A COMPARATIVE STUDY OF PATTERNS OF SEXUAL BEHAVIOUR AMONG ADOLESCENTS IN INTERNALLY DISPLACED PEOPLE'S CAMPS AND NORMAL SETTLEMENTS, IN LIRA DISTRICT

By

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DECLARATION

I, hereby declare that this dissertation is my original work and has not been submitted for a **degree in any University.**

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DEDICATION

This dissertation would not be possible without the loving support of my mother, father, wife and children; I owe them a lot. I find myself overwhelmed in offering them all my thanks in dedicating this dissertation to them.

ACKNOWLEDGEMENT

The writing of a dissertation can be a lonely and isolating experience, yet it is obviously not possible without the personal and practical support of numerous people. Thus my sincere gratitude goes to my parents, all my friends, data collectors and my companions for the love, support and patience over the years.

I wish to thank my supervisors Dr. Jonathan Ochono Odwee and Dr. Natal Ayiga for inspiring and encouraging me to pursue a course in Population and Reproductive Health. This dissertation would not have been possible without their expertise, guidance and advice. Not only were they readily available for me, but generous and always read and respond to my drafts dissertation each time without much delay inspite of their commitment and busy schedules. Of course, despite all the assistance provided by my supervisors, I alone remain responsible for the content and any errors or omissions that may unwittingly remain.

Finally, I thank many people and staff of Institute of Statistics and Applied Economics for all possible assistance and encouragement they gave me in various ways during my course of studies. I am thankful to all lecturers who taught me in this programme. I wish them all the best.

ABSTRACT

This study compared the pattern of sexual behaviour among the adolescents living in internally displaced people's camps and those living in normal settlements in Lira district. This was examined by the social demographic characteristics of the adolescents such as sex, education, age and religion. By virtue of their large numbers and their particular health risks, the reproductive health practices of young people, most especially the vulnerable adolescents in both IDPCs and normal settlements have an impact on their sexual activity.

The study was designed to examine the sexual behaviours of adolescents in IDPCs vis-à-vis those in normal settlements in Lira district as a means of addressing the issue of adolescent camp lifestyle in Northern Uganda as compared with that of an adolescent in a normal settlement. The camps are characterised by lack of privacy, idleness, poverty, early initiation to adult roles, RH services and health education and alcoholism.

The investigations were carried out using both quantitative and qualitative methods employing structured questionnaires administered to 384 adolescents on one hand and interview guides for resourceful persons (10 Key Informants) and four focus group discussions on the other hand.

The findings indicate that of the 384 adolescents interviewed, 54.9% were found to have indulged in sexual intercourse of which 56% were from camps and 44% were from normal settlements. The adolescents in camps within a small range had more sexual partners, as compared to their counterparts in the normal settlements. The camp environment was found to encourage sexual activities by the adolescents.

Information on HIV/AIDS, safe sex and hygiene appeared to be more available to adolescents in camps than in normal settlements. It was further established that the adolescents in normal

settlements had a higher percentage of condom use as compared to their counterparts in camps.

In conclusion, the camp environment was found to contribute to early sex among adolescents. Although information on HIV/AIDS had reached the adolescents, and they were willing to go for VCT, translating this into practice was not possible for camp adolescents due to lack of means of attaining their material needs.

As a result of the above findings the study recommends that there should be restoration of peace in Northern Uganda to allow normal life to prevail. Information on safer sex needs to be passed using appropriate locally based channel like drama whose groups should be given material support. Straight Talk should be contextualised according to the local needs in order for it to be user friendly. In order to provide enough services, more health centres should be constructed in rural areas and adequately staffed with well-motivated health-workers.

Table of Contents

List of Tables

List of Acronyms

AIDS	-	Acquired Immune Deficiency Syndrome
AYA	-	African Youth Alliance
ARLIPI	-	Acholi Religious Leaders Peace Initiative
ASRH	-	Adolescent Sexual Reproductive Health
DDHS	-	District Director of Health Services
DDMC	-	District Disaster Management Committee
DISH	-	Delivery of Improved Services in Health
DMC	-	Disaster Management Committee
FGD	-	Focus group Discussion
GOU	-	Government of Uganda
HC	-	Health Center
HIV	-	Human Immunodeficiency Virus
IASC	-	Inter-Agency Standing Committee
IDPCs	-	Internally Displaced People's Camps
IDPs	-	Internally Displaced Persons
LC	-	Local Council
LDF	-	Local Defence Forces
LRA	-	Lord Résistance Army
MFPED	-	Ministry of Finance Planning and economic Development
MOH	-	Ministry of Health
MSF	-	Medecins Sans Frontieres
NGOs	-	Non-Governmental Organisation
OCHA	-	Office of Coordination of Humanitarian Activities
OPM	-	Office of the Prime Minister
PAG	-	Pentecostal Assembly of God
PEARL	-	Program for Enhancing Adolescent Reproductive Life
POPSEC	-	Population Secretariat
RH	-	Reproductive Health
SCDMC	-	Sub – County Disaster Management Committees
SDA	-	Seven Days Adventist
SRH	-	Sexual Reproductive Health
SPSS	-	Statistical Packages for Social Scientists
STDs	-	Sexually Transmitted Diseases
STIs	-	Sexually Transmitted Infections
UBOS	-	Uganda Bureau of Statistics
UNAIDS	-	Joint United Nations Programme on HIV/AIDS

UNFPA	-	United Nations Population Fund
UNHCR	-	United Nations High Commission for Refugees
UNICEF	-	United Nations Children Fund
UPDF	-	Uganda Peoples Defence Forces
VCT	-	Voluntary Counselling and Testing
WFP	-	World Food Programme
WHO	-	World Health Organisation
WICCE		Women's International Cross Cultural Exchange

CHAPTER ONE: INTRODUCTION

1.1. Background

Lira district is located in Northern Uganda, bordering Pader districts to the north, Abim and Amuria districts to the east, Kaberameido and Dokolo districts to the south and Apac and Oyam districts to the west. The district covers a total area of 7,251 Km^2 and has a population of 757,763 persons *(UBOS, 2002)*. The district has three counties and a municipality: Otuke, Moroto, Erute and Lira Municipality. In these local authorities there are a total of 28 sub-counties, 192 parishes and 2,247 villages.

Internal Displacement has been a phenomenon created mainly by insurgency in the country. At one time or the other, large communities in Uganda have been forced or obliged to flee their homes or places of habitual residence as a result of or in order to avoid the effects of either natural or man-made disasters such as in Northern and Eastern Uganda. As of May 2004, a total of 1.6 million persons had been displaced by the armed conflict in northern and North-eastern Uganda, compared to 1.4 million at the beginning of the year *(OPM 2003; OCHA, 2004)*. Lira Internally Displaced People like those of Gulu, Pader and Kitgum districts are a consequence of the infamous 'Kony' rebellion. The date of establishment of Internally Displaced People (IDP) in Lira district vary from early 2002 to the second half of 2003 for the various camps, when the LRA moved across Lira into Teso region with its atrocities. This led to massive displacement of villages in rural Lira. This displacement left no better alternatives than to bundle people in camps famously known as Internally Displaced Peoples' Camps (IDPCs). There are 33 reported IDP camps in Lira district and an estimated overall population of 212,139 IDPs *(MFPED, 2004)*.

The IDP camps are characterised by lack of privacy between the young and the adults, poor hygiene, poverty and dwindling stocks of food, inadequate water supply, continued inaccessibility to the camps coupled with idleness due to lack of gainful employment, high consumption of alcohol, early initiation to adult roles, lack of RH services and health education,

and breakdown of moral social framework. These conditions caused vulnerability and early sexual activities by the adolescents in the camp. During this conflict, LRA rebels have abducted thousands of children of which about 20% are girls. The young girls must work long hours fetching water and firewood, gathering food, and performing domestic duties for LRA commanders. After they reach puberty, girls are forced into sexual slavery as "wives" of LRA commanders. They are subjected to rape, forced pregnancy, and the risk of sexually transmitted diseases, including HIV/AIDS. Some children manage to escape, and among those who have done so, about 50% have some type of STD. The rates of HIV infection among the abductees or the LRA rebels themselves are unknown, but thought to be very high. Rehabilitation centres for abductees have been offering HIV/AIDS testing to children in their centres in recent years, and have found 15% of 83 children tested HIV+ (*Human Rights Watch, 2005*).

Although the Ugandan government has an obligation to intervene to end such abuses, government forces themselves have been responsible for human rights violations, including cases of torture and rape, summary execution, and arbitrary detention of suspects. Government investigators have pursued some cases of abuse by Uganda People Defense Forces (UPDF) soldiers, but prosecutions have languished and wrongdoers continue to enjoy virtual impunity. Both the UPDF and the Local Defense Force (LDF) have recruited underage boys as soldiers. The government of Uganda has been unable to provide sufficient security and assistance to the population to offset the economic disruption caused by massive displacement (*Human Rights Watch, 2005*).

Renewed fighting, killings and abductions by rebels in northern Uganda have forced 10,000 more children to spend their nights on the streets of major towns in the region (*UNICEF, 2002)*. The report said the new 'night commuters', the name for children who trek nightly to the relative safety of urban centers because of the threat of attacks and abductions by rebels of the Lord's

Resistance Army (LRA), joined another 30,000 who already had been sleeping on the streets, under shop verandas and in bus parks (*Human Rights Watch, 2005*)

People who have been internally displaced are more deprived of their rights to basic social services such as health and nutrition, education, clean water, sanitation and hygiene, than those in the normal settlements. The Ministry of Finance, Planning and Economic Development (MFPED)*, 2004* stated that in conflict areas in Uganda, several factors are responsible for the increased risk of sexually transmitted infections including HIV. In addition to rape and sexual violence, which are sometimes used as a weapon of war by the belligerent forces on the civilian population, others factors prevail. There is severe impoverishment where homes destroyed, goods stolen, children abducted and brutalized, family members killed and raped that has led some women and girls to exchange sex for survival but also mass displacement has led to the break up of families, hence compromising the social cohesion within a family. As a result of conflict there is social disruption, a breakdown of schools, health and communication systems, which are used to **programme** against HIV/AIDS and other development programmes *(MFPED, 2004).*

Recent studies on Voluntary Counselling and Testing (VCT) confirm that high quality VCT is an effective strategy for reducing HIV infections among adults. UNAIDS, (2001) reported that customized VCT programs can be successful in effecting behavioural change resulting in to safer sex practices. However, little is known about its impact on youth and in particular 14 -19 years old adolescents in IDPCs. Sexual behaviour and attitudes have been crucial especially in explaining how quickly the epidemic spreads particularly among men in the age group 15-24 years who have more sexual partners than any other group and are the most frequent purchasers of sex (*UNAIDS/PANOS, 2001*). This study attempted to make a critical comparison on the adolescents in IDPCs vis-à-vis those in normal settlements.

1.2. Statement of Problem

IDP Camps being a new phenomenon in Uganda, data available on adolescent sexual and reproductive health behaviour is not disaggregated according to settlements and even where little exist it can neither resolve nor imply the sexual behavioural patterns of adolescents in IDPCs as compared to those in normal settlements. The African Youth Alliance (AYA) and Programme for Enhancement of Adolescent Reproductive Life (PEARL) studies on Adolescent Sexual Reproductive Health (2002) did not have any quantifiable data on adolescents in conflict areas other than general observations such as “female adolescents in conflict areas of northern and parts of western Uganda have been raped or forced to marry soldiers at an early age. While the PEARL study of 2002 and Straight Talk Uganda observed that, “there was minimal Adolescent Sexual and Reproductive Health (ASRH) focus on Adolescents in especially difficult circumstances such as the internally displaced, refugees and adolescents in child headed household”. It also states that conflicts exacerbate human rights abuses as communities disintegrate and basic services are destroyed. It therefore indicates that either little is known about ASRH in camps and, or the camp environment have had an effect on the adolescent sexual reproductive health services that has led to poor ASRH among camp adolescents as compared to their counterparts in normal settlements. Yet in order to plan for provision of services for adolescents in the country it would be imperative to have data on all categories of adolescents most especially in vulnerable circumstances.

1.3. Justification of the Study

Internal displacement may always seem to be a **temporary problem** that can be resolved immediately after settling the conflict situation responsible for it. In Uganda internal displacement has been experienced since independence though not institutionalised until 1987 in the Eastern part of the country when the Karamojong destabilised the neighbouring districts. Teso region was the most affected since cattle was the backbone of their livelihood. Since then there has been internal displacement in conflict regions and camps have been established in

the different areas with the hope that it would be a short-lived experience for those who are displaced. However, this has been a myth because IDPCs have in some regions (Northern and Eastern) turned out to be institutional homes for the displaced people who have lived in this sort of environment producing children who only know IDPCs as the basic societal settlement arrangements. In the mentioned regions some IDPCs have existed for up to 15 years and the environment is overcrowded: lack privacy, poverty is high, adolescents are sexually abused and there is total breakdown of health services. While HIV/AIDS is a unique sexual and reproductive health issue that needs urgent attention, all the camps visited by the Inter-Agency Assessment team had limited awareness programs on HIV/AIDS *(Inter-Agency Humanitarian Assessment, 2004).* It was therefore necessary to carry out this study so as to gain an insight into the sexual habits and reproductive health problems adolescents faced in such adhoc settlement arrangements compared to other normal settlements.

1.4. General objective

The general aim of the study was to examine the sexual behavioural patterns of adolescents in IDPCs and normal settlements in order to establish the trend in each category in Lira District.

1.4.1. The specific objectives

1) Identify factors, knowledge and information that contribute to the sexual behavioural patterns of sexually active adolescents;
2) Establish the patterns of sexual behaviour of adolescents in the camps and that of normal settlements;

1.5. Hypotheses

1) Adolescents in IDP camps are sexually active at an early age due to inadequate information and knowledge on ASRH as compared to those in normal settlements.
2) Sexual activity among adolescents in IDP camps are characterised by unsafe sexual practices

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter presents the existing information researched and reviewed in journals, other publications and documentations carried out from the late eighties to date on pattern of sexual behaviour.

2.2 Conflict in Northern Uganda

The seventeen-year war in northern Uganda has been characterized by great brutality by the rebel Lord's Resistance Army (LRA), as documented in Human Rights Watch's 1997 report, *The Scars of Death: Children Abducted by the Lord's Resistance Army in Northern Uganda*, and later publications. The atrocities increased in 2002, but international attention has been distracted by less savage emergencies. A Ugandan peace effort, spearheaded by the Acholi Religious Leaders Peace Initiative (ARLPI), has not broken through the parties' desire for a military solution.

The latest effort to bring the war to a close by military means has failed as well. In March 2002, Uganda's army, the Ugandan People's Defense Force (UPDF), launched Operation Iron Fist, a military campaign intended to wipe out the LRA by attacking its southern Sudanese sanctuaries. Instead the conflict inside northern Uganda intensified. The LRA which draws its recruits, mostly abducted children, from the Acholi and Langi population of northern Uganda evaded the UPDF in Sudan and moved back into Uganda in June 2002 where it has stepped up its abduction, killing, looting, and destruction aimed at civilians and their property. The UPDF responded with massive forced displacement and increased arrests. The victimized northern population became more alienated from both sides, and less hopeful about the future, than ever before *(Human Rights Watch, 2005).*

Populations fleeing complex emergencies such as armed conflicts generally face destitution and food shortages. Their situation is made worse because they often have no access to health

care, either because systems have collapsed or simply do not exist in refugee hosting areas. These conflicts can also create conditions through which different sexual behaviour can prevail leading to high risk of contracting infections such as HIV, and may also lead to their spread. This can happen either during the conflict itself, or after it is over. In some cases, armed conflict increases HIV levels or changes HIV distribution patterns.

In other cases, conflict has appeared to serve as a brake on the epidemic. This has led to the view that greatest vulnerability may well occur during the often fragile post conflict period. Differing scenarios show the relationship between HIV and conflict is much more complex and varied than previously thought, and is clearly context specific *(USAID, 2001)*.

Armed conflict can increase the likelihood of exposure to HIV infection in several of the following ways:

- Population displacement: conflict often prompts large numbers of people to flee the fighting, which uproots them from their usual areas of residence. When people move from low prevalence to high prevalence HIV settings, they inevitably face increased risk of HIV exposure. In addition, rapid population movements disrupt social networks and institutions that normally protect and support people. Furthermore, displacement frequently places people in chaotic circumstances in which practicing safer sex become a problem due to lack of condoms and other prevention tools.

- Breakdown of traditional sexual norms: the chaotic conditions associated with conflict often lead to the disintegration of traditional values and norms regarding sexual behaviour, which contributes to an overall increase in high risk of practicing unprotected sex (*Hankins et al., 2002*).

- Women and girls: armed conflict can create conditions of such severe deprivation that women and girls, in particular, are coerced into exchanging sex for money, food or protection. The presence of large numbers of armed men in uniforms often means a sex

industry springs up with associated unprotected sex practice by sex workers and uniformed services personnel (*Hankins et al., 2002*).

- Rape as a 'weapon of war': in a variety of recent conflicts including Bosnia Herzegovina, Democratic Republic of Congo, Liberia and Rwanda combatants have used rape as a weapon of war. A study in Rwanda revealed 17% of women who had been raped tested HIV positive, compared with 11% of women who had not been raped (*UNAIDS/UNHCR, 2003*). In some conflicts, young men and boys have also been targets of rape.

- Collapse of health systems: when an armed conflict triggers health system malfunction and collapse, national blood supply safety is threatened, and HIV prevention and care programmes can disintegrate.

- Increased use of toxic substance: to cope with chaos caused by conflicts, some individuals including children, may seek comfort in increased alcohol consumption, or turn to other psychoactive substances, including glue and illicit drugs. Drug injecting is especially likely when conflicts disrupt supply routes of drugs that are usually ingested, sniffed or smoked. This can lead to drugs being introduced that are more likely to be injected (*Smith, 2002; Strathdee et al., 2002; Hankins et al., 2002*).

Serious armed conflicts occur regularly in many regions of the world. In 2003, more than 72 countries were identified as unstable, and various conflicts have resulted in over 42 million refugees and internally displaced people worldwide (*IASC, 2003*). According to Mephan D, (1998) the relationship between conflict and development is two ways; violent conflict is profoundly damaging to development whilst underdevelopment and poverty can substantially increase the risk of war with armed conflict breaking out. Armed conflict can destroy development advances built up over generations and retard economic and social progress for decades to come. It is, however, important to note that it is not only physical war trauma that

can cause destruction of social services, forced removals and relocations of peoples have the same effects *(Isis – WICCE, 2001)*

Lira district is overwhelmed by the IDP crisis at hand especially since early 2003. With people being displaced, the tax revenue base has declined and funds have become scarce in the district coffers for relief or developmental activities. The inadequate resources available as well as the recognised inadequate technical and personnel capacity have hampered the district's role in coordination *(Inter-Agency Humanitarian Assessment, 2004).*

2.3 Camp structure

Most camps in rural Lira were established as people fled to the trading centres or sub-county headquarters and camped on the verandas of the shops, schools, and other public buildings until an authority allocated land for their settlement. Apart from two camps (Agweng and Ogur) where plots were allocated using a standard measurement, all plot allocation was done randomly. Hence the spacing between the huts or makeshift shelters was left to the people themselves to work out based on land availability. This has led to most camps being congested with little spacing between the huts *(Inter-Agency Humanitarian Assessment, 2004).*

All camps have camp leadership with a camp leader and his/her committee. Different structures prevail in these camps except in Ogur and Agweng IDP camps were the Local Council (LC) structure was duplicated. The Local Government Act requiring 30% women representation in all local government committees is temporarily suspended in the camps. The role of the camp leadership includes mitigation of social conflicts in the camps, keeping records of camp population, report crimes to police or local authorities, ensure maintenance of cleanliness of the camp, provide counselling for traumatised inhabitants of the camp, and in some cases enforce a curfew on movements out of the camps. They also resolve social disputes in collaboration with traditional leaders of the clans, who are still active in most camps where they are based.

Disaster Management Committees (DMC) was supposed to be formed to handle disaster at district and Sub-county levels. The District Disaster Management Committee (DDMC) is in place and has been calling upon the Sub-counties to unify the leadership structures in camps. Very few rural sub-counties have functional Sub-county Disaster Management Committees (SCDMC) and where they exist, they lack financial, technical and personnel capacity to deal with the disaster at hand *(Inter-Agency Humanitarian Assessment, 2004).*

2.4 Marriage and Family Life

In Gulu according to the Isis-WICCE, 2001, many marriages broke down. Many women have been raped leading to unwanted pregnancies and births among females and emotional stress within the population generally.

There was realisation by desperate parents and the girls' themselves that if one's daughters got married to soldiers they would provide some safety net to the parent and the family. This would be through household acquisition of possible source of food from their soldier son in-law. As a result parents pressured their daughters to get married to soldiers and other well off men on whom they could depend for food provision and protection *(Isis-WICCE, 2001).* Forced marriages were reported to have occurred and as a result, a number of girls became pregnant and many of those who became wives of soldiers contracted STD/HIV/AIDS as reported by the leadership of the camps *(Inter-Agency Humanitarian Assessment, 2004).*

2.5 Health

The displacement of people from their homes, the long distances that had to be walked, lack of adequate feeding, hiding in the bush and destruction of health infrastructure all took their toll on the health of the population especially among women and children.

The total population of rural IDPs in Lira district stand at 212,139 with an estimated 42,000 under five years who have had their health status greatly compromised. In all camps health services have deteriorated significantly and in most IDP camps, health services are none

existent at all. Even where the health centre/facility is available, the workers have fled to Lira town for refuge *(Inter-Agency Humanitarian Assessment, 2004).*

According to data available at the District Director of Health Services (DDHS) office, of the 52 health facilities in the district, 35 have been rendered un-operational as of December 2003. At the time of Inter-Agency Assessment, it was only Orum HC IV, which reported operating daily, depending on the availability of drugs. Drug shops operated by mostly unqualified members of the camp emerged and have become the main health provider for those who can afford treatment fees (self prescribed). Death in every IDPCs is reported to be on a daily basis with the common ailments being malaria, diarrhoea, cough, scabies, eye-infection and STIs.

While the LRA incursion is the underlying cause of the breakdown of the basic social service delivery system, the single most intermediate or direct cause of the collapse of the health care service provision has been the displacement of the health personnel, who have been seeking safety in Lira town. The availability of community resource persons was not systematic in the IDPCs, and in cases where they were present they were not equipped with supplies such as drugs. However, Traditional Birth Attendants were reported to be in the camps. Some able patients seek health care in town using available transport.

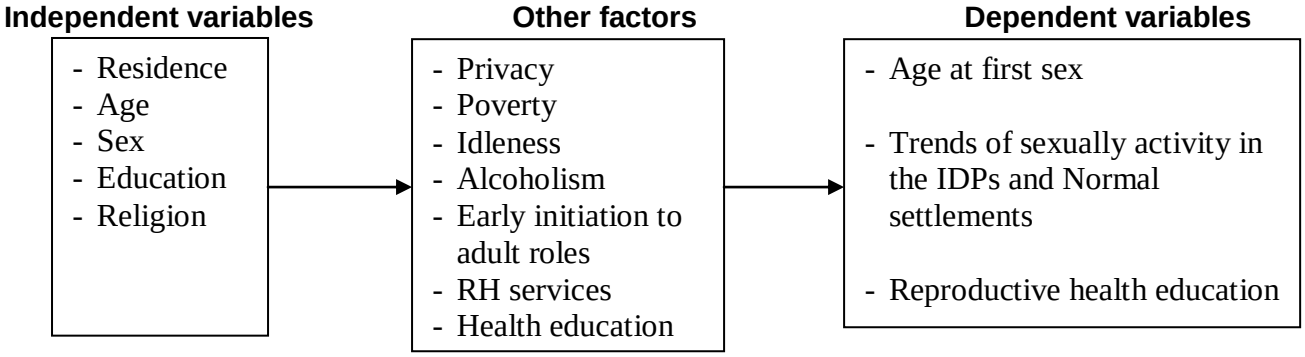
The district has a Health Sector Committee composed of several agencies; among them Ministry of Health, District Health Team, UNICEF, WFP, MSF Holland, Medical Aid Uganda, Uganda Red Cross and Path *(Inter-Agency Humanitarian Assessment, 2004).*

1.6. Conceptual Framework

This framework was designed to show the interface between the various variables with the factors that lead to various modes of sexual patterns. The concept of the study was based on the adolescents' sexual behaviours with the main focus being on their settlements: camps and normal settlements. Comparison of the two groups of adolescents was considered basic due to unique conditions incumbent in camps that have a direct impact on sexual behaviour as

compared to normal settlements. The sexual behaviours in focus were mainly lack of privacy between the young and the adults, poverty, idleness due to lack of gainful employment, high consumption of alcohol, early initiation to adult roles, lack of Reproductive Health (RH) services and health education, and breakdown of moral social framework. In camps, adolescents get involved in unprotected sex at an early age before 18 years. The situation is made worse when the adolescent are not attending school. Adolescents get married also at an early age in camps as compared to their counterparts in normal settlements. In marriage, they are expected to be faithful to their spouses. However, due to congestion coupled with lack of other means of attaining their material needs, they engage in extra-marital sex.

The study further examines whether the adolescents were well informed about dangers of early sexual activity in order to make informed decisions at the on set of sexual activity.



CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter focuses on the study area, data collection techniques and area of the study, the instruments of data collection, the sample selection procedure and size, and methods of data analysis.

3.2 Area of study

Of the districts in Northern Uganda; Gulu, Kitgum, Pader, Amuru, Lira, Dokolo, Amolatar, Oyam and Apac, Lira District was purposively selected due to the fact that it is the only district that has balanced effects of normal settlements and displacement with a total population of 212,139 rural IDPs for comparison purposes. This made it possible for easy accessibility by the researchers taking into account the cost implication of data collection and security. The camps are not planned and are congested with over 35 health facilities rendered non-functional due to insecurity.

3.3 Sample size estimation

To calculate the sample size for the population of the respondents, Cochran (1963)'s equation below was preferred to yield a representative sample for proportions. This formula was used because the number of the study population (adolescents in IDPs and in normal settlements) was unknown.

$$n_0 = \frac{Z^2 pq}{e^2}$$ Equation……1

Where n_o= sample size for an infinite population

e = precision of the study and in the study a precision of ±5% which is 0.05 was used

Z= standard normal deviate corresponding to the 95% confidence interval which is1.96

$q = (1-p)$ where p is the proportion of respondents who were adolescents living in IDPs and in normal settlements. Since p is not known, 50% is used. This is the figure that will give the highest sample size for the given level of significance and precision.

$$n_o = \frac{1.96^2 \times 0.5\,(1-0.5)}{0.05 \times 0.05} = 384 \quad \text{Equation……..2}$$

Therefore the required study sample size was 384. The number of respondents (384) was divided among adolescents in IDPs and those in normal settlements in equal numbers.

3.4 Sampling procedure

The study was stratified in two varying populations: in camp and normal settlements (out of camp settlements). Multi-stage sampling was then carried out applying purposive, simple random and systematic random sampling to arrive at the respondents. Two IDPCs were randomly selected from a sampling frame of 33 camps in the district using simple random sampling. Two areas with normal settlements were then purposively selected basing on the two IDPs selected. Housing units in the selected areas with adolescents aged 14 to 19 were listed to get the total population. In each of the four study areas systematic random sampling was done to select 48 eligible housing units from which 96 eligible respondents (48 female and an equal number of male) were interviewed making a total of respondents (96 x 4 study areas).

3.5 Data collection

The study used quantitative and qualitative methods of data collection. Quantitative data was collected using Pre-tested structured questionnaires administered to adolescents of different sexes in about 192 selected housing units. Qualitative data to triangulate quantitative data was collected through Focus Group Discussions and in-depth interviews with Key Informants. Eight Focus Group Discussions (four in camps and four in normal settlements) with purposely selected male and female adolescents were separately conducted to explore in-depth opinion and perceptions on pertinent adolescent sexuality issues. Each group consisted of 6 – 12 participants moderated by the researcher who was the Principal Investigator. Ten Key Informants; 4 in IDPCs, 4 in normal settlement's administrative levels and 2 at the District level using a key informant interview guide were done.

3.6 Data Management

Data compilation and analysis was carried out using respective statistical software for quantitative and qualitative data. Quantitative data was analyzed using SPSS statistical software. Dependent variables such as sexually or not sexually active were cross tabulated with residence and subjected to multivariate test to establish the significance of their relationships. Regression analysis was carried out to predict the sexual behavioral patterns by age. The model used was given by the formula $y = f(b_1, b_2, b_3 \text{ and } b_4)$,

where y = sexual behavioral patterns

b_1 = Condom use as prevention method

b_2 = Faithfulness as prevention method

b_3 = Abstinence as prevention method

b_4 = VCT as prevention method

Qualitative data was coded by theme, entered and analysed using content analysis techniques for triangulating the quantitative data.

3.7 Ethical consideration

Consent or assent was sought from all the respondents depending on their age bracket having explained to them the procedures and risks involved. Participation was voluntary and participants were made to know that they were free either to participate or opt out at any stage of the study. They were also informed of the confidentiality with which the information received would be treated and kept anonymous.

CHAPTER FOUR: FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter lays out the findings of the study. The findings have been analysed and presented in percentage distributions and frequencies where found necessary. In the subsequent presentations, the percentage distributions of respondents' social demographics have been used according to how they influence the variables of the study. Regression of sexual behaviour was done with the age of the respondents to predict the sexual behavioral patterns. The respondents' sex, religion, education and age by residence were established separately to gain a deep understanding of the population being studied. Residence and sex were considered in most of the analysis in order to establish their influence in the sexual behavioural patterns. The researcher, in these findings, explains the sexual behavioural patterns among adolescents, factors that contribute to lack of privacy between the young and the adults, and factors that led to breakdown of moral and social framework among adolescents in IDPCs and those in normal settlements.

4.2 Background to the results

Three hundred and eighty four (384) respondents were interviewed of which 188 (49%) were male, 196 (51%) were female as indicated in Figure 1. Of the male, 106 (53.8%) were from the camp and 82 (43.9%) from normal settlement, while of the female, 91 (46.2%) were from camp and 105 (56.1%) from normal settlement. Camp respondents were 197 (51.3%) and that of normal settlement were 187 (48.7%).

Table 4.1: Distribution of Respondents' Gender by Residence

Residence		Gender of the respondent		
		Male	Female	Total
Camp	Frequency	106	91	197
	Percentage of Total	27.6%	23.7%	51.3%
Normal settlement	Frequency	82	105	187
	Percentage of Total	21.4%	27.3%	48.7%
Total	Frequency	188	196	384
	Total Percentage	49.0%	51.0%	100.0%

Figure 1: Gender of Respondents by Residence

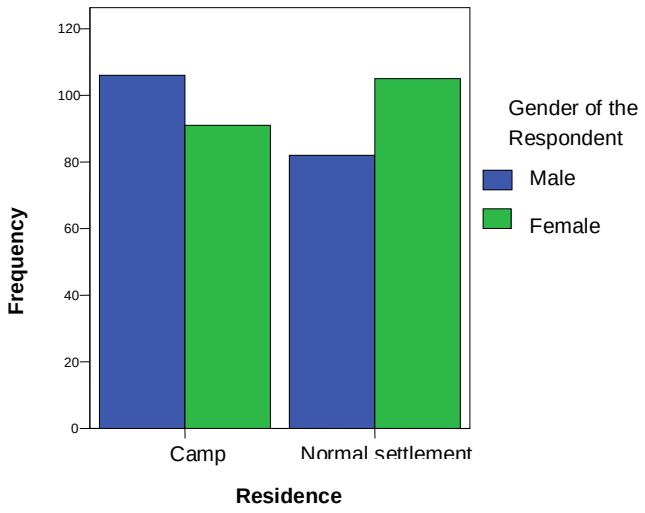


Table 4.2 gives a clear picture of age distribution of the male category of the respondents. The majority of the respondents were of the age bracket 15 to 20 (91%) with only 17 (9.0%) being in age bracket 12-14.

Table 4.2: Male respondents' age by residence

		Male Respondents age			
		12-14	**15-17**	**18-20**	**Total**
Camp	Frequency	3	48	55	106
	Within Residence	2.8%	45.3%	51.9%	100%
	Total	1.6%	25.5%	29.3%	56.4%
Normal settlement	Frequency	14	35	33	82
	Within Residence	17.1%	42.7%	40.2%	100%
	Total	7.4%	18.6%	17.6%	43.6%
Total	Frequency	17	83	88	188
	Within Residence	9.0%	44.2%	46.8%	100%
	Total	9.0%	44.2%	46.8%	100%

Table 4.3 shows that the majority of the female adolescents were within the age bracket of 15-17 (53%) compared to the other age groups (12-14 and 18-20) with 23.5% each. This also contrasts with the male counterparts who were nearly two times that percentage at 46.8% in the age group 18 – 20.

Table 4.3: Female respondents' age by residence

Residence		Female Respondents age			
		12-14	15-17	18-20	Total
Camp	Frequency	19	57	15	91
	Within Residence	20.9%	62.6%	16.5%	100%
	Total	9.7%	29.0%	7.7%	46.4%
Normal settlement	Frequency	27	47	31	105
	Within Residence	25.7%	44.8%	29.5%	100%
	Total	13.8%	24.0%	15.8%	53.6%
Total	Frequency	46	104	46	196
	Within Residence	23.5%	53%	23.5%	100%
	Total	23.5%	53%	23.5%	100%

Having a glance at the education levels of the respondents (Table 4.4) purposively considered having influence on patterns of sexual behavior among adolescents in camps and those in normal settlements, of the male, 76.7% were attending school during the time of the study, 22.3% had dropped out of school and 1% had never been at school. Considering by type of settlement, 41% of the male respondents were from the camps and 35.7% from normal settlements were attending school while 15.4% and 6.9% had dropped out of school in the camps and normal settlements respectively. Only 2 (1%) respondents were found to have never attended school and were all from normal settlements.

Table 4.4: Male respondents' Education status by Residence

Residence		Education status			
		Currently attending	Dropped out of school	Has never attended school	Total
Camp	Frequency	77	29	0	106
	% within Residence	72.6%	27.4%	.0%	100.0%
	% of Total	41.0%	15.4%	.0%	56.4%
Normal settlement	Frequency	67	13	2	82
	% within Residence	81.7%	15.9%	2.4%	100.0%
	% of Total	35.7%	6.9%	1.0%	43.6%
Total	Frequency	144	42	2	188
	% within Residence	76.7%	22.4%	1.0%	100.0%
	% of Total	76.7%	22.3%	1%	100.0%

Looking at the female adolescents that were included in the study (Table 4.5), 76.5% were attending school, 22.5% had dropped out of school and 1% had never attended school. Out of

those who were attending school, equal numbers of 38.3% were from both camps and normal settlements while the respondents who had dropped out of school 14.7% were from normal settlement and 7.7% were from the camps. The respondents who had never attended school were found to be 2 (1%).

Table 4.5: Female respondents' Education status by Residence

Residence		Education status			
		Currently attending	Dropped out of school	Has never attended school	Total
Camp	Frequency	75	15	1	91
	% within Residence	82.4%	16.5%	1.1%	100.0%
	% of Total	38.3%	7.7%	.5%	46.5%
Normal settlement	Frequency	75	29	1	105
	% within Residence	71.4%	27.6%	1.0%	100.0%
	% of Total	38.3%	14.7%	.5%	53.5%
Total	Frequency	150	44	2	196
	% within Residence	76.5%	22.5%	1.0%	100.0%
	% of Total	76.5%	22.5%	1.0%	100.0%

The percentage distribution of the female (76.5%) and that of male (76.7%) respondents indicate that the study had almost an equal percentage of female and males attending school. Of the respondents, 22.3% and 22.5% of male and female respectively had dropped out of school and each category had 1% who had never attended school hence having similar categories of respondents among the female and male in terms of education. It can be empirically argued that most of the adolescents in both types of residence interviewed could read and write hence being in position to access information on SRH issues.

The results from Table 4.6 indicate that of the male adolescents interviewed in the camps, 20.7% were Protestants, 32.4% were Catholics, 0.5% were Islam and 2.7% were from Pentecostal Assembly of God (PAG). While the male adolescent respondents from the normal settlements were 20.2% Protestants, 11.7% Catholics, 1.1% Islam, 1.6% Seventh Days Adventist (SDA), 7.4% Pentecostal Assembly of God (PAG) and 0.5% were Atheist.

Table 4.6: Male respondents' religion by residence

		Respondent's religion							
		Protestants	Catholics	Islam	SDA	PAG	Atheist	None of the above	Total
Camp	Frequency	39	61	1	0	5	0	0	106
	Within Residence	36.8%	57.5%	.9%	.0%	4.7%	.0%	.0%	100.0 %
	Total	20.7%	32.4%	.5%	.0%	2.7%	.0%	.0%	56.4%
Normal settlement	Frequency	38	22	2	3	14	1	2	82
	Within Residence	46.3%	26.8%	2.4%	3.7%	17.1%	1.2%	2.4%	100.0 %
	Total	20.2%	11.7%	1.1%	1.6%	7.4%	.5%	1.1%	43.6%
Total	Frequency	77	83	3	3	19	1	2	188
	Within Residence	41.0%	44.1%	1.6%	1.6%	10.1%	.5%	1.1%	100.0 %
	Total	41.0%	44.1%	1.6%	1.6%	10.1%	.5%	1.1%	100.0 %

Looking at the religious affiliation on the side of the female respondents in the camps (Table 4.7), 18.9% were Protestant, 23% were Catholics and 4.6% were Pentecostal Assembly of God (PAG). In normal settlements, the female adolescent respondents were 26% Protestants, 13.3% Catholics, 0.5 Islam, 2.6% Seventh Days Adventist and 9.2% were from Pentecostal Assembly of God (PAG).

Table 4.7: Female respondents' religion by residence

		Respondent's religion							
		Protestants	Catholics	Islam	SDA	PAG	Atheist	None of the above	Total
Camp	Frequency	37	45	0	0	9		0	91
	Within Residence	40.7%	49.5%	.0%	.0%	9.9%		.0%	100%
	Total	18.9%	23.0%	.0%	.0%	4.6%		.0%	46.4%
Normal settlement	Frequency	51	26	1	5	18		4	105
	Within Residence	48.6%	24.8%	1.0%	4.8%	17.1%		3.8%	100%
	Total	26.0%	13.3%	.5%	2.6%	9.2%		2.0%	53.6%
Total	Frequency	88	71	1	5	27		4	196
	Within Residence	44.9%	36.2%	.5%	2.6%	13.8%		2.0%	100%
	Total	44.9%	36.2%	.5%	2.6%	13.8%		2.0%	100%

It was important to gauge the implied influence of religion to patterns of sexual behaviors of adolescents by taking into consideration their religious affiliation. This is because different

religious doctrines have different approaches towards SRH issues with some like Catholics emphasizing abstinence by singles, faithfulness by the married and in particular discourage use of condoms. In regard to the role of religion in influencing patterns of sexual behavior a resource person from a health unit had this to say:

> *"Religious belief especially among the Catholics has also hindered the use of condoms. They do not recommend family planning as good practice before God"* ***(Health official H/C III).***

4.2 Factors, knowledge and information on sexual and reproductive health among adolescents

In order to gauge the knowledge and practice of sexual and reproductive health among adolescents, knowledge of methods of prevention against STIs was regressed with the age of the adolescents to predict the influence age had in the choice of the prevention method. This reveals the pattern of sexual behaviour among different age groups of the adolescents.

Table 4.8: Regression indicating the Coefficients of the prevention methods

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	23.011	24.757		.929	.353
Prevention method Condom use	.086	.072	.073	1.196	.232
Prevention method Faithfulness	.132	.063	.114	2.091	.037
Prevention method Abstinence	-.115	.057	-.115	-2.032	.043
Prevention method VCT	.146	.086	.089	1.699	.090

From table 4.8 it can be observed that faithfulness (p value = 0.037) and Abstinence (p value =0.043) have significant relationship with the age at which the adolescents have sex. The table further reveals that there is a positive direct relationship between faithfulness as prevention method with the age of the adolescent and, a unit change in age, means .132 units' change in faithfulness. Abstinence however, revealed inverse relationship with the age of the adolescent, a unit increase in age reveals a decrease in abstinence and a unit increase in age predicts a decrease in abstinence by .115 units. This indicates that the more the adolescents become older, or mature, the less they abstain from sex. On the same table VCT and condom use relates positively with age as a prevention method though the table reveals that the relationship (p value =0.090) has no strong significance. A unit change in age would mean .146 unit change in VCT.

The adolescents in camp when asked about knowledge on proper condom use, the results presented on Table 4.9, indicate that 30.2% within the camp responded to have knowledge on

condom use as opposed to 69.8% within the camp who expressed lack of knowledge on proper use of condoms. It was at the same time revealed that the situation was more pronounced in the normal settlements where only 21.4% expressed to have knowledge on proper use of condoms as opposed to 78.6% who did not have knowledge on the use of condoms.

As earlier mentioned, knowledge of condom use contributes a lot in the decision to use or not use a condom. This determines the sexual practices one gets involved in and in turn develops the patterns of sexual behavior in that community. The results indicate that majority of adolescents (74%) did not know how to use condoms while only 26% knew how to use condoms implying that most adolescents do not practice safe sex hence exposed to risks such as that of acquiring STIs.

Table 4.9: Percentage distribution of the Knowledge of correct use of Condom

Residence		Knowledge on how to use a condom		
		Yes	No	Total
Camp	Frequency	61	141	202
	% within Residence	30.2%	69.8%	100.0%
	% of Total	15.9%	36.7%	52.6%
Normal settlement	Frequency	39	143	182
	% within Residence	21.4%	78.6%	100.0%
	% of Total	10.2%	37.2%	47.4%
Total	Frequency	100	284	384
	% within Residence	26.0%	74.0%	100.0%
	% of Total	26.0%	74.0%	100.0%

The Chi-Square Test gave a p value of 0.51 indicative of no significant relationship between knowledge of proper condom use and residence. Adolescents in camps and normal settlement all lack knowledge of proper use of condoms though there are slight differences in the knowledge levels between the residences.

On proper use of condoms, the Focus Group Discussions with the adolescents both in camps and normal settlements reveals very exciting expressions of knowledge of proper use of condoms as can be exemplified by the quotes below:

First one has to cut the finger nails short, open condom carefully to avoid damage, remove condom from the cover, hold the tip to squeeze out air, put condom on erect penis and roll downward, play the partner carefully by using one condom at a time, remove condom after ejaculation when the penis is still erect, put the used condom in a white pill and throw in a pit latrine ***(FGD Camp, Boys)***.

However, there are some situations that make it difficult for the adolescents to get condoms for reasons as was observed in the arguments of resource persons in the community and health sector. This has a direct implication on the proper use of condoms since it is a practically based knowledge. Some resource persons in the community and health sector argued that:

"The adolescents lack enough services like condoms supplies without which their lives are in a great risk. The adolescents also lack income generating activities that would have enabled them get money to purchase condoms or newspapers" ***(Youth representative)***

Knowledge on whether HIV/AIDS has a known cure helps to make a deeper understanding of the attitude of adolescents towards sexual practice. If there is no known cure of HIV/AIDS, then adolescents will participate in sex with a lot of caution, while presence and knowledge of known cure would naturally motivate them to engage carelessly into sex. From Table 4.10 it appears that, though a bigger percentage of adolescents in the camps (44.5%) and 44.3% in normal settlements were aware that HIV/AIDS has no known cure, a significant percentage of 6.5% of adolescents in camps and 1.3% in normal settlements think there is cure. However, there are sections of adolescents who expressed ignorance (1.6% in camps and 1.8% in normal settlements) about HIV/AIDS cure. This lot are not different from those who claimed that HIV/AIDS has cure due to the fact that they can act irrationally and expose themselves into unsafe sexual practices. Some of the excerpts below are confessions by the adolescents on the position of HIV/AIDS.

HIV/AIDS; "we are always told by health workers and camp leaders that AIDS exist and that when you catch it, there is no cure' so avoid loving sugar mammies and heavy alcohol drinking that can make one's mind confused to the extent of wanting to play sex with any woman" ***(FGD Boys Camps)***.

Table 4.10: Percentage distribution of Knowledge of known cure of AIDS by Residence

Residence		HIV Cure			
		Yes	No	Do not Know	Total
Camp	Frequency	25	171	6	202
	% within Residence	12.4%	84.7%	3.0%	100.0%
	% of Total	6.5%	44.5%	1.6%	52.6%
Normal settlement	Frequency	5	170	7	182
	% within Residence	2.7%	93.4%	3.8%	100.0%
	% of Total	1.3%	44.3%	1.8%	47.4%
Total	Frequency	30	341	13	384
	% within Residence	7.8%	88.8%	3.4%	100.0%
	% of Total	7.8%	88.8%	3.4%	100.0%

The p value of 0.002 in Chi-Square Test indicates a high significant relationship between HIV cure and type of residence as reflected by a higher percentage in camps who express knowledge of known cure of HIV/AIDS compared to a much lower percentage in normal settlement with similar expression.

The adolescents' knowledge depended on the awareness campaigns carried out by HIV/AIDS activists. The discussants gave the information below:

> *"We are always advised to go for sex when we are ready and mature to get married and also told to ensure single use of sharp instruments (syringes and razorblade) to avoid catching AIDS. We are taught to maintain proper hygiene by having shelter, clean toilet, brushing teeth daily and bathing, maintaining water sources clean. We are told to desist from abortion because it kills and a great sin before God and good nutrition to feed young children to keep them health by giving them balance diet"* ***(FGD Boys Normal settlement).***

The question was asked to all adolescents who participated in the study to gauge their knowledge on how HIV/AIDS is spread. This would guide the adolescents on safer sexual practices. Table 4.11 shows that the majority of the male adolescents in the camps (57.1%) and 40.1% in normal settlements indicated sexual intercourse as the main channel through which HIV/AIDS is spread. However, some small percentage of male adolescents did not have any knowledge on sexual intercourse as the main channel through which HIV/AIDS spreads. Among these, 2.3% were from the camps and 0.6% was from normal settlements. The results therefore imply that adolescents in both settlements think that sexual intercourse accounts for up to 90% and above.

Table 4.11: Distribution of Knowledge among male adolescents on how HIV/AIDS is spread through sexual intercourse by Residence

Residence		How HIV is spread Sexual intercourse		
		Yes	Not mentioned	Total
Camp	Frequency	101	4	105
	% within Residence	96.2%	3.8%	100.0%
	% of Total	57.1%	2.3%	59.3%
Normal settlement	Frequency	71	1	72
	% within Residence	98.6%	1.4%	100.0%
	% of Total	40.1%	.6%	40.7%
Total	Frequency	172	5	177
	% within Residence	97.2%	2.8%	100.0%
	% of Total	97.2%	2.8%	100.0%

The p value of 0.340 of male adolescents indicates that there was no significant relationship between knowledge on how HIV is spread through sexual intercourse and type of residence.

Looking at the knowledge of female adolescents on how HIV/AIDS is spread, the result is quite similar to that of the male adolescents in Table 4.11. Table 4.12 shows that more adolescents 52.7% from normal settlements compared to 43.5% from camps indicated sexual intercourse as the main channel through which HIV/AIDS is spread. The minority of the adolescents in both settlements (3.4%) in the camps and 0.5% in normal settlements had no knowledge on sexual intercourse as channel through which HIV/AIDS is spread.

Table 4.12: Distribution of Knowledge among female adolescents on how HIV/AIDS is spread through sexual intercourse by Residence

Residence		How HIV is spread Sexual intercourse		
		Yes	Not mentioned	Total
Camp	Frequency	90	7	97
	% within Residence	92.8%	7.2%	100.0%
	% of Total	43.5%	3.4%	46.9%
Normal settlement	Frequency	109	1	110
	% within Residence	99.1%	.9%	100.0%
	% of Total	52.7%	.5%	53.1%
Total	Frequency	199	8	207
	% within Residence	96.1%	3.9%	100.0%
	% of Total	96.1%	3.9%	100.0%

The p value of 0.019 indicates that the female adolescents believe sexual intercourse has high significant relationship with HIV spread by residence. This is reflected by higher percentage of knowledge in the normal settlements as compared to the camps.

Spread of HIV through contaminated sharp instruments as mentioned by the male respondents according to Table 4.13, indicated that of the male adolescents interviewed, the camp adolescents (49.2%) had knowledge of sharp instruments as one of the means through which HIV is spread while only 10.2% of the said adolescents had no knowledge of sharp instruments as a means of spread. The table also portrays that a small percentage (24.9%) of male adolescents in normal settlement had knowledge that sharp instruments spread HIV as compared to their counterparts in Camps at 49.2%. At the same time, the male adolescents in normal settlement who did not indicate knowledge of sharp instruments as a means of spread were 15.8% which is small though still higher than those adolescents in the camps (10.2%).

Table 4.13: Distribution of Knowledge among male adolescents on HIV spread through sharing sharp instruments by Residence

Residence		HIV spread sharing contaminated sharp instruments		
		Yes	Not mentioned	Total
Camp	Frequency	87	18	105
	% within Residence	82.9%	17.1%	100.0%
	% of Total	49.2%	10.2%	59.3%
Normal settlement	Frequency	44	28	72
	% within Residence	61.1%	38.9%	100.0%
	% of Total	24.9%	15.8%	40.7%
Total	Frequency	131	46	177
	% within Residence	74.0%	26.0%	100.0%
	% of Total	74.0%	26.0%	100.0%

On carrying out a Chi-Square Test, the p value was found to be 0.001 indicative of a high significance of sharp instruments as a means of spread of HIV. From the analysis as indicated in Table 4.13, it can be deduced that in the normal settlement the male adolescents exhibited low knowledge about sharp instruments as a significant means of spread of HIV. However, the unique issue in this finding is that even when the adolescents exhibited low knowledge of sharp instruments as a means of spread of HIV, the p value indicates that the male adolescents thought that it is one of the most significant means through which HIV is spread.

The picture among the female adolescents is rather different as shown in Table 4.14, with the camp adolescents (34.3%) and normal settlement adolescents (39.1%) of small margin of

difference indicating sharp instruments as a means of spread of HIV. In this category, the female adolescents who did not have knowledge of sharp instruments as means of spread of HIV were 12.6% in camps and 14% in normal settlements giving averagely the same percentage of the male and the female adolescents who did not have knowledge on sharp instruments as a significant means of HIV spread.

Table 4.14: Distribution of Knowledge among female on HIV spread through sharing sharp instruments by Residence

Residence		HIV spread sharing contaminated sharp instruments		
		Yes	Not mentioned	Total
Camp	Frequency	71	26	97
	% within Residence	73.2%	26.8%	100.0%
	% of Total	34.3%	12.6%	46.9%
Normal settlement	Frequency	81	29	110
	% within Residence	73.6%	26.4%	100.0%
	% of Total	39.1%	14.0%	53.1%
Total	Frequency	152	55	207
	% within Residence	73.4%	26.6%	100.0%
	% of Total	73.4%	26.6%	100.0%

The Chi-Square Test of the adolescents results present a p value of 0.943, indicative of no significance in the relationship between sharp instruments and spread of HIV.

HIV is also said by the adolescents to be spread through Blood transfusion. According to Table 4.15, most male adolescents in camps did not have knowledge on Blood transfusion as one of the known means through which HIV is spread. The male adolescents who knew Blood transfusion as a means of spread among the males in camp were 10.7%, while those of normal settlements were 3.4%. Looking at the overall picture among the male adolescents across the two settlements, only 14.1% had expressed knowledge of Blood transfusion as a means of spread of HIV while 85.9% did not mention it as a means of spread. The results indicate that Blood transfusion was the least known means of spread of HIV among the male adolescents.

Table 4.15: Distribution of Knowledge among male adolescents on HIV spread through Blood transfusion by Residence

Residence		HIV spread Blood transfusion with HIV contaminated blood		
		Yes	Not mentioned	Total
Camps	Frequency	19	86	105
	% within Residence	18.1%	81.9%	100.0%
	% of Total	10.7%	48.6%	59.3%
Normal settlement	Frequency	6	66	72
	% within Residence	8.3%	91.7%	100.0%
	% of Total	3.4%	37.3%	40.7%
Total	Frequency	25	152	177
	% within Residence	14.1%	85.9%	100.0%
	% of Total	14.1%	85.9%	100.0%

Subjecting the male response to a Chi-Square Test yielded a p value of 0.067, indicating that there was no significant relationship between residence type and knowledge on Blood transfusion as means of HIV spread.

Among the female adolescents the picture is not much different from their male counterparts. The results in Table 4.16 indicate that 7.7% of the female adolescents in camps and 4.3% in normal settlements knew Blood transfusion as a means of HIV spread. In general the 12.1% of the female adolescents had knowledge on Blood transfusion as means of HIV spread. The other 87.9% did not have an idea of Blood transfusion as a means of spread.

Table 4.16: Distribution of Knowledge among female adolescents on HIV spread through Blood transfusion by Residence

Residence		HIV spread Blood transfusion with HIV contaminated blood		
		Yes	Not mentioned	Total
Camp	Frequency	16	81	97
	% within Residence	16.5%	83.5%	100.0%
	% of Total	7.7%	39.1%	46.9%
Normal Settlement	Frequency	9	101	110
	% within Residence	8.2%	91.8%	100.0%
	% of Total	4.3%	48.8%	53.1%
Total	Frequency	25	182	207
	% within Residence	12.1%	87.9%	100.0%
	% of Total	12.1%	87.9%	100.0%

The Chi-Square Test just like among the female respondents gave a p value of 0.067 indicative of no significant relationship between Knowledge of Blood transfusion as a means of spread of HIV and type of residence.

Knowledge on mother to child transmission as means of HIV spread is one of the ways that has become rampant as most HIV positive mothers continue to conceive and have babies. Knowledge on how it is spread was therefore important to be gauged among the adolescents. Of the male adolescents in camps (Table 4.17), 5.1% only mentioned mother to child transmission indicating that only that percentage knew of it as a means of spread, while of the adolescents in normal settlements, only 2.3% had knowledge of mother to child as a means of spread. Looking at the overall picture, only 7.4% of the male adolescents had knowledge of mother to child as a means of HIV spread.

Table 4.17: Distribution among male adolescents' knowledge on HIV spread Mother to child transmission

Residence		HIV spread Mother to child transmission		
		Yes	Not mentioned	Total
Camp	Frequency	9	96	105
	% within Residence	8.6%	91.4%	100.0%
	% of Total	5.1%	54.2%	59.3%
Normal settlement	Frequency	4	68	72
	% within Residence	5.6%	94.4%	100.0%
	% of Total	2.3%	38.4%	40.7%
Total	Frequency	13	164	177
	% within Residence	7.4%	92.6%	100.0%
	% of Total	7.4%	92.6%	100.0%

From the Chi-Square Test, the p value of 0.45 of male adolescents indicates that there was no relationship between type of residence and knowledge of mother to child as means of spread of HIV. This reinforces the results from the table which shows almost insignificant difference in percentage distribution of knowledge among the male adolescents in camps and normal settlements on mother to child as means of spread of HIV.

Among the female, the results from Table 4.18 shows that mother to child transmission in the camps was mentioned by 5.8% respondents as means of spread of HIV, while in normal settlements, only 1.9% had this knowledge showing a difference among the female respondents in knowledge of mother to child as a means of spread. The overall picture is still indicative of mother to child transmission as the least known means of spread of HIV among the female adolescents with only 7.7% mentioning it.

Table 4.18: Distribution among female adolescents' knowledge on HIV spread Mother to child transmission

Residence	HIV spread Mother to child transmission			
		Yes	Not mentioned	Total
Camp	Frequency	12	85	97
	% within Residence	12.4%	87.6%	100.0%
	% of Total	5.8%	41.1%	46.9%
Normal settlement	Frequency	4	106	110
	% within Residence	3.6%	96.4%	100.0%
	% of Total	1.9%	51.2%	53.1%
Total	Frequency	16	191	207
	% within Residence	7.7%	92.3%	100.0%
	% of Total	7.7%	92.3%	100.0%

The Chi-Square Test of female adolescents gave a p value of 0.019 indicating that there was significant relationship between knowledge of mother to child transmission and type of residence. This is reflective in the difference between the percentage distributions among the female adolescents who had knowledge in camps as compared to those from normal settlements.

The question on prevention methods was asked to find out whether the adolescents where knowledgeable about safer sex. This was to determine the sexual practices of the adolescents in the camps and those in normal settlements. From the Table 4.19, almost an equal number of adolescents (45.3%) in normal settlements and 47.1% in the camps had knowledge on any method of prevention of STIs. However, some group of adolescents interviewed expressed lack of knowledge of any method of prevention of STIs. Of these, 5.5% were from camps compared to 2.1% from normal settlements. This indicates that such a group may get involved into unprotected sex ignorantly and eventual acquiring of STIs.

Table 4.19: Distribution of adolescents' Knowledge of any method of preventing STIs by Residence

Residence		Knowledge of any method of preventing STIs		
		Yes	No	Total
Camp	Frequency	181	21	202
	% within Residence	89.6%	10.4%	100.0%
	% of Total	47.1%	5.5%	52.6%
Normal settlement	Frequency	174	8	182
	% within Residence	95.6%	4.4%	100.0%
	% of Total	45.3%	2.1%	47.4%
Total	Frequency	355	29	384
	% within Residence	92.4%	7.6%	100.0%
	% of Total	92.4%	7.6%	100.0%

The p value of male adolescents of 0.026 indicates that there was significant relationship between knowledge on any method of preventing STIs and type of residence. The camps adolescents had more knowledge as compared to the adolescents in normal settlements.

Knowledge on condom use as a means of prevention has a direct relationship with its use in prevention against STIs. According to results from Table 4.20, among the male adolescents, 50.8% were from the camps were found to be knowledgeable of condom use as a prevention method, while 34.5% of the male adolescents who expressed knowledge of condom use to prevent STIs contractions were from the normal settlements. At the same time, 14.3% of the male adolescents from the camps and 6.2% from the normal settlements did not have knowledge on condom use as a prevention method against STIs.

Table 4.20: Percentage distribution among male on Knowledge of condom use as prevention method against STIs by Residence

Residence		Prevention method Condom use		
		Yes	Not mentioned	Total
Camp	Frequency	90	15	105
	% within Residence	85.7%	14.3%	100.0%
	% of Total	50.8%	8.5%	59.3%
Non-camp	Frequency	61	11	72
	% within Residence	84.7%	15.3%	100.0%
	% of Total	34.5%	6.2%	40.7%
Total	Frequency	151	26	177
	% within Residence	85.3%	14.7%	100.0%
	% of Total	85.3%	14.7%	100.0%

A Chi-Square Test of male adolescents gave a p value of 0.855, however, indicates that there was no significant relationship between knowledge on condom use as a prevention method against STIs and type of residence. Taking the p value results and distribution of the responses in both types of settlements, it can be concluded that the majority of the adolescents had knowledge on condom use as a preventive method against STIs despite their settlement patterns.

Table 4.21 indicates that the female adolescents who had knowledge of condom use as prevention method against STIs were 33.3% from camps and 43.0% from normal settlements, while 13.5% and 10.1% of adolescents from camps and normal settlements respectively did not have knowledge on condom use as a prevention method. Among the female adolescents in camps themselves, 71.1% new about condom use as means of prevention, while in normal settlements, 80.9% among the female adolescents new condom use as means of prevention indicative of a slight difference in knowledge between the two groups.

Table 4.21: Percentage distribution among female adolescents on Knowledge of condom use as prevention method against STIs by Residence

		Prevention method Condom use		
Residence		**Yes**	**Not Mentioned**	**Total**
Camp	Frequency	69	28	97
	% within Residence	71.1%	28.9%	100.0%
	% of Total	33.3%	13.5%	46.9%
Normal settlement	Frequency	89	21	110
	% within Residence	80.9%	19.1%	100.0%
	% of Total	43.0%	10.1%	53.1%
Total	Frequency	158	49	207
	% within Residence	76.3%	23.7%	100.0%
	% of Total	76.3%	23.7%	100.0%

A p value of 0.099 indicated that among the females, there was significant relationship between the type of settlement they are in and knowledge of condom use as a prevention method against STIs. Drawing from the above percentage distribution of female adolescents and Chi-Square p value it can be concluded that the type of settlement determines the level of knowledge on condom use as a prevention method against STIs.

Knowledge of faithfulness as a prevention method among the adolescents in camps was found to be 17.5% while in normal settlements it was found to be 6.8%. The percentage distribution of the adolescents who did not know faithfulness as a prevention method was found to be a little higher than those who knew at 41.8% in the camps and 33.9% in normal settlements.

Table 4.22: Percentage distribution among male adolescents on Knowledge of faithfulness as prevention method against STIs by Residence

Residence		Prevention method Faithfulness		
		Yes	**Not mentioned**	**Total**
Camp	Frequency	31	74	105
	% within Residence	29.5%	70.5%	100.0%
	% of Total	17.5%	41.8%	59.3%
Normal settlement	Frequency	12	60	72
	% within Residence	16.7%	83.3%	100.0%
	% of Total	6.8%	33.9%	40.7%
Total	Frequency	43	134	177
	% within Residence	24.3%	75.7%	100.0%
	% of Total	24.3%	75.7%	100.0%

A p-value of male adolescents of 0.050 following the Chi-Square Test depicts a significant relationship between the type of settlement and knowledge on faithfulness as a preventive method against STIs. It can be deduced that the percentage distribution among the male adolescents is indicative of low knowledge of faithfulness as a prevention method against STIs.

The female respondents according to Table 4.23 in camps who knew faithfulness as a method of prevention against STIs were found to be 11.6% while in normal settlements, it was at 11.6% which is lower than the percentage of those who did not know faithfulness as a method of prevention that stood at 35.3% in camps and 41.5% in normal settlements.

Table 4.23: Percentage distribution among female on Knowledge of faithfulness as prevention method against STIs by Residence

Residence		Prevention method Faithfulness		
		Yes	Not Mentioned	Total
Camp	Frequency	24	73	97
	% within Residence	24.7%	75.3%	100.0%
	% of Total	11.6%	35.3%	46.9%
Normal settlement	Frequency	24	86	110
	% within Residence	21.8%	78.2%	100.0%
	% of Total	11.6%	41.5%	53.1%
Total	Frequency	48	159	207
	% within Residence	23.2%	76.8%	100.0%
	% of Total	23.2%	76.8%	100.0%

The p value of female adolescents of 0.619 does not show any significant relationship between type of settlement and knowledge of faithfulness as a method of prevention against STIs. The percentage distribution reveals that most female adolescents just like their male counterparts whether in camps or normal settlements did not consider faithfulness as a prevention method against STIs.

The trend in knowledge on abstinence as a preventive method against STIs according to Table 4.24 was at 39% male adolescents in camps and 26% in normal settlements, while those who did not mention abstinence as a prevention method was at 20.3% and 14.7% in camps and normal settlements respectively.

Table 4.24: Percentage distribution among male adolescents on Knowledge of abstinence as prevention method against STIs by Residence

Residence		Prevention method Abstinence		
		Yes	Not mentioned	Total
Camp	Frequency	69	36	105
	% within Residence	65.7%	34.3%	100.0%
	% of Total	39.0%	20.3%	59.3%
Normal settlement	Frequency	46	26	72
	% within Residence	63.9%	36.1%	100.0%
	% of Total	26.0%	14.7%	40.7%
Total	Frequency	115	62	177
	% within Residence	65.0%	35.0%	100.0%
	% of Total	65.0%	35.0%	100.0%

Looking at the p value of 0.803, it is indicative of no relationship between type of settlement and knowledge on abstinence as a prevention method among the male adolescents. It can further be observed that the percentage distribution (65%) of the male adolescents' respondents' knowledge on abstinence as a prevention method suggests that it is considered to some extent as one of the prevention methods though this is not in relationship with the type of settlement.

The percentage distribution (Table 4.25) among the female adolescents on abstinence as a prevention method against STIs was at 23.2% and 35.7% in camps and normal settlements respectively. The female adolescents who did not have knowledge on abstinence as a method of prevention stood at 23.7% in camps and 17.4% in normal settlements.

Table 4.25: Percentage distribution among female adolescents on Knowledge of abstinence as prevention method against STIs by Residence

		Prevention method Abstinence		
Residence		**Yes**	**Not mentioned**	**Total**
Camp	Frequency	48	49	97
	% within Residence	49.5%	50.5%	100.0%
	% of Total	23.2%	23.7%	46.9%
Normal settlement	Frequency	74	36	110
	% within Residence	67.3%	32.7%	100.0%
	% of Total	35.7%	17.4%	53.1%
Total	Frequency	122	85	207
	% within Residence	58.9%	41.1%	100.0%
	% of Total	58.9%	41.1%	100.0%

The Test p value of 0.009 clearly indicates that according to the female adolescents there was high significant relationship between type of settlements and knowledge on abstinence as a prevention method against STIs. The percentage distribution (58.9%) however, is indicative of average knowledge of abstinence as a prevention method among the female adolescents.

Knowledge of sero-status is expected to guide the adolescents on how they would make their choices on sexuality. It is also expected that blood testing could have been gone through after counselling hence preparing an individual for change of attitude and behaviour. This should determine whether one abstains from sex, uses a condom, remains faithful to partner or lives positively. Hence from Table 4.26, of the sampled adolescents from the camps, only 13% had

undergone blood testing for HIV while in normal settlements also13.3% had done the same. Another glance at the table reveals that 39.6% adolescents in camps and 34.1% in normal settlements had not endeavoured to know their sero-status. The picture one gets from the responses is that more adolescents both in camps and normal settlements (73.7%) are not knowledgeable of their sero-status.

Table 4.26: Percentage distribution of the adolescents who had Undergone VCT by Residence

		Ever obtained Voluntary Counselling and Testing		
Residence		**Yes**	**No**	**Total**
Camp	Frequency	50	152	202
	% within Residence	24.8%	75.2%	100.0%
	% of Total	13.0%	39.6%	52.6%
Normal settlement	Frequency	51	131	182
	% within Residence	28.0%	72.0%	100.0%
	% of Total	13.3%	34.1%	47.4%
Total	Frequency	101	283	384
	% within Residence	26.3%	73.7%	100.0%
	% of Total	26.3%	73.7%	100.0%

The Chi-Square Tests gave p value of 0.467 showing no significant relationship between type of residence and undergoing Voluntary Counseling and Testing.

4.3 Adolescents' sexual behaviours

In investigating the sexual behaviours of adolescents, three key questions were put to the selected adolescents in both settings. The questions sought to establish the age at first sex, number of and current sexual partners, use and non-use of condoms with reasons for either situations.

Tables 4.27 and 4.28 present the percentage distribution of the respondents' age at first sex by residence. This established the age at first sex in both camps and normal settlements for the purpose of understanding how much adolescents delay to have sex under different circumstances and drawing deductions on their sexual behaviours by age. Observing from Table 4.27, more male adolescents in camps between age groups 6-8 (1.1%), 9-11 (4.3%), 12-14 (13.3%), 15-17 (17%) and 18-20 (6.4%) had had sex compared to their counterparts in the normal settlements within the same age groups.

Table 4.27: Male respondents' age at first sex by residence

		Age at first sex - Male							
		<6	**6-8**	**9-11**	**12-14**	**15-17**	**18-20**	**N/A**	**Total**
Camp	Frequency	1	2	8	25	32	12	26	106
	Within Residence	.9%	1.9%	7.5%	23.6%	30.2%	11.3%	24.5%	100.0%
	Total	.5%	1.1%	4.3%	13.3%	17.0%	6.4%	13.8%	56.4%
Normal settlement	Frequency	2	1	1	8	13	9	48	82
	Within Residence	2.4%	1.2%	1.2%	9.8%	15.9%	11.0%	58.5%	100.0%
	Total	1.1%	.5%	.5%	4.3%	6.9%	4.8%	25.5%	43.6%
Total	Frequency	3	3	9	33	45	21	74	188
	Within Residence	1.6%	1.6%	4.8%	17.6%	23.9%	11.2%	39.4%	100.0%
	Total	1.6%	1.6%	4.8%	17.6%	23.9%	11.2%	39.4%	100.0%

From Table 4.28, it can be observed that more female adolescents delayed sexual encounters in normal settlements with none engaging in sex at the age group of 0 – 11 years and mostly started engaging in sex at 15 years with 16.8% of the female adolescent respondents assenting to have engaged in sex for the first time.

Table 4.28: Female respondents' age at first sex by residence

		Age at first sex - Female							
		<6	**6-8**	**9-11**	**12-14**	**15-17**	**18-20**	**N/A**	**Total**
Camp	Frequency	1		1	7	25	4	53	91
	Within Residence	1.1%		1.1%	7.7%	27.5%	4.4%	58.2%	100.0%
	Total	.5%		.5%	3.6%	12.8%	2.0%	27.0%	46.4%
Normal settlement	Frequency	0		0	8	33	7	57	105
	Within Residence	.0%		.0%	7.6%	31.4%	6.7%	54.3%	100.0%
	Total	.0%		.0%	4.1%	16.8%	3.6%	29.1%	53.6%
Total	Frequency	1		1	15	58	11	110	196
	Within Residence	.5%		.5%	7.7%	29.6%	5.6%	56.1%	100.0%
	Total	.5%		.5%	7.7%	29.6%	5.6%	56.1%	100.0%

The finding has revealed that more male adolescents (42.6%) had had sex in the camp compared to (18.1%) in the normal settlement, a reflection of the influence their environment had on their sexual behaviours. It further revealed that among the female adolescents, by the age of 11, 1% of the female had had sex in camps while none had had sex in normal settlements.

The discussions with a resource person support what the results reveal as was observed by a health worker in this extract:

> *"In the camps generally, we have problems. If you went to Olilim and Ogwete Camps in the border of Kotido and Olilim, really you would see adolescents sexually active. There is rape of girls by soldiers in the camps who are meant to protect them. But because life is hard and the family is not sure of the next day's meal, mothers end up selling/giving their daughters for sex to any man who can give her money. Girls who are young as 14 – 16 years are given away as means of getting food for the family"***.**
> ***(Health Official H/C III).***

This observation supports the empirical findings that there are more sexually active adolescents in the camps as compared to those in normal settlement.

Table 4.29 revealed that more male adolescents in the camps of 10.6% had sexual partners during the time of the study compared to 5.3% in normal settlements. For those who reported having no sexual partner, 45.7% were from the camps and 38.3% from normal settlements.

Table 4.29: Male respondents having sexual partners currently by residence

		Having any sexual partner currently		
		Yes	**No**	**Total**
Camp	Frequency	20	86	106
	%Within Residence	18.9%	81.1%	100.0%
	Total	10.6%	45.7%	56.4%
Normal settlement	Frequency	10	72	82
	%Within Residence	12.2%	87.8%	100.0%
	Total	5.3%	38.3%	43.6%
Total	Frequency	30	158	188
	%Within Residence	16.0%	84.0%	100.0%
	Total	16.0%	84.0%	100.0%

Considering Table 4.30, almost an equal number of female adolescents 10.2% in the camps and 11.2% in the normal settlements reported having sexual partners during the time of the study. On the other hand, 36.2% in the camps and 42.3% in normal settlements reported having no sexual partners.

Table 4.30: Female respondents currently having sexual partners by residence

		Having any sexual partner currently		
		Yes	**No**	**Total**
Camp	Frequency	20	71	91
	Within Residence	22.0%	78.0%	100.0%
	Total	10.2%	36.2%	46.4%
Normal settlement	Frequency	22	83	105
	Within Residence	21.0%	79.0%	100.0%
	Total	11.2%	42.3%	53.6%
Total	Frequency	42	154	196
	Within Residence	21.4%	78.6%	100.0%
	Total	21.4%	78.6%	100.0%

The results reveal that more adolescents in both camps and normal settlements have reported not having sexual partners at the time of study and these are in percentages of 84% male and 78.6% female.

It can be concluded that due to experience of their first sexual encounters where many reported to have had sex, and the circumstances under which such encounters occurred, the

adolescents' sexual behaviors in camps are changing from high percentage of having had sex to less of those who have sexual partners.

Table 4.31 pointed out that 9.6% of the male adolescents in the camps reported having one sexual partner while 1.1% reported having two sexual partners. This was compared to 5.3% of the male adolescents in the normal settlements having one sexual partner and none had two sexual partners during the time of the study. While the majority of the male adolescents 45.7% from camps and 38.3% from normal settlements reported not having any sexual partner at the time of the study.

Table 4.31: Male respondents' current number of sexual partners by residence

		Current number of sexual partners			
		1	2	None	Total
Camp	Frequency	18	2	86	106
	Within Residence	17.0%	1.9%	81.1%	100.0%
	Total	9.6%	1.1%	45.7%	56.4%
Normal settlement	Frequency	10	0	72	82
	Within Residence	12.2%	.0%	87.8%	100.0%
	Total	5.3%	.0%	38.3%	43.6%
Total	Frequency	28	2	158	188
	Within Residence	14.9%	1.1%	84.0%	100.0%
	Total	14.9%	1.1%	84.0%	100.0%

Table 4.32 presented the current numbers of sexual partners that female adolescents had during the time of the study. Of these, 8.7% from the camps had one sexual partner while 1% had two sexual partners compared to 10.7% in the normal settlements with one sexual partner and 0.5% with two sexual partners.

Table 4.32: Female respondents' current number of sexual partners by residence

		Current number of sexual partners			
		1	2	None	Total
Camp	Frequency	17	2	72	91
	Within Residence	18.7%	2.2%	79.1%	100.0%
	Total	8.7%	1.0%	36.7%	46.4%
Normal settlement	Frequency	21	1	83	105
	Within Residence	20.0%	1.0%	79.0%	100.0%
	Total	10.7%	.5%	42.3%	53.6%
Total	Frequency	38	3	155	196
	Within Residence	19.4%	1.5%	79.1%	100.0%
	Total	19.4%	1.5%	79.1%	100.0%

For those who had no sexual partners among the male, 45.7% were from the camps and 38.3% were from normal settlements. The implication of the above is that male adolescents in the normal settlements could have been practicing faithfulness by avoiding having multiple sexual partners compared to their counterparts in the camps. At the same time the results indicate that more female adolescents in the normal settlements (42.3%) as compared to their counterparts (36.7%) in camps do not take risks of having multiple sexual partners.

Willingness to go for VCT has of recent become a practice associated with safe sexual practice because of the role it plays in influencing attitude change. From Table 4.33 it can be observed that 35.4% from camps and 23.4% from normal settlements were willing to go for VCT as compared to 17.2% in camps and 24% from normal settlements that were not willing to go for the same. Taking the two types of settlements, more adolescents from camps were willing to go for VCT than those in normal settlements.

Table 4.33: Percentage distribution of willingness to go for VCT by Residence

		Willingness to go for Voluntary Counseling and Testing		
Residence		**Yes**	**No**	**Total**
Camp	Frequency	136	66	202
	% within Residence	67.3%	32.7%	100.0%
	% of Total	35.4%	17.2%	52.6%
Normal settlement	Frequency	90	92	182
	% within Residence	49.5%	50.5%	100.0%
	% of Total	23.4%	24.0%	47.4%
Total	Frequency	226	158	384
	% within Residence	58.9%	41.1%	100.0%
	% of Total	58.9%	41.1%	100.0%

A p value of 0.000 indicates high significant relationship between the type of residence one was found in and willingness to go for VCT.

Table 4.34, revealed the distribution of male adolescents who use condoms with their sexual partners at the time of the study. Of these, 6.9% who reported having single sexual partners were found to be using condoms with their partners at the time of the study, while only 1.1% with two sexual partners reported use of condoms with their partners. The results also reveal that 6.9% of the male adolescents with single sexual partners reported non use of condoms.

Table 4.34: Male respondents using condoms with sexual partners by current number of sexual partners

		Current number of sexual partners			
		1	**2**	**None**	**Total**
Yes	Frequency	13	2	0	15
	Within using condoms with the sexual partners	86.7%	13.3%	.0%	100.0%
	Total	6.9%	1.1%	.0%	8.0%
No	Frequency	13	0	1	14
	Within Using condoms with the sexual partners	92.9%	.0%	7.1%	100.0%
	Total	6.9%	.0%	.5%	7.4%
Not mentioned	Frequency	2	0	157	159
	Within Using condoms with the sexual partners	1.3%	.0%	98.7%	100.0%
	Total	1.1%	.0%	83.5%	84.6%
Total	Frequency	28	2	158	188
	Within Using condoms with the sexual partners	14.9%	1.1%	84.0%	100.0%
	Total	14.9%	1.1%	84.0%	100.0%

The distributions of the female adolescents using condoms with their sexual partners are presented in Table 4.35. 4.1% of female adolescents with one sexual partner reported using condoms with them during the time of the study while 1% with two sexual partners reported the same. A bigger percentage of female adolescents (14.8%) who reported having one sexual partner were not using condoms with them compared to 0.5% of those who reported having two sexual partners. The findings could be supported by the fact that condom use is normally initiated by the male partner and the female partner have very little to say if any.

Table 4.35: Female respondents using condoms with the sexual partners by current number of sexual partners

		Current number of sexual			
		1	2	None	Total
Yes	Frequency	8	2	0	10
	Within Using condoms with the sexual partners	80.0%	20.0%	.0%	100.0%
	Total	4.1%	1.0%	.0%	5.1%
No	Frequency	29	1	1	31
	Within Using condoms with the sexual partners	93.5%	3.2%	3.2%	100.0%
	Total	14.8%	.5%	.5%	15.8%
Not mentioned	Frequency	1	0	154	155
	Within Using condoms with the sexual partners	.6%	.0%	99.4%	100.0%
	Total	.5%	.0%	78.6%	79.1%
	Frequency	38	3	155	196
	Within Using condoms with the sexual partners	19.4%	1.5%	79.1%	100.0%
	Total	19.4%	1.5%	79.1%	100.0%

Given the percentage of adolescents who reported not using condoms overall, it can be argued that those who do not use condoms with their sexual partners are either married or have tested for HIV and found themselves negative hence trust each other on sexual engagement.

However, in the in-depth discussions with resource persons and groups of adolescents in camps and normal settlements, they attributed non-use of condoms to factors such as; lack of money to afford condoms and non-availability of condoms.

> *'The adolescents do not use condoms due to lack of money to buy it. I think they should use condoms to protect themselves from not only AIDS but also gonorrhoea and syphilis. I tell you when some one dies of AIDS and you draw a factor tree, it almost affect everybody. In fact both boys and girls are dying* ***(Youth representative)'.***
>
> *'Existence of condom which is not always enough encouraging adolescents to get involved into sex and in case of lack of condom, they go live ending up getting infected with HIV* ***(FGD Boys Camp)'***

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1. Introduction

This chapter gives a summary of the discussions arising out the analysis of the empirical data collected for the study, lays out the possible implications of the findings and suggests recommendations for interventions. The study further looked at other factors responsible for the sexual patterns in the two settlements as presented earlier and came to the conclusions below:

5.2. Conclusions

Of the 384 adolescents interviewed, 220 were found to have indulged in sexual intercourse at one point in life of which 32.8% and 24.5% were from camps and normal settlements respectively. The adolescents in the camps were at the same time more sexually active at the age group of 15 – 17 and 12 – 14 as compared to their counterparts in normal settlements. They then get married shortly after getting involved in sex. When determining which group had more sexual partners, the adolescents in camps, still within a small margin, exceeded their counterparts in the normal settlements.

On the first sexual encounter, the adolescents in the camps who had involved themselves in sex were found to be greater in number than their peers in the normal settlements.

Knowledge and practices of sexual and reproductive health issues were gauged and of specific concern were the proper use of condoms, which was viewed as vital for having protected and safe sexual practice. Knowledge of its use was reported higher in camps as compared to normal settlements. The overall picture from the findings indicate that sexual intercourse is the means most known by the adolescents responsible for the spread of HIV, while mother to child transmission is the least known means of HIV spread among the adolescents. This may be because most of them are not yet in the motherhood bracket.

In the sexual practices, it was established that the adolescents in normal settlements had a higher percentage of condom use as compared to their counterparts in camps. However in camps, the adolescents reportedly practise faithfulness at a slightly higher percentage than their counterparts in normal settlements.

The study gauged the willingness by adolescents to undertake VCT and in both camps and normal settlements there was overwhelming willingness however, with a slightly higher percentage in the camps. It was further revealed that the adolescents in normal settlements may be having slightly more access to HIV testing services and the positive attitude towards blood testing for HIV.

Overall in practice it was found that failure to afford services was the main constraint in both camps and normal settlements. While in the normal settlements, the service providers' method of work were cited as the next constraint, the camp adolescents cited lack of drugs as their second major constraint which appears as the third major constraint in normal settlements.

5.3. Recommendations

The stakeholders gave their opinions on how the services could be improved to suit the adolescents, which forms the basis of the recommendations on the way forward.

- Overall there were suggestions that the ideal situation would have been restoration of peace to permit the incoming of skilled health workers to help the suffering people in the camp. However, under the circumstances it is recommended that the health workers be provided with the necessary security and logistical support to encourage them to resume their duties and ensure that they can reach the adolescents in the IDPs without obstacles, while a lasting solution is being sought through peace talks.
- There is need for responsible authorities like the government, NGOs, religious bodies and well wishers to provide essential commodities to young people especially in the camps such as soap, sugar, salt and clothing to make them avoid risking their lives in favour of such commodities in exchange of sex in the short run.

- The adolescents in both study stratum, asserted that there is need for adolescents to improve on their reading ability so that they can understand the messages in Straight and Young Talks as well as paying attention to radio programs. Such programmes and newspapers especially on reproductive health issues can generate helpful debate among the adolescents where they share experiences with their fellow peers irrespective of settlement areas making them aware of danger of practicing unsafe sex.

- Straight and Young Talks service should be contextualised thus extended to the rural locals and improve on the distribution to reach a wider area/audience of the district so that more adolescents can access it. The publishing of such newspapers should be done in local languages for the community to understand and encourage the adolescents to form straight talk clubs to share their experiences on safe sex activities.

- The adolescents recommended that NGOs support the programs they initiate and implement such programs themselves to avoid corruption, which has been, identified as one of the major course of failure of projects. Drama groups that were in the area doing a lot of sensitization on adolescents to avoid engaging into early sexual activity needed to be supported both financially and materially. The assistance can be in form of uniform, equipments and transport so that they can be motivated and spread the gospel of truth about safe sex. Such drama should be played on local FM radios so that it can serve a wider audience in the district and beyond.

- Mass education on proper use of condoms is needed as the finding revealed that a bigger percentage of adolescents (74%) in both settings did not know proper use of condom as a measure of practicing safe sex. The other 26% of the adolescents that expressed their knowledge on proper use of condom should not be totally ignored in this kind of education so that they are constantly armed with safe sex practice. Mass

education on proper use of condom should as well be accompanied with constant supply so that adolescents are not caught off guard in case they cannot control their sexual feelings.

- Soft loans should be extended to the adolescents at a minimal or no interest rate for them to have some form of income generating activities and avoid idleness. Since the adolescents both in camps and normal settlements do not have gainful employment, this would be an alternative to keep them busy and avoid temptation of engaging into early sexual activity as the only means of handling their boredom.

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Appendix I: Focus Group Discussion Guide; Adolescents

Introductory Remarks

We are a team from Makerere University conducting research on pattern of sexual behaviour among adolescents between age of 14 to 19 years in internally displaced people's camps and normal settlement, in Lira district. The aim of the research is to examine the sexual pattern of the two groups with a view of comparison purposes. You have been invited to participate in this discussion because you know your problems and can articulate them better than any other person.

We, therefore, request for your participation in the discussion freely. All that you say will be taken in strict confidence and remain just between us. Please talk one at a time because every body will have a chance to talk.

Identification of the participants

Type of participants	
Number of participants	
Average age of participants	
Time at start of the discussion	
Time at the end of the discussion	
Parish	
Sub-Frequencyy	
Frequencyy	
Date	

SECTION 1: Knowledge and Awareness of Adolescent health problems

1. Who is an adolescent?
    - Secondary Sexual Characteristics
    - Behaviours

2. What sexual and reproductive health problems **(by category)** do adolescents in this area face?

Category of adolescents

- Girls
- Boys

3. What factors contribute to the above problems for each of the above groups?
    - Culture/customs
    - Beliefs and attitudes
    - Exposure to the media
    - Curiosity
    - Unprotected sex
    - Peer influence
    - Lack of recreation activities
    - Multiple sexual partner
    - Poverty
    - Alcohol and drug influence

- Lack of sexual and reproductive services and information
- Low educational levels
- Lack of guidance and counselling
- Leaving environment

4. How do adolescents in this area protect themselves against the above sexual and reproductive health problems?

5. How can a person ensure proper use of a condom whenever having sexual intercourse?
Probe for: *(Proper dressing up to pubic area with space left at the tip, removal soon after ejaculation, use of one condom per session, proper disposal in pit latrines)*

SECTION 2: Sexual and Reproductive Health Information and services

6. What information is available to adolescents in this area on sexual and reproductive health?

- STDs/HIV/AIDS
- Family planning
- Safe sex
- Fertility
- Abortion and post–abortion care
- Nutrition
- Hygiene
- Physiology and anatomy of the body
- Menstruation
- Impotence

7. What are the channels of this information?

8. What sexual and reproductive health services/programs are available to the different categories of adolescents in this area?

9. What constraints do the different categories of adolescents face in utilizing these services/programs?

10. How would you like these services/programs improved?

Thank the participants for sparing their time and providing useful information for the study.

Appendix II: Key Informant Interview Guide; Community Resource Persons

Introductory Remarks

We are a team from Makerere University conducting research on pattern of sexual behaviour among adolescents between age of 14 to 19 years in internally displaced people's camps and normal settlement, in Lira district. The aim of the research is to examine the sexual pattern of the two groups with a view of comparison purposes. You have been identified as one of the potential person to participate in this interview so that we can gain a deeper insight about the two groups.

We therefore request for your participation in this interview freely. All that you say will be taken in strict confidence and remain just between us. Please, can we now begin.

Identification of the Respondent

Name of Respondent	
Designation	
Date of Interview	
Time at start of the interview	
Time at the end of the interview	

SECTION 1: KNOWLEDGE AND AWARENESS OF ADOLESCENT SEXUAL HEALTH PROBLEMS

1. What sexual health problems do adolescents in this area face?

Sexual Health problems

- STD/HIV/AIDS
- Early marriage
- Early pregnancies
- Drug abuse
- Rape / defilement
- Reproductive health cancers
- Loss of libido
- Impotence

Category of adolescents

- Girls
- Boys

2. What factors contribute to the above problems for each of the above groups?

    - Culture/customs

- Beliefs and attitudes
- Exposure to the media
- Curiosity
- Unprotected sex
- Peer influence
- Lack of recreation activities
- Multiple sexual partner
- Poverty
- Alcohol and drug influence
- Lack of sexual and reproductive services and information Educational levels
- Lack of guidance and counseling
- Displacement/over crowded accommodation

SECTION 2: SEXUAL HEALTH SERVICES AND INFORMATION

3. What sexual and reproductive health facilities /services are available to adolescents in this area? ***(Probe for specific services/program available for adolescents in IDPCs/Normal settlements***)

    - Health units
    - Private clinics
    - Drug shops
    - Pharmacies
    - Traditional Birth Attendant
    - Traditional healers
    - Community Based Distribution Agents
    - Trained counselors

4. What information is available to adolescents in this area on sexual health?

5. What are the channels of this information?

6. What is your role in providing sexual health information/service to adolescents in this area?

7. What constraints do adolescents in this area face in accessing available sexual health services? (*IDPCs/Normal settlements*)

Thank the respondent for sparing his or her time and providing useful information for the study.

Appendix III: Adolescent Questionnaire

A Comparative Study of Pattern of Sexual Behaviour Among Adolescents in Internally Displaced People's Camps and Normal Settlements, in Lira District

Strictly Confidential

SECTION 1: LOCATION

101. County

102. Résidence — Camp | Non Camp

103. Village/LC1

104. Code of Respondent ***(Identification Number)***

105. Housing Unit Number

SECTION 2: STAFF DETAILS AND SURVEY TIME

201. Name of interviewer

02. Date of interview

203. Time at start of interview

204. Time at end of interview

205. Name of supervisor

206. Date of inspection

207. Responses codes

1. Completed
2. Partially completed
3. Not done at all

208. Reasons for response codes 2 and 3

1. No competent respondent at the time of visit
2. Entire household absent for study period
3. Refused
4. Other (specify) ----------

SECTION 3: CHARACTERISTICS OF THE RESPONDENT

301. How old are you? **(*In complete years*)**

302. Religion of the respondent

303. Sex of Respondent:
   1. Male
   2. Female

For those living in camps ask Qns 304 and 305

304. At what age did you start living in the camp?

305. How long have you lived in the camp?

306. With whom are you living?
   1. Both mother and father
   2. Father
   3. Mother
   4. Grand parent
   5. Uncle
   6. Aunt
   7. Sibling
   8. By myself
   9. Spouse
   10. Other (Specify) ……

307. For how long have you lived with him/her/by yourself?

308. What is your education status?
   1. Currently attending school
   2. Dropped out of school ***(Skip to 310)***
   3. Has never attended school ***(skip to 311)***

309. If currently attending school, in which class are you?

310. What was the major reason for leaving school?
   1. Death of a parent(s)

2. Poverty
3. Internal displacement
4. Abduction
5. Lack of proper parental guidance
6. Disability
7. Pregnancy
8. Forced marriage
9. Lack of interest
10. Child labour
11. Others (specify) ----------

311. If you have never been to school what was the major reason for not attending school?

1. Death of a parent
2. Poverty
3. Internal displacement
4. Abduction
5. Lack of proper parental guidance
6. Disability
7. Lack of interest
8. Child labour
9. Others (specify) ----------

312. What is your marital status?

1. Married
2. Single
3. Divorced
4. Separated
5. Widowed
6. Co-habiting

313. How many of you sleep in the same room

SECTION 4: SEXUAL BEHAVIOUR AND PRACTICES

NOTE: Now I would like to ask you questions about your sexual behaviour and practices. The questions may appear personal and sensitive. I would therefore request you to feel free and give correct answers. All the answers you provide will be held in strict confidence between you and me and will be used to find solutions to health problems faced by adolescents. You have the right to refuse to answer any question that you feel uncomfortable with. If in the course of our interaction we identify any problem I will be glad to refer you to an appropriate health facility.

401. Have you ever had sexual intercourse? ☐

1. Yes
2. No ***(Skip to 501)***

402. At what age was your first sexual intercourse? ☐

403. Who was your first sexual partner? ☐

1. Girl/boy friend
2. Spouse
3. Commercial sex worker
4. Mother/father
5. Female /male relative
6. Brother/sister
7. House boy/girl
8. Teacher/tutor
9. Guardian/ step parent
10. Do not remember
11. Other (Specify) ……

404. How do you compare your age with that of your partner at your first sexual intercourse? ☐

1. Same age as partner
2. Much older than partner
3. Much younger than partner
4. Don't know/don't remember

405. Under what circumstance was your first sexual intercourse? ☐

1. Love
2. Money
3. Lured

4. Defiled/forced
5. Need to please partner
6. Marriage
7. Curiosity to get experience
8. Favours (a job, marks)
9. Desire
10. Food
11. Protection
12. Rape
13. Peer influence
14. Under the influence of alcohol/drugs
15. Other (Specify) ……

406. What was the social status/occupation of the sexual partner? ☐

1. Government soldier
2. Rebel
3. Camp leader
4. Health worker
5. Community Worker
6. Teacher
7. Student
8. Porter
9. Businessman
10. Idler
11. Subsistence farmer
12. Other (Specify)……..

407. Did you use a condom on your first sexual intercourse? ☐

1. Yes (***skip to 409)***
2. No

408. If no, why did you not use a condom? ***(Multiple responses)***

1. Condom was not available
2. Was not planned
3. Partner did not approve
4. Do not like it – reduces pleasure

1 ☐
2 ☐
3 ☐
4 ☐

5. Did not know about it
6. Could not afford
7. Not reliable
8. Fear to use
9. Fear to buy condoms
10. Show of trust/Trust my partner
11. Wanted to get pregnant
12. Other (specify) ……

5 6 7 8 9 10 11 12

409. Do you currently have any sexual partner(s)?
   1. Yes
   2. No *(Skip to 416)*

410. If yes, how many sexual partners do you currently have?

411. What is the social status/occupation of the sexual partners? ***(Multiple responses***)

1. Government soldier
2. Rebel
3. Camp leader
4. Health worker
5. Community Worker
6. Teacher
7. Student
8. Porter
9. Businessman
10. Idler
11. Subsistence farmer
12. Other (Specify)……..

1 2 3 4 5 6 7 8 9 10 11 12

412. Do you use condoms with these partners?
   1. Yes
   2. No ***(skip to 414)***

413. If yes, why do you use condoms?
   1. To prevent pregnancy
   2. To avoid contracting STIs

1 2

3. To avoid spreading STIs 3
4. I don't trust partner 4
5. Other (specify) …….. 5

414. In your opinion, how risky is it to contract STI/HIV infection in this area?

1. No risk
2. High risk
3. Moderate risk

415. Where do you obtain the condoms you use?

1. Government health center 1
2. Private/NGO health center 2
3. Drug shop 3
4. Private clinic 4
5. Ordinary shop 5
6. Market 6
7. Friends 7
8. Partner 8
9. Other (specify) …… 9

416. Do you know how to use a condom correctly?

1. Yes
2. No.

417. Have you gone for HIV/AIDS Test?

1. Yes
2. No.

418. Have you ever been pregnant or made anybody pregnant?

1. Yes
2. No ***(Skip to 501)***

419. If yes, was the pregnancy carried to full term?

1. Yes ***(Skip to 501)***
2. No

420. If no, what happened to the pregnancy?

1. Got a miscarriage
2. Aborted (Induced)
3. Other (specify) ……..

421. If aborted what was the reason? ☐

SECTION 5: SEXUAL HEALTH: KNOWLEDGE, ATTITUDE AND BELIEFS

501. What sexual health problems do you know of? ***(Multiple responses)***

1. STI infection 1 ☐
2. Abortion 2 ☐
3. Pregnancy related complications 3 ☐
4. Menstrual related problems 4 ☐
5. Other (specify) …….. 5 ☐

502. Have you ever heard about sexually transmitted infections (STIs)?

1 Yes

2. No ***(Skip to 507)***

503. If yes, which one have you heard about? ***(Multiple responses)***

1. HIV/AIDS 1 ☐
2. Candida /Trichonomous 2 ☐
3. Gonorrhoea 3 ☐
4. Herpes genitals 4 ☐
5. Genital warts 5 ☐
6. Hepatitis B 6 ☐
7. Lymphogranuloma venerium 7 ☐
8. Syphilis 8 ☐
9. Other specify) …….. 9 ☐

504. What are the signs and symptoms believed to be associated with the sexually transmitted infections (STIs) in this area? ***(Multiple responses)***

1. Genital itching 1 ☐
2. Urethra discharge 2 ☐
3. Genital sore 3 ☐
4. Skin rash 4 ☐
5. On and off fever 5 ☐

6. Loss of weight
7. Lower abdominal pain
8. Pain while urinating
9. Coughing for a long time
10. Red lips
11. Diarrhoea
12. Curly hair
13. Other (Specify) ……..

6 ☐
7 ☐
8 ☐
9 ☐
10 ☐
11 ☐
12 ☐
13 ☐

505. If you contracted STIs/HIV, how would you feel? ☐

1. Normal
2. Stigmatised
3. Spread
4. Committing suicide
5. Other (specify)…….

506. If one had HIV/AIDS in this community, how is she/he treated? ☐

1. Isolated
2. Abandoned
3. Cared for and supported
4. Other (specify)……

507. Do you know of any method that can be used to prevent STIs? ☐

1. Yes
2. No ***(Skip to 509)***

508. If yes, which methods do you know? ***(Multiple responses)***

1. Use of condoms
2. Faithfulness
3. Abstinence
4. Other (Specify) ……

1 ☐
2 ☐
3 ☐
4 ☐

509. How is HIV/AIDS spread? ***(Multiple responses)***

1. Sexual intercourse
2. Sharing of contaminated sharp piercing instruments
3. Blood transfusion with HIV contaminated blood and blood products
4. Mother to child transmission
5. Others (specify) ……..

1 ☐
2 ☐
3 ☐
4 ☐
5 ☐

510. Can HIV infection be cured?

1. Yes
2. No
3. Don't know

511. Where can one get treatment for STIs? ***(Multiple responses)***

1. Health unit 1
2. Traditional health practitioner 2
3. Pharmacy 3
4. Drug shops 4
5. Private clinics 5
6. Community health workers 6
7. Youth centres 7
8. Religious leaders 8
9. TBAs 9
10. Ordinary Shops 10
11. Other (Specify) …….. 11

512. What conditions expose adolescents to the risks of acquiring HIV\AIDS infections? ***(Multiple responses)***

1. Drug and substance abuse 1
2. Peer influence 2
3. Poverty 3
4. Lack of parental guidance 4
5. Pornography 5
6. Video and dances 6
7. Idleness 7
8. Desire for material things 8
9. Other (specify) …… 9

SECTION 6: SEXUAL HEALTH PROBLEMS, SERVICES AND INFORMATION

601. What social sexual health problems have you ever experienced? ***(Multiple responses)***

1. Unwanted pregnancy 1
2. Physical abuse 2
3. Defilement 3
4. Rape 4

5. Indecent assault 5
6. Other (specify) …… 6

602. What biological sexual health problems have you ever experienced? ***(Multiple responses)***

1. STI infection 1
2. Abortion 2
3. Pregnancy related complications 3
4. Impotence 4
5. Menstrual related problems 5
6. Other (specify)…… 6

603. Have you experienced any of the following signs or symptoms in the last **six months?**

(Read out)

1. Genital itching 1
2. Urethra discharge 2
3. Genital sore 3
4. Skin rash 4
5. On and off fever 5
6. Loss of weight 6
7. Lower abdominal pain 7
8. Pain while urinating 8
9. Coughing for a long time 9
10

604. Have you ever suffered from STIs

5. Yes
6. No ***(Skip to 611)***

605. The last time you had a sexual health problem where did you seek assistance?

(Multiple responses)

1. No where 1
2. Health units 2
3. Traditional practitioner 3
4. Pharmacy 4
5. Drug shops 5
6. Peers/friends 6
7. Community health worker 7
8. Youth centres 8
9. Spiritual healer 9
10. Peer educators 10

11. Parents 11
12. Untrained health worker 12
13. TBA 13
14. Police 14
15. Other (specify) …… 15

606. If sought, what type of assistance? ***(Multiple responses)***

1. Medical 1
2. Social 2
3. Traditional 3
4. Legal 4
5. Other (specify) …… 5

607. If no assistance was sought/or and provided what were the reasons? ***(Multiple responses)***

1. Lack of money
2. Lack of information of treatment sources 1
3. Fear of being stigmatised 2
4. Long distance from health unit 3
5. Unfriendly health unit staff 4
6. Other (specify) …… 5
6

608. Were you satisfied with the treatment you received?

1. Yes
2. No ***(Skip to 610)***

609. If yes, what were the reasons for the satisfaction? ***(Multiple responses)***

1. Friendly health workers 1
2. Short waiting time 2
3. Attended to by the right health workers 3
4. I got drugs 4
5. I got credit facility 5
6. Free treatment 6
7. Others (specify) …… 7

610. If no, what were the reasons for non-satisfaction? ***(Multiple responses)***

1. Health workers were rude 1
2. Long waiting time 2

3. Did not get the right health worker 3
4. I was not examined 4
5. Did not get drugs 5
6. High cost 6
7. Others (Specify) …… 7

611. What sexual health information is available to the adolescents in this area? ***(Multiple responses)***

1. STDs/HIV/AIDS 1
2. Family planning 2
3. Safe sex 3
4. Fertility 4
5. Abortion and post–abortion care 5
6. Nutrition 6
7. Hygiene 7
8. Physiology and anatomy of the body 8
9. Menstruation 9
10. Impotence 10
11. Other (specify) ---------- 11

612. What is the source of the information? ***(Multiple responses)***

1. Television 1
2. Radio 2
3. News papers/magazines/ 3
4. TBA 4
5. Peers/friends 5
6. Health workers/health units 6
7. Teachers/schools 7
8. Trained counsellors 8
9. Community health workers 9
10. Religious leaders 10
11. Other (specify) …….. 11

613. Have you ever heard of Voluntary Counselling and Testing (VCT)

1. Yes
2. No ***(Interviewer to explain and skip to 618)***

614. If yes, what is involved? ***(Multiple responses)***

1. Counselling on HIV/AIDS 1
2 Blood test for HIV 2
3. Release of results 3

615. Have you ever obtained VCT services?

1. Yes ***(Skip to 618)***
2. No

616. Would you be willing to go for VCT?

1. Yes ***(Skip to 618)***
2. **No**

617. If no, why not? ***(Multiple responses)***

1. Fear of result 1
2. Ignorance 2
3. Lack of cure 3
4. Does not know where to go for VCT 4
5. Others (specify) …… 5

618. Whom do you discuss your Sexual and reproductive health problems with? ***(Multiple responses)***

1. Father 1
2. Mother 2
3. Grand parent 3
4. Uncle 4
5. Aunt 5
6. Teacher 6
7. Religious leaders 7
8. Brother 8
9. Sister 9
10. Friend 10
11. Other (specify)…….. 11

620. Why would you go to the person(s) you have mentioned?

621. What constraints do you face in utilizing adolescent sexual health services/programs?

(Multiple responses)

1. The service providers are not friendly 1 ☐
2. Long distances to service points 2 ☐
3. Lack of confidentiality at the service points 3 ☐
4. Cannot afford services 4 ☐
5. Others (specify) …….. 5 ☐

622. What do you suggest would improve the sexual health of adolescents in this area?

623. What comments (if any) would you like to make?

Thank you very much for providing useful information for the study.