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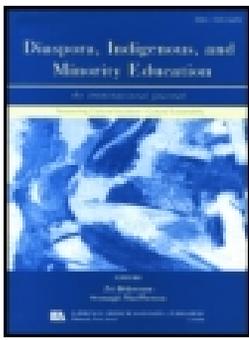


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On the Limits of Sexual Health Literacy: Insights From Ugandan Schoolgirls

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This article makes the case that current conceptions of sexual health literacy have limited relevance to the Ugandan context because they assume that knowledge of unsafe sexual practices will lead to changes in behavior and lifestyle. Drawing on a longitudinal case study with 15 Ugandan schoolgirls in rural Uganda from August 2004 to September 2006, this study argues that despite being well-informed about the risks and responsibilities of sexual activity, poverty and sexual abuse severely constrained options for these young women. Although many believed in the value of abstaining from sexual activity until marriage, they engaged in transactional sex to pay for school fees, supplies, clothing, and food. Further, fear of sexual abuse, early pregnancy, and HIV–AIDS compromised attempts to embrace sexuality. The article concludes with implications of the study for research and policy on sexual health literacy in Uganda and other poorly resourced regions of the world.

The young person who is trained to be disciplined will, in the final analysis, survive better than the one who has been instructed to wear a piece of rubber and continue with “business as usual.” (Uganda’s First Lady, Museveni, at the United Nations Child Summit, 2002; quoted in Stammers, 2003, p. 366)

Girls in Uganda are a hundred percent affected because they fear to talk. They just keep quiet, which is not good at all. They also face the problem of being forced [to have sex] by some people such as teachers, doctors, old men because they fear them. Girls in Uganda have faced the problem of dying for nothing because of abortion, and lose their chance of education due to unprotected sex. (Secondary school girl, Uganda, May, 2006)

Health literacy is recognized as being related to, but separate from, health education. Health education is concerned with the dissemination of information and the teaching of various life skills to provide individuals with skills and knowledge pertaining to their personal health and the health of their community at large (Kickbusch, 2001; Nutbeam, 1998). By being "health literate," on the other hand, it is understood that one actively embodies and acts on these skills and knowledge: "Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions" (Nutbeam, 1998, p. 357). Health literacy, therefore, extends beyond the mere dissemination of information and provides the individual with the tools to cultivate agency that enables her or him to actively pursue healthy choices and lifestyles and negotiate the world of health care, given the particular context of the individual's life. By extension, sexual health literacy references the ability not only to understand sexual health information, but also to act on the information available. Indeed, if one takes seriously the views of the U.S. Surgeon General (Satcher, 2001), it could be argued that "sexual health behavior" and "sexual health literacy" are synonymous:

Sexual health . . . includes the ability to understand and weigh the risks, responsibilities, outcomes and impacts of sexual actions and to practice abstinence when appropriate. It includes freedom from sexual abuse and discrimination and the ability of individuals to integrate their sexuality into their lives, derive pleasure from it, and to reproduce if they so choose. (Letter from the Surgeon General; Satcher, 2001)

From our longitudinal research with young women in rural Uganda, and our extensive review of the literature concerned with the sexual practices of adolescents in a wide range of contexts, particularly in Africa, we have found that such definitions of sexual health literacy, helpful as they may be for wealthy countries, have limited applicability in many developing countries. As a result, we call into question many of the assumptions on which sexual health policy and practice are developed internationally. We take the position that unless policymakers of sexual health education are fully aware of the complexities of the health challenges faced by poor young women in the developing world, policy objectives will have limited success.

Uganda, a country in East Africa, is characterized by chronic poverty, unfavorable health conditions, and gender imbalance (Bigsten & Kayizzi-Mugerwa, 1999). In this context, various studies have been conducted on the sexual health understandings, sexual practices, and effectiveness of sexual health programming for adolescents in the country (Kinsman et al., 1999; Neema & Bataringaya, 2000; Neema, Musisi, & Kibombo, 2004; Kinsman, Nyanzi, & Pool, 2000; Nyanzi, Pool, & Kinsman, 2001). Research on health literacy in Uganda has revealed that factors influencing the sexual behavior

of adolescent girls include social and gendered dynamics, socioeconomic and cultural practices, and local understandings of the relationship among love, intimacy, trust, and sex. Our qualitative research seeks to foreground the voices of adolescent girls and to go beyond the statistics to better understand their sexual behaviors and choices. Although our study cannot claim to be conclusive, the experiences of the young women in our study are illustrative of the experiences of many young women in other parts of Uganda, and Africa more broadly. As such, we hope it will be able to inform research and policy on sexual health literacy in poorly resourced regions of the world.

Drawing on the views of the U.S. Surgeon General quoted earlier, the questions to be addressed in this article are as follows:

1. To what extent are the young women in our study informed of the risks, responsibilities, outcomes, and impacts of sexual actions?
2. To what extent are these young women free from sexual abuse and discrimination, and can they pursue abstinence where appropriate?
3. To what extent do these young women have the freedom and opportunity to embrace their sexuality and make choices concerning reproduction?

BACKGROUND

This sexual health literacy study forms part of a larger study begun in 2003 by Bonny Norton and Maureen Kendrick of the University of British Columbia. The research design of the larger project involves longitudinal, qualitative, multiple-case studies of a select number of women and adolescents in three sites in Uganda. Across all three sites, our research seeks to investigate the complex relation between literacy and development and to better understand the participation of women and girls in literacy practices associated with development, although the research foci and questions vary in the different contexts. The indicators of development that are central to this research include health, education, work, local and national government, transportation, and leisure. Findings from the larger research project are being disseminated in diverse contexts (Kendrick, Jones, Mutonyi & Norton, in press; Mutonyi & Norton, 2007; Norton & Mutonyi, in press).

For the purposes of this article, we focus on a group of secondary school girls approximately 17 years of age in Senior Four (the equivalent of Grade 11, or the final year of "O" Level) in Kyato Secondary School (KSS)¹ in Kyato Village. Kyato Village borders a trading center that is approximately 7 miles from the nearest town center, Ganda, in southwestern Uganda. Poverty in this rural area

¹Pseudonyms are used for the names of the school, village, and research participants to protect the identities of those who participated in, and those who were associated with, this study.

of the country is endemic and acute. Most of the students' families survive by subsistence-level farming, with small incomes sometimes earned through men's employment (e.g., as laborers or in other occupations such as tailoring or driving taxis), the sale of crafts such as mats and baskets made by women, or the sale of extra food grown in the family gardens. The official per capita income is less than \$1 per day, although it is likely that many families live on less than \$1 per day. Malnutrition, disease, and poor living conditions are widespread, and it has been one of the areas in the world hardest hit by the HIV–AIDS pandemic.

As in other parts of Uganda, educational costs place an immense burden on parents and prevent many children from completing secondary schooling. Although primary schooling is free, there are tuition fees (“school fees”) for secondary school students in both public and private schools. The tuition fees at KSS were 150,000 Ugandan shillings (approximately \$80 U.S.) a year for day students, and 450,000 Ugandan shillings (approximately \$250 U.S.) a year for boarders. Due to the low incomes of their families, the majority of students miss portions of schooling (ranging in length from several days to several months) as a result of being “sent home for school fees.”

The school itself has a mixed population of approximately 200 girls and boys, with 13 teachers—11 men (including the headteacher and deputy headteacher) and 2 women. The teachers are poorly paid and often underqualified; there are few textbooks, and no electricity. It does, however, have a close affiliation with the Kyoto Community Library (KCL), which is located on the KSS property. Although the two institutions are separately managed, they work in tandem to serve the KSS student population. For many students, KCL is their only source of books, newspapers, and other educational resources.

THEORETICAL FRAMEWORK

The theoretical framework for this study draws on the “literacy practices” unit of analysis and the “literacy ecology” theoretical framework that guide the overarching, multisite project (Barton & Hamilton, 1998; Hornberger, 2003; Kramsch, 2002). In this view, rather than isolating literacy practices to understand them, we seek to understand literacy practices in their wider sociocultural, economic, and historical contexts. According to Street (1993/1997b), literacy practices are processes based on “... both behaviour and conceptualisations related to the use of reading and/or writing” (p. 12). The notion of literacy practices is also informed by the work of Freire (1972/1993), who posited that “the literacy process must relate *speaking the word to transforming reality*” (p. 213). Thus, if literacy education is meant to result in empowering and transformative capabilities, then literacy and human agency are inextricably linked (Egbo, 2000). An important component of the literacy process, then, is to identify and examine

sources of “disempowerment” and to work actively toward dismantling those to create a more just and equitable society.

For the purposes of this study, we consider literacy practices as well as literacy ecologies as they relate to the sexual health understandings and practices of adolescent girls in a rural Uganda context. We consider literacy practices to be the behaviors and conceptualizations of the participants with respect to the sexual health information they receive. In addition to their processing of this information and their general levels of sexual health awareness, we also explore the nature of the “ecologies” in which their sexual health knowledge intersects with human agency and proactive decision making. In essence, we explore the links and disconnects between sexual health literacy and sexual health practices.

METHOD

This ethnographic study used a number of qualitative data collection methods over the course of 2 years (August 2004–September 2006). It included 15 girls from KSS who, over this period, transitioned from S3 to S5 or vocational training.² Data were collected through interviews, observations, questionnaires, journals, and document analysis. Two questionnaires were particularly important for data collection—one administered in May 2005 by Shelley Jones and a second administered in September 2006 by a local research assistant, Daniel Ahimbisibwe. Thirteen girls completed the first questionnaire, hereafter referred to as Q1; 12 girls completed the second questionnaire, hereafter referred to as Q2. Fieldwork was conducted primarily by Shelley Jones from August 2004 to August 2005, during which time she lived full time in Kyato Village. Shelley Jones and Bonny Norton had made an initial visit to the site in August 2003, and Bonny Norton returned to the site in October 2004 and February 2006 during which time she participated in data collection.

Shelley Jones integrated herself into the community by teaching English to the Senior 3 (or S3, the equivalent to Grade 10) class at KSS in which the 15 girls were students. Shelley Jones also co-facilitated a weekly lunch-hour sexual health club, the Straight Talk Club, based on a nationally distributed sexual

²There are two kinds of secondary level education: an academic program and programs of post-primary studies offered by technical and vocational institutes that run parallel to the academic system. The academic program is based on the British model of lower and upper academic secondary education. The O-Level (Ordinary Level or lower secondary level) courses, Senior 1 through 4 (S1–S4 or the equivalent of Grades 8–11), lead to the Uganda Certificate in Education; and A-Level (Advanced Level or senior level secondary) courses, Senior 5 through 6 (S5–S6 or the equivalent of Grades 12–13), culminate in the Uganda Advanced Certificate in Education. Once students complete their O-Level exams (contingent on their exam results), they can advance to either A-Level studies or enter a range of alternative educational institutes such as technical and commercial schools and colleges and primary teacher training colleges.

health newsletter, *Straight Talk*, designed for youths. She visited women's and other community groups; taught an adult literacy class at the community library; and visited the local primary schools, health clinics, and other institutions while working closely with the research assistant and translator, Daniel Ahimbisibwe.

The goal of this research was to understand the complex web of inter-connections between education and these young women's lives through "thick description" (Geertz, 1973). Jones began the research process with group discussions and meetings, followed by individual interviews and "shadowing." Throughout the research process, Jones took detailed fieldnotes; kept a journal; and learned first-hand about the girls' families, homes, and communities, as well as their aspirations and challenges (academic, personal, and health related). Five of these girls were also regular members of the Straight Talk Club, and all of the girls participated in Straight Talk meetings on at least one occasion. The girls also completed general questionnaires that were given to both male and female students of KSS; they participated in photography, art, drama, and music projects, which encouraged them to investigate gender roles as well as the various challenges they faced in their lives.

FINDINGS AND DISCUSSION

In presenting our findings, we discuss the three research questions outlined earlier, which address, respectively, the girls' sources of sexual health information, their freedom of choice with respect to sexual decision making, and their opportunities to embrace their sexuality and make informed choices about reproduction.

Sources of Sexual Health Information

At present, dissemination of sexual health information in Uganda is aimed at combating the HIV–AIDS epidemic, which has ravaged the country since the early 1980s. The epidemic has been the cause of death of over half a million people in the country, and it is estimated that currently 1.5 million Ugandans are infected with HIV (Mbulaiteye et al., 2002). The dissemination of AIDS information is a joint effort among government agencies such as the AIDS Control Program and the Uganda AIDS Commission (UAC), nongovernmental organizations such as The AIDS Support Organization, and donor agencies.

Students in most secondary schools in Uganda receive education about sex through formal (classroom-based, curricular) and non-formal (non-curricular) sources. There is no comprehensive sex education component of the curriculum, although sex education is part of the central national curriculum taught in subjects like biology, religious education, and health education. It is also taught as part

of the Presidential Initiative on AIDS Strategy for Communication to Youth, which is used in primary schools. However, some cultural leaders posit that sex education has no place in the schools and that youths should receive information about sexual matters upon marriage (*New Vision*, 2004). Teachers, in concurrence with these cultural beliefs or out of fear of being seen to resist them, often give only cursory attention to matters of sex and sexual health.³ Thus, the prevailing and predominant message to youths concerning matters of sex in the formal education sector is “abstain.” Other studies have shown that informal sources of sex education include friends, peers, clinics, local organizations, newspapers, radio, and *Straight Talk*⁴ (Hulton, Cullen, & Khalokho, 2000; Kinsman et al., 2001; Ndyanabangi & Kipp, 2001; Neema & Bataringaya, 2000). Our research corroborates this.

Studies in Uganda⁵ suggest that most youths have a high level of awareness of fundamental safe-sex and contraceptive measures, particularly around the use of condoms (i.e., that condoms are effective in both contraceptive and disease preventative capacities). However, the prevalence of condom use and other contraceptive measures is extremely low amongst sexually active adolescents: only 7.2% of adolescents use any form of contraception (Neema & Bataringaya, 2000). Thus, there is an apparent disconnect between sexual health information and actual sexual practices (Hulton et al., 2000). This discrepancy between knowledge and practice is alarming as adolescents, especially girls, constitute the group at highest risk for contracting HIV–AIDS and suffering severe, sometimes life-threatening, health and socioeconomic consequences of mistimed pregnancy (UAC, 2002, 2004; UNAIDS, 2004).

In Q2, we asked the girls the following questions: Do you think you have received enough information about matters relating to sex and sexual health? Do you have questions relating to sex and sexual health? From where have you received most of your information regarding sex and sexual health? With whom do you discuss sexual matters? The responses to these questions were highly informative. Whereas 7 of the 12 girls said they had adequate information about sexual health, 11 of the 12 said that they still had many questions. Representative examples of what they said they knew about sexual health are as follows: “I know that sex health is having the knowledge and ability to prevent unwanted

³See Amuyunzu-Nyamongo et al., 1999; Burns, 2002; Kinsman, Nyanzi, & Pool, 2001; Ndyanabangi & Kipp, 2001.

⁴The Straight Talk Foundation (STF) has been a registered nongovernmental organization since 1997. It publishes *Straight Talk*, a monthly newsletter distributed as an insert in one of the national newspapers, *New Vision*, as well as posted directly to some schools that have Straight Talk Clubs. In addition, the STF publishes *Young Talk* (for primary school students) and *Parent Talk*, and produces weekly 1/2-hr radio programs (in English and 2 local languages) that focus on sexual health issues.

⁵See, for example, Agyei and Epema (1992); Agyei, Mukiza-Gapere, and Epema (1994); Hulton, Cullen, and Khalokho (2000); Kinsman et al. (2001); Ndyanabangi and Kipp (2001); Neema and Bataringaya (2000).

pregnancy. [I]t [is] also [the] ability [to] protect yourself from HIV/AIDS”; “Since sexual health means the ability to prevent unwanted pregnancies and to protect ourselves from HIV and other STDs [sexually transmitted diseases], I think to prevent unwanted pregnancy is to abstain or to use condoms but the best way is to abstain because AIDS will also be avoided.” The range of questions the girls still had included: “If my partner is affected with AIDS do you think that I am already affected?”; “Is oral sex cause AIDS?”; “Is there medicine for AIDS?”

In addition to friends at school, older sisters, paternal aunts, *Straight Talk*, and other media, the girls considered the Internet as a source of sexual health information. The girls discussed sexual matters with mostly female friends but also some male friends, teachers, and health professionals. It is significant to note that although none of the girls discussed sexual matters with their parents, 5 indicated that they would value this opportunity, if it were possible. In general, then, the girls seemed reasonably confident about their knowledge of sexual health and their access to health information.

Freedom of Choice and the Pursuit of Abstinence

As the U.S. Surgeon General has noted, sexual health includes freedom from sexual abuse and discrimination and the ability to practice abstinence where appropriate. Thus, our second research question sought to establish to what extent the young women in our study were free from sexual abuse and discrimination and in a position to practice abstinence. As indicated later, our findings suggest that poverty and sexual abuse compromise freedom of choice for these girls, notwithstanding their support for abstinence.

Poverty and transactional sex. Our research indicates that poverty plays a key role in influencing sexual choices and behaviors among many girls and women in Uganda and other sub-Saharan African countries.⁶ In addition, women, especially young women in poor and rural areas, have far fewer opportunities than men and boys to earn an income; thus, transactional sexual relationships are common for this particular population. Adolescent boys in rural areas can earn money by making bricks, digging land, building houses, clearing brush, fetching water, tending animals, transporting goods by foot or by bicycle, collecting firewood, and other odd jobs (Jones, 2007; see also Nyanzi et al., 2001). Generally, these same opportunities do not exist for girls (Freedman & Poku, 2005). “Unlike the boys, the girls are rarely allowed by parents to seek employed labour” (Nyanzi et al., 2001, p. 87). Thus, girls have no access to money unless their parents, or perhaps relatives, have extra money to give them, which is

⁶See Blum (2004); Freedman and Poku (2005); Hulton et al. (2000); Kuate-Defo (2004); Lacey (2003); Leach, Fiscian, Kadzamira, Lemani, and Machakanja (2003); Luke (2003); Neema and Bataringaya (2000); Nyanzi et al. (2001); Twa-Twa (1997).

rarely the case. This puts the girls in an exceedingly difficult position, as they are often confronted with the immense burden of finding money to pay not only for education-related expenses, such as school fees and supplies, but also for the most basic of personal necessities such as shoes, clothing, soap, and food. This disadvantage is compounded by the fact that boys are generally favored over girls when it comes to education. If parents cannot afford to send all of their children to school, they will generally choose to send sons over daughters (African Development Fund, 2005; Forum for African Women Educationalists, 2001; Global Campaign for Education, 2005). Transactional sex can thus serve as the means to an education for girls.

In Q1, 12 of 13 girls noted that the problem of girls having sex to pay for school fees and supplies was a common one in Uganda; in Q2, 9 of the 10 sexually active girls noted that they had received gifts or money for sex. The money received was used to buy books, stationery, clothing, food, and toiletries. As one girl said, "I used that money to buy things that helped me to stay at school because I was at home lacking things to use." Another said, "It is true that girls usually expect money or gifts in exchange for sex because some parents failed to pay school fees for girls and then she decide to exchange sex in order to get money." Their sexual partners, however, have not always given money to the girls, but rather services in kind. Thus, whereas the "sugar daddy" generally gives the girl cash, the teacher gives "high marks in the teacher's subject," "good results," and "guideline in studying"; whereas the *boda-boda*⁷ man provides "easy transport," "taking you to school," and "lifts."

Our study also suggests that some parents are complicit in the transactional sex of their daughters. In answer to the Q1 question, "Do you know of any parents who have encouraged girls to have sex in order to pay school fees?," 12 of 13 girls answered "yes." Further, in a focus group interview in January 2005, one of the girls noted as follows:

Our mother can force us to, to go and practice fornication. If you say at home, "Mum, I want books, pencils. I don't have a uniform," she can tell you that "I don't have money. What can you do? You can go and practice fornication in order to get money."

For many of these girls, then, sex has become an exchangeable commodity; a "resource" that the girls, some with the encouragement of parents, can use to cover costs of schooling and basic necessities. Nyanzi et al. (2001) made the case that in a girl's perception of a sexual relationship with boys, there must be

⁷The original *boda-bodas* were bicycle taxis that operated in eastern Uganda and took people them over the border to Kenya; the etymological origin of the *boda-boda* is "border-to-border," the call of bicycle owners seeking customers. Bicycle *boda-bodas* still exist, but the ones commonly used for longer distances are 500 cc motorbikes, upon which the passengers ride on the back.

some form of material gain, especially a monetary one. Money is in fact seen to be an indicator of sexual interest on the boy's part. Under such harsh social and economic conditions, the freedom of choice and the pursuit of abstinence is an enormous challenge for girls in Uganda (Hardon, 2005). Indeed, transactional sex seems to be fairly commonplace for adolescent girls in many African (and other developing) countries, with both boys their own age as well as older men (Luke, 2003; Ndyabangi & Kipp, 2001; Nyanzi et al., 2001; Okee-Obong, 2000; Twa-Twa, 1997). In fact, some studies claim that sex in exchange for money or gifts is the norm and that there is an expectation by girls that boys and men will pay for sex: "Gifts have become a symbol of the girl's worth and a man's interest, and girls feel offended if they do not receive something in return" (Luke, 2003, p. 73; see also Nyanzi et al., 2001).

It is important to note, however, that most of the girls in the study saw great virtue in abstinence until marriage. In Q2, comments in this regard include, "Please young girls abstain from sex till you grow up"; "The comment I would like to share is with those who are not engaged in sex is to abstain until they get married"; "I would like to comment about girls because they are most affective with HIV/AIDS. So they should use this method: A—Abstinence from sex; B—Being faithful; C—condom use."

However, although the girls believed in the virtue of abstinence, 10 of the 12 girls in Q2 noted that they were sexually active, having begun sexual activity at the average age of 16. Although 5 girls had had only one sexual partner, 5 had had multiple partners, mostly with adolescent boys but also with sugar daddies, teachers, and boda-boda men. Pressure from the partner was cited most commonly as the reason why the girls engaged in sexual activity, although the need for money was almost equally important. Only 1 girl said that she had sex because she "wanted to." This concurs with similar studies that have found that, "[t]here were contradictions between behaviour and attitudes, with many more young people reporting that they engaged in sexual behavior than reporting that they approved of premarital sex" (Agyei et al., 1994, p. 219). For example, a study by Kinsman et al. (2001) in Masaka District, Uganda, found that an HIV–AIDS education program taught in secondary schools was unsuccessful in influencing students' sexual behavior for several reasons, including the lack of acknowledgment or understanding of the adolescents' motivations for engaging in sex, in addition to the complicated negotiations of sexual relationships, which often involved money, gifts, and status. Under such social and economic conditions, explored further later, sexual health literacy would have limited relevance to the girls, notwithstanding desires to abstain from sexual activity.

The prevalence of sexual abuse. Rape, forced sex, and various kinds of abuse are alarmingly common in Uganda and other sub-Saharan African countries (Hulton et al, 2000; Leach, Fiscian, Kadzamira, Lemani, & Machakanja, 2003;

Luke, 2003; Nyanzi et al., 2001). Hulton et al.'s study of a group of adolescent girls elicited from them a wide spectrum of abuse including "rape," "abuse from boys," "boys trying grope you," and being "strongly convinced" (p. 43). In our study, 11 of 12 girls in Q2 said that they had been afraid to refuse a request for sex, the consequences of which included the following:

- When I refused he forced me until I get sex with him.
- You can be abused and punished by these people.
- The teacher had started beating me at school without any reason.
- The person hates you until death.

Luke (2003) uncovered similar findings: "The research offers numerous examples of older partners, such as teachers and relatives, and peers (and sometimes groups of peers) who forced girls to have sex" (pp. 74–75).

Tragically, the context of the school in which adolescent girls should be receiving support and encouragement to develop autonomy, self-confidence, and strength in negotiating equality is the very environment in which girls are often at risk of sexual, physical, and emotional abuse. Exploitative sexual relations between teachers and students is, in fact, considered a widespread problem in Uganda.⁸ In Nyanzi et al.'s (2001) research, 54% of the students mentioned teachers among the three most common types of sugar daddy:

The adolescents claimed that teachers seduced, intimidated and sometimes forced students to have sex with them. They said that teachers used ploys ranging from sweet words of praise, the promise of marriage and a secure future, and undeserved high marks, to threats of manual labour and corporal punishment in order to secure compliance. The headmaster of this particular school gave the example of a teacher who had recently been expelled from the school for making a pupil pregnant. (p. 90)

Our research corroborates this. In Q1, all 13 girls said they knew of girls who had had sex with teachers. In a questionnaire administered to teachers at both the secondary school and two primary schools in the village, 17 out of 30 teachers knew of teachers who had had sexual relationships with their students; 20 out of 30 teachers believe this to be a general problem in Uganda. The girls in our study indicated that having sex with a teacher might help a girl receive "money and . . . marks"; "being graded [more] highly than the others"; "status"; and "high marks in class during examination period." In Q2, three girls said that they had been afraid to refuse sexual advances made by teachers: 1 girl (who had sex with her teacher) said, "I was fearing him . . . he would have beaten [me] in class and punished me every time"; another girl said she "fear[ed being] mistreated at school."

⁸See Edinburgh Global Partnerships (2006), Lacey (2003), Luke (2003), Ndyabangi and Kipp (2001), Nyanzi et al. (2001), Okee-Obong (2000), Scheier (2006), Twa-Twa (1997).

Sexual Pleasure and Reproduction

Our final research question addresses the extent to which the girls in our study could embrace their sexuality and reproduce when they chose. Love, intimacy, and the prospect of a future family were all greatly desired by the girls in our study. One girl noted that when she has sex with a boy her own age, what she desires is “true love,” whereas another said that she hoped that her sugar daddy would not only give her money but “fulfilled love.” Sexual health, for another girl, is “the union of two people with opposite sex for the purpose of enjoyment.” Freedom from fear is a prerequisite for sexual pleasure; however, for the girls in the study, and for many young women throughout Africa, sex is associated with two cardinal fears: the fear of early pregnancy and the fear of HIV–AIDS. We address each of these issues in turn.

Fear of early pregnancy. With regard to early pregnancies, Uganda has one of the highest teenage pregnancy rates in the world.⁹ It is claimed that about one half of women become pregnant before the age of 18 years (Hulton et al., 2000; Neema & Bataringaya, 2000), and 64% are mothers by the time they are 19 (Hulton et al., 2000). Further, the pregnancy rate (61%) is highest in rural areas and lowest in the urban centers (34%; Agyei & Epema, 1992). Of particular concern is the high level of maternal and infant mortality associated with this age group (Neema & Bataringaya, 2000). Further, there is also a high abortion rate, despite the fact that abortion is illegal, except for specific medical purposes; therefore, most abortions are not conducted under medical supervision. Unsafe abortions constitute about 22% of maternal deaths (Neema & Bataringaya, 2000), and most unsafe abortions are done by unmarried girls who feel they have little choice but to resort to illegal services (Neema & Bataringaya, 2000). It is impossible to determine exactly how many unsafe abortions are performed, but there are some studies that show that the numbers are high: Approximately 15% of female youths who had ever been pregnant had terminated a pregnancy (Agyei & Epema, 1992). A study done by the Family Planning Association of Uganda in Mbarara in 1997 revealed that most adolescents (82%) knew of a girl who had got pregnant, and 78% knew one who had an induced abortion (Neema & Bataringaya, 2000; Twa-Twa, 1997). Adolescent girls are very much aware of risks associated with pregnancy and abortion and express these as major concerns with regards to embracing their sexuality.

Young women are also aware of the very serious consequences unplanned pregnancies can have on their education and their future prospects. If a girl becomes pregnant while still in school, she is almost always expelled (Hulton et al., 2000). This initiates a cycle of economic hardship as well as severe

⁹See Agyei and Epema (1992), Hulton et al. (2000), Ndyabangi and Kipp (2001), Neema and Bataringaya (2000), Okuonzi and Epstein (2005), Twa-Twa (1997).

social consequences. Unmarried mothers with limited educational attainment have few opportunities for earning an income or achieving economic independence. Nonetheless, despite girls' understanding of how pregnancy occurs and what the socioeconomic consequences of mistimed pregnancy are, many girls who begin secondary school do not complete it because of early pregnancy (Agyei & Epema, 1992; Hulton et al., 2000; Twa-Twa, 1997).

Data from our research supports many of these assertions. In Q2, 11 out of 12 girls said most girls know condoms help to reduce the chances of pregnancy, and 9 of the 10 sexually active girls indicated that they asked their partners to use condoms to prevent both pregnancy and HIV–AIDS transmission. It is interesting to note that the fear of pregnancy appeared to be of even greater concern than HIV–AIDS. As one said, “I had a fear that I can get pregnancy but I had no fear of getting AIDS”; whereas another said, “In Uganda we have a saying that studying students are most fearing pregnancy not AIDS.”

However, power differentials in terms of gender and age, combined with the financially dependent position of the girl, often make it impossible for the girl to insist on protected sex. As Stromquist (1990) noted, “[a] key element in the subordination of women has been men’s control over women’s sexuality and . . . norms such as virginity, limited physical mobility, the penalization of abortion, and the association of the use of contraceptives with sexual promiscuity” (p. 98). Indeed, as Kuate-Defo (2004) argued, the more financially dependent girls are, the less scope they have to protect themselves. In our study, although the vast majority of girls asked their partners to use condoms, 5 said that men usually do not use condoms when they have sex with adolescent girls. Reasons given include the following:

- Because some of them want to impregnate them and stop them from school.
- They say that sex with condoms are not interested to them and they not get satisfaction. They said that having sex with condom is like eating packed sweet.
- The majority do not use condoms. They are affected and they say why do we use condoms for what They say “Do AIDS cost money?”

It is significant that in Q2, 10 of the 12 girls said that they knew many unmarried girls who had had unplanned pregnancies. Many had terminated their pregnancies, some had got married, and some had remained home with their child. The comment of one girl sums up the responses to the question, “What did these girls do?”: “Some marry the boy but they are in poor families. Others abort and some died while aborting. Some give birth and stay home with their parents.” Another noted as follows:

We as young girls we face many problems like early pregnancies. I give to those who [experience] early pregnancies an advice when they are in school to abort because they have nothing to give their babies. But get a real clinic.

Fear of HIV–AIDS. In Africa, HIV–AIDS transmission occurs predominantly through heterosexual contact (Malinga, 2001), and almost 50 % of the HIV–AIDS infected population are youths. Although the male:female ratio of HIV infection among adults is 1:1, it is 1:4 among adolescents (Neema & Bataringaya, 2000), and some research indicates that girls in the 15 to 19 year age range are up to six times more likely to contract HIV than boys in their age cohort (Malinga, 2001; Mirembe & Davies, 2001; Okuonzi & Epstein, 2005). Women are more prone to infection for physiological reasons because the HIV viral load is denser in semen than in vaginal fluid, and the vaginal wall is highly susceptible to ulcerations and chaffing (Kuate-Defo, 2004).

In addition to physiological factors, however, the reasons for this acute differential in HIV–AIDS infection rates between young men and women also have to do with sociocultural and economic factors, many of which have been addressed earlier. Ankrah (1991) noted, for example, that the “low status and powerlessness of the African woman have been identified as leading contributors toward their vulnerability to HIV infection” (p. 971). Leach et al. (2003) claimed that adolescent girls generally enter into sexual relationships with older men due to force, financial need, or the desire for love or marriage; a desire that is often rooted in financial need, and “Age mixing in sexual relationships between older men and adolescent girls has been offered as a likely explanation for these differences, because men often have higher rates of HIV infection than adolescent boys” (Luke, 2003, p. 67; see also Leach et al., 2003).

Seeley et al. (1994) quoted a study of women in Kampala, Uganda that found that the income of women was a significant predictor of HIV status: “Women with incomes regarded as high, ranging from \$12 to \$20 a month, had the lowest chance of being HIV infected” (p. 79). Although initially a strong proponent of a policy called ABC (A for Abstinence, B for Be faithful, and C for Condom usage), it is of great concern that President Museveni has now begun to condemn the distribution of condoms to school pupils, largely as a result of conservative donor pressure. For example, he recently noted as follows: “I will open war on the condom sellers. Instead of saving life they are promoting promiscuity among young people” (Ssejoba, 2004).

The girls in the research group had a fundamental level of awareness of effective measures they could take to help prevent themselves from contracting HIV–AIDS and other STDs. In Q2, 10 of the 12 girls indicated that they could avoid becoming infected with HIV–AIDS by abstaining from sexual activity; many also mentioned condom use. Nine out of 12 girls indicated that they believe most girls know that condoms can be used as a preventative measure against HIV–AIDS infection. However, as indicated earlier, most adolescent girls are already sexually active by the age of 15 or 16, many as a result of poverty; these girls cannot insist that their partners wear condoms. What exacerbates the situation for young women is the belief that questioning a boy or man about

his HIV status can be interpreted as questioning his faithfulness and perhaps implying promiscuity. For a female, insisting on condom use is often interpreted as implying that she believes her partner to be infected with HIV–AIDS or that she herself has HIV–AIDS and wants to use protective measures to avoid infecting her partner (Nyanzi et al., 2001). Thus, the fear of AIDS, like the fear of an unplanned pregnancy, makes it difficult for girls to embrace their sexuality.

CONCLUSIONS AND RECOMMENDATIONS

We have argued in this article that current definitions of sexual health literacy are problematic because they assume that if people are fully informed of the risks and consequences of unsafe sexual practices, they will change their sexual behavior in the interests of improved health and longevity. Further, sexual health literacy programs in Uganda and elsewhere often assume an equal playing field, rather than taking seriously the unequal conditions that lead to unsafe sexual practices (Swart-Kruger & Richter, 1997). Sexual health programs often fail to realize the many and complex reasons individuals engage in sexual activities (Hardon, 2005; Leach et al., 2003).

In essence, little attention is paid to the ecologies within which sexual health literacy is located. Sexual health literacy programs do not typically engage individuals in critical analysis of inequitable and harmful sociocultural assumptions, beliefs, and practices, or work to eradicate them. Rather, the onus is placed on those most at risk (i.e., adolescent girls) to mediate these inequities, unsupported by social infrastructure, and armed only with “information.” However, as we argued earlier, if literacy is meant to be transformative—and, in this case, change risky sexual behavior—literacy must also be used to develop the agency necessary to negotiate behavior change. The development of agency will require an exploration and understanding of dominant hegemonic practices that are associated with power and privilege on the one hand and powerlessness and oppression on the other hand. Social transformation will require either engaging with those hegemonic practices or consciously resisting them. Thus, the foundational goal of effective sexual health literacy programs must be to engage individuals in critical analysis about the oppressive attitudes, beliefs, and practices that prevent them from having the freedom to exercise agency and make safe decisions for their lives.

We have drawn on our study, as well as a vast body of research, to argue that many young women in Africa, especially in impoverished, rural areas, are subject to powerful and restrictive sociocultural practices and beliefs that profoundly undermine their autonomy and decision-making abilities (Ankrah, 1991; Baylies & Bujra, 2000; Heise & Elias, 1995; Leach et al., 2003). Sexual health *literacy practices* have failed to result in *sexual health literacy*, defined

from an agentive perspective, because in many circumstances the girls cannot exercise agency in contexts that do not support their sexual health decisions and choices. In addition, or perhaps because of this, women learn at a young age that their bodies can be used as commodities. As there are few other options for young women to earn an income, sex in exchange for money and gifts is often the norm: "Indeed sex has been referred to as the currency by which women and girls are frequently 'expected to pay for life's opportunities, from a passing grade in school to a trading license or permission to cross a border'" (Baylies, 2000, p. 7). And, where socioeconomic circumstances and gender oppression tend to dictate sexual practices, such as condom use and abstinence, there is little opportunity for negotiation (Leach et al., 2003). Further, as Hulton et al. (2000) noted, girls are not convinced that abstinence is a practical means of avoiding either pregnancy or HIV, because men's frequent use of physical force to obtain sex is disempowering. Thus, social position, economic circumstances, cultural norms, community influences, and family pressures merge to weigh in on sexual practices.

What we have learned about the daily life circumstances of many adolescent girls in rural Uganda is that their limited life chances often prevent them from applying their sexual health knowledge in ways that would serve their long-term interests. We have argued that these girls have learnt and understood fundamental and important sexual health messages but that their immediate needs for schooling, food, and clothing militate against practicing sexual health literacy as understood in wealthy, industrialized nations. The girls in our study had access to information, but they had little freedom of choice as to when and with whom they could engage in sexual activity; abstinence was often not an option for them, and deriving pleasure from sex was seldom mentioned. They understood that reproduction is often unplanned and sometimes deadly.

What then are the implications of our research for policymakers? As Butegwa (1998) noted, special attention must be paid to the actual and particular needs, desires, and life circumstances of adolescent girls and young women as they themselves understand and perceive them. In this spirit, we begin to address this question by taking seriously what the girls in the study have recommended.

First, the girls are well aware that personal choices are limited by the poverty in their lives, much of which has historical roots in the ravages of colonialism in which the North is complicit. If the world would take seriously the struggle against poverty in Africa, girls in Uganda and other parts of the developing world would have greater life chances. As one girl said, "Parents can provide basic needs for their children to prevent such problems because many children attracted for sex in order to get basic needs." Second, early pregnancy and HIV/AIDS create havoc in the lives of young women. Again, early sexual activity and

AIDS infection must be understood on both economic and gendered terms. As one girl said, “[Girls] get early pregnancy by lacking enough money. They cause AIDS due to early sex.” Young women need free and easy access to condoms, birth control options, and sensitive and informed health professionals who can advise them on appropriate measures for safe and non-reproductive sex. As one said, “I would like to get a counselor to counsel us about AIDS.” Third, the girls have expressed a desire for better communication with their parents, suggesting that sexual health education could include both family and individual counseling. In this spirit, educators should develop better connections between the home and school, so that there are enhanced opportunities to share knowledge and develop trust. To achieve this, they will need to take seriously incidents of sexual abuse and strive to make schools places of safety for young women. One young woman summarized:

So if you provide seminars concerning with HIV/AIDS, providing condoms for free and advise them to use them because they are at a high price; providing school fees for some girls because some girls have a problem with school fees, that’s why they engage in sex before marriage . . . it can help us so much.

Sexual health literacy is anchored in, and linked to, an enormous array of activities and contexts; therefore, effective sexual health literacy programs must be conceived, planned, and evaluated with full engagement of those whom the programs are meant to benefit to identify and meet specific needs within complex ecologies. Furthermore, these programs must be grounded in the participants’ multiple roles and real-life conditions—economic, family, community, cultural, political—in both the *particular local* and the *general global* contexts within which they interact. The sexual health literacy of Ugandan schoolgirls is not only a local challenge but a national, regional, and global one. Kickbusch (2001) argued, in fact, that “[c]omponents of health literacy, such as access to information and knowledge, informed consent, and negotiating skills must constitute part of the overall development effort” (p. 294). We must challenge premises that assume equitable relations of power between men and women, rich and poor, urban and rural, North and South, and acknowledge that the literacy ecologies within which sexual health practices are embedded are particular and complex. A failure to provide sexual health literacy programming that fully understands and addresses these ecologies, and strives to bring about equity within these ecologies, will be of little practical use. Sexual health policy remains sterile in the absence of a full appreciation of the gendered and economic challenges of these young women. A worthy goal for educators, politicians, and economists is to create conditions in which sexual health literacy can indeed be equated with freedom of choice and the ability to embrace sexuality without fear.

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