5. What support system do you establish with the parents/guardians of the teen parents to be able to support the teen parents better (**family /community involvement in ASRH**)
6. What challenges have you experienced supporting teen parents?
7. And any suggestions you think could help address the challenges to promote better care for adolescents' sexual reproductive health?

ANNEXURE 6

Procedures for the FGD

- Ensure that consent forms have been signed (**all participants should complete a consent form**).
- The moderator will use a prepared script to welcome participants, remind them of the purpose of the group and also sets ground rules (see below for expected procedures).
- Projected time duration for FGDs will take between 2 hours and 30 minutes

FOCUS GROUP INTRODUCTION

WELCOME

Thanks for agreeing to be part of the focus group. We appreciate your willingness to participate.

INTRODUCTIONS

Moderator; assistant moderator

PURPOSE OF FOCUS GROUPS

We have been asked by Ajok Florence to conduct the focus groups.

The reason we are having these focus groups is to find out more about the role of community in support of adolescents sexual reproductive health in the Acholi Sub-region in a bid to improve further community participation in ASRH matters

We need your input and want you to share your honest and open thoughts with us.

GROUND RULES

1. WE WANT YOU TO DO THE TALKING.

We would like everyone to participate.

I may call on you if I haven't heard from you in a while.

2. THERE ARE NO RIGHT OR WRONG ANSWERS

Every person's experiences and opinions are important.

Speak up whether you agree or disagree.

We want to hear a wide range of opinions.

3. WHAT IS SAID IN THIS ROOM STAYS HERE

We want you to feel comfortable sharing when sensitive issues come up.

4. WE WILL BE TAPE RECORDING THE GROUP

We want to capture everything you have to say.

We don't identify anyone by name in our report. You will remain anonymous.

NB The questions are divided in to four sub-sections: **sub-section one is applicable to all.**

Each of the remaining sub-sections will be administered according to:

- i. Parents and guardians, and other community members
- ii. Cultural leaders
- iii. Religious leaders

FGDs question guide

Question No	FGD guiding question
(a) Rapport building	I would like to begin by going around where you are seated and asking each of you to tell us a little about yourself and how you have supported young people (adolescents) in your household or community
(b) Understanding ASRH	<ul style="list-style-type: none"> - In a brainstorming approach: why do you think it is important to understand the needs of adolescents? <p><u>Sex education</u></p> <ul style="list-style-type: none"> - In some communities, discussing sex and sexuality is not promoted and or considered a taboo (attaching a lot of stigma to sex) what makes this a taboo? - What can be done to de-stigmatize sex? <p>As children grow and become adolescents, sexual urge and feelings sets in and it's a normal part of growth, how have you supported adolescents to understand this as a normal part of growth- explore for:</p> <ul style="list-style-type: none"> - How is sex education promoted for both boys and girls? <p><u>Sexual orientation</u></p> <p>In communities, children and adolescents are being told of the different ways of having sexual practices (not straight way of sexual practices), what is your opinion and what role do you play in counseling and guidance to children and adolescents on sexual orientation?</p>
(c) Impact of the LRA civil war:	<p>For over two decades, the LRA war affected the entire sub-region, what effects did the war have on the social support structures for young people and their futures?</p> <ul style="list-style-type: none"> - Family life and parental support to children (adolescents) - Education among young people - Access to health services - The morals and behaviors of young people (adolescents) - With special focus on Adolescents sexual reproductive health, some children became adolescents during the war time; how did the war impact on their SRH needs?
(d) Roles of community (social capital)	<p><u>Knowledge on ASRH</u></p> <p>Growing up in to adolescents is normal and all people go through this stage, what role do you play in supporting smooth transition of adolescence?</p> <ul style="list-style-type: none"> - The discussion to explore the kind of counseling and guidance promoted by the community to help adolescents understand ASRH- - How is the counseling done and under what circumstances <p><u>Use of media to promote ASRH</u></p>

Question No	FGD guiding question
	<p>The use of media (radio, TV, internet and phone) is increasingly becoming vital source of information including information on SRH.</p> <ul style="list-style-type: none"> - What is your opinion on the use of media to promote ASRH? (explore for both the good and negative aspects of media) - And what role can you play in guiding children and adolescents in using media to access information? <p><u>Gender issues and ASRH</u></p> <ul style="list-style-type: none"> - In some communities, the expectations for the boys and girls children are different; in this sub-region, what does the community expect for boy and girl child? - What socio-cultural factors influence their expectations of the boy and girl child? - How do these expectations impact on both boy and girl child? - And how do these expectations impact on ASRH for the boy and girl child? - What can be done to address these expectations in order to promote equal rights to matters of ASRH?
(e) Challenges & Recommendations	<p>What challenges do cultural and religious leaders face in supporting ASRH needs? (health systems factors- the structure at community level to promote ASRH- VHTs, secretary children's affairs, household, and other institutions -empowering them with skills, IEC materials,</p> <p>What recommendations do you suggest to address the above challenges?</p>

ANNEXURE 7

Key informant interviews (KIIs) with religious and cultural leaders

Procedures:

- This will be done one on one or face to face with the targeted key informants in their office
- Ask individual KI for their consent by going through the consent form to help them make an informed decision and ask them to sign the consent form

Section one: Bio data information

- Name.....
- Title.....
- Sex.....
- Name of the cultural and or religious institution

For over two decades, the LRA war affected the entire sub-region, the moral fiber were eroded and this coupled with the modern development, concerted efforts are needed, as cultural and religious institutions, you a major role. This study is exploring your role in support of ASRH. We are interested in the following areas to get your views

Sex education

- In some communities, discussing sex and sexuality is not promoted and or considered a taboo (**attaching a lot of stigma to sex**) what makes this a taboo?
- What can be done to **de-stigmatize sex**?
As children grow and become adolescents, sexual urge and feelings sets in and it's a normal part of growth, how have you supported adolescents to understand this as a normal part of growth- explore for:
- How is sex education promoted for both boys and girls?

Sexual orientation

In communities, children and adolescents are being told of the different ways of having sexual practices (not straight way of sexual practices), what is your opinion and what role do you play in counseling and guidance to children and adolescents on sexual orientation?

Use of media to promote ASRH

The use of media (radio, TV, internet and phone) is increasingly becoming vital source of information including information on SRH.

- What is your opinion on the use of media to promote ASRH? (explore for both the good and negative aspects of media)
- And what role can you play in guiding children and adolescents in using media to access information?

Gender issues and ASRH

- In some communities, the expectations for the boys and girls children are different; in this sub-region, what does the community expect for boy and girl child?
- What socio-cultural factors influence their expectations of the boy and girl child?
- How do these expectations impact on both boy and girl child?
- And how do these expectations impact on ASRH for the boy and girl child?

- What can be done to address these expectations in order to promote equal rights to matters of ASRH?

What recommendations do you suggest to address the above challenges?

ANNEXURE 8

Key informant interviews (KIIs) with policy makers

Procedures:

- This will be done one on one or face to face with the targeted key informants in their office
- Ask individual KI for their consent by going through the consent form to help them make an informed decision and ask them to sign the consent form

Section one: Bio data information

- Name.....
- Title.....
- Sex.....
- Name of the district and department

Section two: community Responsiveness to the adolescents' sexual reproductive health policy framework

In reference to the ADH policy framework, how responsive is the policy in supporting community (community stakeholders as defined in the study) participation in adolescents' sexual reproductive health?

- The roles- parents/family/ cultural and religious leaders
- Empowering them with skills and knowledge on ASRH
- Materials for use: IEC materials on ASRH for use by community stakeholders
- Linkage and referral systems

Section three: use of modern IT and local media in promoting ASRH

- What influence (both positive/negative) is the media having on ASRH promotion
- The use of IT/ media is part of development, how best could this channels be used to promote ASRH
- What oversight role do you play in ensuring the quality of ASRH information that is promoted through the media in your district/ National level?

Section four: ASRH and gender and sexual diversity

Of recent there are key gender and sexual diversity issues and as a county, Uganda position is clear, however, on the other hand, human rights advocates and development players are key stakeholders on this matter: what can be done to ensure that adolescents/ community make informed choices?

What could be the role of different community stakeholders in this matter of gender and sexual diversity?

ANNEXURE 9

Questionnaire for individual adolescent's interviews

Procedure: help the respondent to fill the assent form

No	Questions and filters	Responses	Code s	Skips
	Date.....			
	District:.....			
	Area	Urban		
		Semi-urban		
		Rural		
	Interviewer's name:			
	Supervisor's name:			
	Questionnaire serial number (all forms shall be pre-coded prior to the field visit)			
	PLEASE NOTE: DISTRICT/AREA /LOCATION/RESPONDENT CODE			
	Section A			
	1.1 Respondents Bio-data			
1.	Sex of the respondent	MALE FEMALE	1 2	
2.	How old were you at your last birthday (RECORD COMPLETE YEARS)	<input type="text"/> YEARS		
3.	Which religion are you?	CATHOLIC PROTESTANT MUSLIM PENTECOSTAL OTHER SPECIFY.....	1 2 3 4 96	
4.	Have you ever attended school?	YES NO	1 2	→Qn 6
5.	What is the highest level of school you attended (RECORD COMPLETE LEVEL)	LOWER PRIMARY(P1-P4) UPPER PRIMARY(P5-P7) O' LEVEL A' LEVEL TERTIARY UNIVERSITY NONE	1 2 3 4 5 6 98	
6.	Are your both parents alive? No	YES NO	1 2	→Qn 9
7.	Which parent is alive?	ONE PARENT A LIVE BOTH PARENTS ARE DEAD	1 2	→Qn 9
8.	What is the orphan-hood	MATERNAL ORPHAN (LOST THE	1	

	status?	MOTHER) PATERNAL ORPHAN (LOST THE FATHER)	2	
9	Are you working?	YES NO	1 2	→SECTION B
10	What work do you do? (Occupation)	FARMER BUSINESS/SELF EMPLOYED CASUAL OTHERS (SPECIFY).....	1 2 3 96	
Section B Growth and Development				
11	Who is an adolescent? (PROBE FOR AGE)	UNDER 10 YEARS 10-19 YEARS 20+ YEARS	1 2 3	
12	What are some of the characteristic of adolescence? (TICK ALL THAT APPLY)	BODY CHANGES ATTRACTION TO THE OPPOSITE SEX SEXUAL DESIRES BEGIN MOOD CHANGES URGE TO DISCOVER NEW THINGS OTHERS (SPECIFY).....	1 2 3 4 5 96	
13	As an adolescent, what changes have you experienced in your body? (TICK ALL THAT APPLY)	GIRLS- DEVELOPMENT OF BREASTS GROWTH OF PUBIC HAIR BODY ODOR ENLARGEMENT OF PRIVATE PARTS MENSTRUATION SMOOTHENING OF THE SKIN SOFT VOICE DEVELOPMENT OF PIMPLES OTHERS (SPECIFY)..... BOYS- DEEPENING OF THE VOICE GROWTH OF PUBIC HAIR BODY ODOR ENLARGEMENT OF PRIVATE PARTS WET DREAMS DEVELOPMENT OF PIMPLES OTHERS (SPECIFY).....	1 2 3 4 5 6 7 8 96 1 2 3 4 5 6 96	
Section C: Sexual Activity				
<i>In this section I am going to ask you questions relating to your sexual activities and these questions are very personal and sensitive but they are very important for this study. But I assure you of confidentiality that the information will not be shared outside the study team. As part of growing up as an adolescent, one may be attracted to the opposite sex and this attraction is a normal experience in adolescence,</i>				
14	Do you have a boy/girl-friend?	YES NO	1 2	→Qn 16
15	Do you plan to get boy/girl-friend as an adolescent (10-19 years)?	YES NO	1 2	ALL →Qn 18

16	How long have you known each other	1-5 MONTHS 6-12 MONTHS ABOVE 1 YEAR	1 2 3	
17	How old is your current boy/girl friend?	10-19 20-24 25 AND ABOVE	1 2 3	
18	Have you ever had sex?	YES NO	1 2	→Qn 22
19	What was your age at first sexual encounter? (RECORD COMPLETE YEARS)	<input type="text"/> YEARS		
20	Have you had sex with your current boy/ girl friend?	YES NO	1 2	
21	Apart from your current boy/girlfriend do you have any other sexual partner/s?	YES NO	1 2	
22	Have you ever gotten attracted sexually to the same sex?	YES NO	1 2	→Qn 24
23	Have you ever had sexual relationship with the same sex?	YES NO	1 2	
24	Have you ever heard about condom?	YES NO	1 2	→Qn 26
25	Where did you get to know about condom? (TICK ALL THAT APPLY)	HEALTH CENTER SCHOOL CHURCH FRIENDS/PEERS PARENTS RADIO PRINT MEDIA OTHERS (SPECIFY).....	1 2 3 4 5 6 7 96	
CHECK POINT:				
IF RESPONDENT ANSWERED NO TO QUESTION 18, SKIP QN. 26, 27 AND 28				
26	Have you ever used a condom?	YES NO	1 2	→Qn 29
27	How often do you use a condom?	ALL THE TIME SOME TIMES	1 2	
28	The last time you had sex, did you use a condom?	YES NO	1 2	
29	Where do you get a condom in case you need them?	HOSPITAL HEALTH CENTER SHOP	1 2 3	

	(TICK ALL THAT APPLY)	CLINIC FRIENDS/PEERS BOY/GIRL FRIEND OTHERS (SPECIFY).....	4 5 6 96	
30	Are you aware about the dangers of unsafe sexual practices?	YES NO	1 2	→SECTION D
31	What are the dangers of unsafe sex? (TICK ALL THAT APPLY)	UNPLANNED/UNWANTED PREGNANCY HIV/AIDS STIs/STDs OTHERS (SPECIFY).....	1 2 3 96	
<u>SECTION D: SEXUAL REPRODUCTIVE HEALTH</u>				
As an adolescent growing up, knowledge on sexual reproductive health is important for your future and the sexual reproductive decision you make now will impact on your future. Unsafe sexual practices are the major causes of ASRH problems. Helping adolescents become aware of the dangers of unsafe sexual practices empower adolescents make transit through adolescence.				
32	Which of the following ASRH information are you aware of? (TICK ALL THAT APPLY)	Body changes during adolescence Attraction of the opposite sex Early sexual debut Unplanned pregnancy Pregnancy prevention (abstinence) Abortion HIV/AIDS Other STIs/STDs Condom Methods of family planning and contraceptives	1 2 3 4 5 6 7 8 9 10	
33	Where do you get this information from?	PEERS PARENTS/GUARDIANS TEACHERS HEALTH WORKER RELIGIOUS LEADER CULTURAL LEADER PRINT MEDIA TV RADIO INTERNET OTHERS (SPECIFY).....	1 2 3 4 5 6 7 8 9 10 96	
34	What is your preferred source of information on adolescents' sexual reproductive health? (TICK ONLY ONE)	PEERS PARENTS/GUARDIANS TEACHERS HEALTH WORKER RELIGIOUS LEADER CULTURAL LEADER PRINT MEDIA	1 2 3 4 5 6 7	

		TV RADIO INTERNET OTHERS (SPECIFY).....	8 9 10 96	
35 .	Why do you prefer (the above source)? (TICK ALL THAT APPLY)	CHEAP ACCESSIBLE TRUST/RELIABLE CONFIDENTIAL CONVENIENT PRIVACY OTHERS (SPECIFY).....	1 2 3 4 5 6 96	
36 .	Did the (source) help you?	YES NO	1 2	→END
37 .	How would you rate the information you got from the above source? (TICK ONLY ONE)	Very satisfied Satisfied Somewhat satisfied Not satisfied	1 2 3 4	
	Any other comments you have observed:			
	THANK THE RESPONDENT AND END THE INTERVIEW			

ANNEXURE 10

FGD guide for adolescents

Procedures for the FGD

- Ensure that consent forms have been signed (**all participants should complete a consent form**).
- The moderator will use a prepared script to welcome participants, remind them of the purpose of the group and also sets ground rules (see below for expected procedures).
- Projected time duration for FGDs will take between 2 hours and 30 minutes

FOCUS GROUP INTRODUCTION

WELCOME

Thanks for agreeing to be part of the focus group. We appreciate your willingness to participate.

INTRODUCTIONS

Moderator; assistant moderator

PURPOSE OF FOCUS GROUPS

We have been asked by Ajok Florence who is currently pursuing her PhD with the University of South Africa to conduct the focus groups.

The reason we are having these focus groups is to find out more about the role of community in support of adolescents sexual reproductive health in the Acholi Sub-region in a bid to improve further community participation in ASRH matters

We need your input and want you to share your honest and open thoughts with us.

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1. WE WANT YOU TO DO THE TALKING.

We would like everyone to participate.

I may call on you if I haven't heard from you in a while.

2. THERE ARE NO RIGHT OR WRONG ANSWERS

Every person's experiences and opinions are important.

Speak up whether you agree or disagree.

We want to hear a wide range of opinions.

3. WHAT IS SAID IN THIS ROOM STAYS HERE

We want you to feel comfortable sharing when sensitive issues come up.

4. WE WILL BE TAPE RECORDING THE GROUP

We want to capture everything you have to say.

We don't identify anyone by name in our report. You will remain anonymous.

Section one: Sexual education

- As adolescents grow up, they require information regarding sexual and reproductive health. Who in your community helps you to learn issues of sexual reproductive health?

- What ASRH information do communities share with you?
- What additional ASRH would you have wished to learn from the community? In addition to the ASRH information you have received from the community to make you understand ASRH better
- What challenges do you experience in learning sexual education
- What recommendation do you make to improve sex education for children and young people?

Section two: sexual diversity

- Of recent, children and young people are getting involved in homosexual relationships, what influence young people to engage in such relationships
- In your community, what sources have you used to learn about sexual diversity?
- Among other issues, is the right to information and choices, What is your opinion regarding sexual diversity?
- What do you think can be done to help children and young people make informed choices on matters of sexual diversity?

Section three: Access to sexual reproductive health services

- From your community where do you get information on ASRH?
- What has been your experience in accessing ASRH services?(friendliness of services)
- What challenges are you facing in accessing ASRH services in your community? (stigma, gender, cost etc)
- What recommendations would you give to address the above challenges?

Section four: Media

- What kind of ASRH information do you learn through the media?
- How helpful has the media been in helping you understand ASRH information
- What is the preferred source of media for accessing ASRH in your community?
- What challenges do you experience in using the media to access ASRH?
- What recommendation would you give to improve the use of media in accessing ASRH information?

ANNEXURE 11

Observation and document review check list

1. IEC materials used by community in support of adolescent sexual reproductive health

- Print and posters, leaflets, charts on ASRH-
- Newspapers articles- straight talk
- Recorded- visual aid on ASRH
- Awareness and issues discussed informally by parents on ASRH
- Informal talks by aunties and uncles

2. Medical records of adolescents cases

- Frequencies of medical follow up
- Medical presentation- what conditions and or services received
Grouped in to the following:
 - Family planning services
 - Maternal and newborn services
 - Management of other medical conditions- Malaria, cough etc
- Any concerned raised/ and or counseled the attendee on
- Action plan drawn for the concerns of the attendee

ANNEXURE 13

Ethical clearance from the Department of Health Studies, Unisa



**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

REC-012714-039

HS HDC/336/2014

Date: 8 October 2014 Student No: 3439-874-0
Project Title: Exploring community support of adolescents' sexual reproductive health in the Acholi Sub Region of Uganda.
Researcher: Ajok Florence Odongpinny
Degree: D Litt et Phil Code: DPCHS04
Supervisor: Prof GB Thupayagale-Tshweneagae
Qualification: D Tech
Joint Supervisor: -

DECISION OF COMMITTEE

Approved Conditionally Approved

**Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

**Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE 14

Approval from Makerere University, HDREC to conduct the study

MAKERERE

P.O. Box 7072 Kampala Uganda

Website: www.musph.ac.ug



UNIVERSITY

Tel: 256 414 532207/543872/543437

Fax: 256 414 531807

COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH
HIGHER DEGREES, RESEARCH AND ETHICS COMMITTEE

04th December, 2015

Ms. Ajok Florence Odong Pinny
Principal Investigator, Protocol (371)
University of South Africa

Re: Approval of Proposal titled: Exploring community support of adolescents' sexual reproductive health in the Acholi sub region, Uganda

This is to inform you that, the Higher Degrees, Research and Ethics Committee (HDREC) has granted approval to the above referenced study, the HDREC reviewed the proposal during the 134th HDREC meeting held on 27th October, 2015 and made some suggestions and comments which you have adequately incorporated:

Please note that your study protocol number with HDREC is 371. Please be sure to reference this number in any correspondence with HDREC. Note that the initial approval date for your proposal by HDREC is 04th/12/2015, and therefore approval expires at every annual anniversary of this approval date. The current approval is therefore valid until: 03rd/12/2016.

Continued approval is conditional upon your compliance with the following requirements:

- 1) No other consent form(s), questionnaire and/or advertisement documents should be used. The consent form(s) must be signed by each subject prior to initiation of any protocol procedures. In addition, each subject must be given a copy of the signed consent form.
- 2) All protocol amendments and changes to other approved documents must be submitted to HDREC and not be implemented until approved by HDREC except where necessary to eliminate apparent immediate hazards to the study subjects.



- 3) Significant changes to the study site and significant deviations from the research protocol and all unanticipated problems that may involve risks or affect the safety or welfare of subjects or others, or that may affect the integrity of the research must be promptly reported to HDREC.
- 4) All deaths, life threatening problems or serious or unexpected adverse events, *whether related to the study or not*, must be reported to HDREC in a timely manner as specified in the National Guidelines for Research Involving Humans as Research Participants.

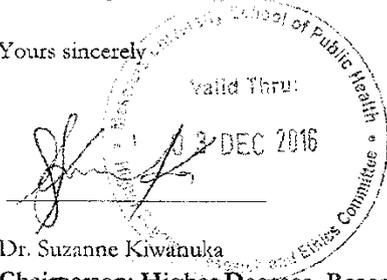
- Please complete and submit reports to HDREC as follows:

- a) For renewal of the study approval – complete and return the continuing Review Report – Renewal Request (Form 404A) at least 60 days prior to the expiration of the approval period. The study cannot continue until re-approved by HDREC.

- b) Completion, termination, or if not renewing the project – send a final report within 90 days upon completion of the study.

- Finally, the legal requirement in Uganda is that all research activities must be registered with the National Council of Science and Technology. The forms for this registration can be obtained from their website www.uncst.go.ug. Please contact the Administrative Assistant of the Higher Degrees, Research and Ethics Committee at wtusiime@musph.ac.ug or telephone number (256)-393 291 397 if you encounter any problems.

Yours sincerely



The stamp is circular with the text "MUSPH School of Public Health" around the top edge and "Higher Degrees, Research and Ethics Committee" around the bottom edge. In the center, it says "Valid Thru:" followed by "31 DEC 2016".

Dr. Suzanne Kiwanuka

Chairperson: Higher Degrees, Research and Ethics Committee

Enclosures:

- a) A stamped, approved study documents (informed consent documents):