Adolescents in Kumi: Their True Stories

A REPORT ON OPERATIONS RESEARCH OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN KUMI DISTRICT (May - July 1998)

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EXECUTIVE SUMMARY

Introduction

Kumi district is one of the three districts that constitute the Teso region in Eastern Uganda. The population there is predominantly Iteso, largely rural (95%) and depend on subsistence farming as the main source of livelihood. Adolescents and children above 5 years (the adolescents of the coming years) constitute 38% of the population in Kumi district (Statistics Department, 1992).

Kumi District Health Project (KDHP) is a four-year project (1996-2000) whose overall goal is to assist government and the people of Kumi to achieve a better health status through:

- Increased community ownership and demand for essential health services,
- Effective and efficient essential health services provided by government, NGO and private sector providers, and
- Effective and efficient district level management and supervision of essential services.

Adolescent Reproductive Health (ARH) is one of the key aspects of health targeted by the project, basing on findings of the project baseline survey that showed among others that:

- Rate of adolescent pregnancy seems to be very high. About one third (32%) of girls/women aged 14-18 years had already given birth to at least one child. The national average is 11.3%. Sexual activities appear to be starting very early in Kumi overall the usual age of first sex for girls is likely to be much lower than that for boys. The most common age of first sex was 12 years for girls and 15 years for boys.

- Birth intervals in Kumi are shortest among adolescents, further increasing the risks for the adolescents themselves and their children. The average birth interval in women less than 20 years of age in 28 months, which is 6 months shorter than the average figure of 34 months for women more than 24 years old.

Study Objectives

This study was undertaken as part of the process to respond to these critical issues in SRH. The main objectives of the study were to:

- Assess the knowledge of adolescents in Kumi (age 10-18 years) on key RH issues such as contraception and pregnancy, STI's and HIV.
- Identify the key RH problems affecting adolescents in Kumi.
- Collect information on the factors affecting adolescent sexuality and RH in Kumi
- Identify and document social and other cultural factors/barriers that affect ARH in Kumi
- Identify adolescent strategies for coping with RH problems
- Identify existing social structures for addressing adolescent RH problems in Kumi

- Identify the sources of RH information for adolescents in Kumi
- Assess the knowledge, attitude and practice of teachers, parents, and relatives of adolescents, and health service providers towards the ARH issues in Kumi and identify how they could possibly work with the project to address these issues
- Identify the best possible avenues for reaching adolescents in Kumi with RH information

Study Process

The conceptual framework for this study was based in the PRECEDE-PROCEED model (Green and Kreuter, 1991). The main issues of focus were the current SRH situation of adolescents, the factors determining this, and the current interventions addressing the SRH needs of adolescents. Purposive sampling was done in all the three counties in the district, including adolescents in and out of school as well as adults associated to them such as parents, teachers, community leaders and health service providers. The data collection events conducted include 68 Focus Group Discussions, 151 Key Informant Interviews and 123 Survey Interviews. School and health facility

Situation of adolescents

Regarding the concept of adolescents the common view held by both adolescent and adult respondents was related to the ***transitory nature of adolescence.*** It was described as a period of both physical and psychological change; during which a person has no permanent characteristics but is transformed from childhood to adulthood. It is seen as a time when young people recognise, understand and are prepared for their ultimate roles as adults. Key among such hopes is marriage, reproduction and raising ones own family. At this stage they become closer to each other as individuals as well as group associates. Adolescent respondents noted that this association contributes much to the perceptions, values and behaviours they develop.

Reproductive practices of adolescents

It was found out that the attitude of adolescents towards contraception (as expressed by adolescent respondents or seen by adults) was largely negative, although there is acknowledgement of growing appreciation of the benefits of contraceptive use and protected sex. Adolescents discussed a range of contraceptive methods, including pills, condoms, safe periods (rhythm), withdrawal, injections and spermicides. Traditional contraceptive methods mentioned include herbs (**Olich**) and tying a thread around the waist.

The negative attitude of adolescents towards contraceptives was expressed in numerous disadvantages they perceive in them, especially pills and condoms. Pills were said to cause increased bleeding during menstruation (referred to as double periods), lead to weight gain, make it more difficult to get children when desired (because they destroy the eggs), and lead to abnormalities in children produced after their use. It was noted that many girls and women are not able to follow the instructions for use of pills very well.

Regarding pregnancy and childbirth alone (without its other consequences) it was

found out that this is desired by many adolescents as well as by adults - for their adolescent children. It is viewed as proof of fertility, prestigious for boys and increasing the chances of marriage for girls.

The consequences of pregnancy noted to induce fear and regret in adolescents include coping with the pregnancy, considering and often conducting abortion, complications of labour and difficulties in raising the child born.
Pregnancy for girls in school leads in most cases to dropping out. This also applies to boys in school who impregnate girls and get reported.

Out of school adolescent girls who get pregnant, or those sent out of school because of pregnancy, are often sent out of the parents home, to go to the boy or man responsible for the pregnancy. Denied by the boys or men responsible, some of these girls have to cope entirely on their own. They have to find other means to independent livelihood - often including risky jobs like alcohol selling and prostitution.

Abortion was said to be a common practice both in schools and in the community; often suggested and facilitated by the boy responsible for the pregnancy.

> ***"The ones who have got pregnant have often aborted due to fear of their parents and the need to continue with their education. The ones who leave school decide to marry, with the view that when they come together they can become one and will have no problem."*** (KI; Student Leader SSS; Female.)

Regarding STIs, syphilis was most discussed while gonorrhoea and AIDS were mentioned less frequently. Delayed appearance of symptoms, difficulties in disease recognition and interest to keep the illness secret were mentioned as factors possibly contributing to a higher presence of STD's than currently recognised. It was noted that many adolescents who get sick with STD's endure them silently and only a few seek advice or treatment. Advice is mainly sought from peers and siblings; and on rare occasions, from parents and other adults.

It can therefore be concluded that, there is remarkable understanding of adolescence and its challenges and opportunities, although many of the facts known are not linked or associated with the consequences.

There is inadequate awareness among adolescents about contraception, and they also have partial information and misinformation which may contribute to the low use of contraceptives.

Determinants of this Situation
Respondents in this study recognised that the SRH behaviour of adolescents is often influenced by factors within themselves, such as knowledge, skills and attitudes as well as factors external to the person. Among the factors discussed as critical in the social environment of adolescents are the values held and prevalent practices with respect to sex. The home and school environments, where adolescents spend most of their time were seen as critical in influencing perceptions and subsequent behaviours. Perceptions and actual levels of poverty; as well as culture and religion are other

factors in the social environment recognised to exert significant influence on the behaviour of adolescents.

Sexuality and the Home Environment

The home environment was recognised as the setting for initial socialisation and up bringing of children. However, it was noted that currently there is little instruction and guidance for children and adolescents in many homes. While mothers continue to play a significant role in guiding children, fathers are seen as largely ineffective both as role models for children in early life and during adolescence, as well as in setting operating rules and regulations for the home.

Sexuality and The School Environment

The school environment (as well as the journey to and from there) is recognised as a meeting place for adolescents and adults with no blood relationships; and thus potentially sexual partners. The other unique characteristic of the school setting noted is the large numbers of young people brought together there, and the difficulty for monitoring and control by the few adults in place charged with the task.

Rules, regulations and policies governing sexual relations and service delivery are an integral component of the school setting discussed, with both positive and negative contributions to SRH development. Most respondents, including the adolescents to whom they apply, largely appreciate those rules seen as protective and helpful to ensure their future, although some adolescents (both boys and girls) do view them as unnecessarily restrictive and often disobeyed.

Sexuality and Poverty

Both adults and adolescents recognised the importance of poverty in its reality and perceptions of one's poverty levels as compared to other people. Also noted to be of critical importance is the difference between perceptions of adults (parents) and adolescents about the basic needs of adolescents and the best approaches to meeting them. Many of the priority needs as seen by adolescents are considered to be irrelevant extras by parents and they expect the young people to contribute to this process. On the other hand, adolescents expect their parents to meet all their needs, and short of that, many consider sexual relations as one of the easier means of getting the needs met.

Culture and Religion

Culture and religion are recognised as important in shaping the values and norms of adolescents. The current mixing of traditional cultural values with western cultural influences as well as religion (both Christianity and Islam) was noted.

The perceptions and values attached to sex related talk and practice are important in both culture and religion. Sex and sexuality are viewed as sacred and not to be talked about or engaged in openly. On the rare occasions that such issues are discussed, the language used is not direct and very specific, which may be misunderstood or misinterpreted by the adolescents.

> ***"The word sex is still looked at as immoral and obscene; not fit to be talked about in public."*** (KI; Teacher; Male.)

The culture of housing whole families in one hut, often without demarcation into rooms was pointed out as contributing to early exposure of adolescents to sex. The cultural institution of elders was noted as well established and respected by many adolescents. Parents mentioned it as one of the community resources that can be involved in promoting SRH development for adolescents. Religious institutions were also recognised as key actors in current SRH interventions and with potential to do more.

In addition to environmental factors, there are other factors that were identified as influencing ASRH. These included predisposing, reinforcing and factors. The main factors predisposing adolescents to sexual activity are their own attitudes towards sex, and the influence of other people in their surroundings. Self-efficacy considerations may be important but respondents in this study do not extensively discuss them. Most respondents saw the attitudes of adolescents towards sex as based in the perceived benefits from sex both social and material, and their limited knowledge and low expectation of risk in sex. Adolescents perceive the sex urge as an uncontrollable natural desire.

The benefits from sex - adolescent respondents mentioned a variety of benefits from sex that are a critical motivating factor to having sex. These include immediate or short-term social and material benefits as well as long-term benefits that are realised later in life. Social benefits discussed include sweetness and satisfaction, as well as more love for and from the sexual partner. Sexual intercourse is perceived as the ideal way to express love, a form of leisure and relaxation and an indicator that you are worth the attention of others. Benefits mentioned as desired and often received by girls include money, clothes, body decorations and cosmetics.

Knowledge and expectation of risk in sex - The perceived consequences of STD's, such as infertility for gonorrhoea, effect on babies born (for syphilis), and severe ill health or death from AIDS, are largely in the far future and compare unfavourably with the numerous immediate benefits seen. Apart from knowledge about risks, general knowledge about adolescent growth and development, and the functioning of reproductive organs are seen as important but largely lacking.

> ***"They say that you can control your sexual desire, yet within yourself you cannot control your appetite."*** (FGD; SSS; Male)

Social influence - The main categories of people said to influence adolescents include adults and fellow adolescents. Persons that offer material inducements to adolescents to get them into sexual relationships were seen as very influential. Both adult and adolescent respondents noted that many adolescents start sexual relationships because of the influence of peers other than sexual partners, both as individuals and groups. It was noted that both boys and girls desire to belong to specific peer groups and they go to great lengths to adopt the behaviours they perceive as existing or desirable in the group.

Observed behaviours - The sexual behaviours adolescents see in others, both peers and adults, and the perceived reinforcements that accompany such behaviours influence their own behaviours. For example, observation of peers or siblings who have sex and seem to gain from it motivates adolescents to try it out too.

> ***"They learn from old brothers and sisters. They peep through windows or even hide under the bed, then they go to practice what they have seen".*** (FGD; PS; Male.)

The other reinforcing factors discussed mainly relate to social reinforcement derived at a personal level, encouragement from the sexual partner and from peers; as well as material rewards and benefits accruing from having sex.

While numerous factors were discussed that predispose to risk taking behaviours, respondents also pointed out factors that discourage adolescents from risky behaviours or encourage them to undertake and maintain positive behaviours. The fear of pregnancy, disease, competition and conflict and accidents or negative expectation of a sexual encounter were among the factors mentioned that would deter the adolescents from engaging in risk behaviour.

Intervention and Services

Respondents discussed a variety of intervention programmes that are currently in place. They include education and skills building interventions focused on the adolescents to influence their behaviour, as well as efforts to provide supports in the environment that facilitate decision-making by adolescents with respect to health promoting behaviours. Integrated approaches that combine educational and environment-focused interventions were recognised as important and particularly effective, but currently lacking. Among the existing interventions include; IEC and guidance counselling.

Information, Education and Communication (IEC)

The IEC interventions discussed by respondents are mainly based in institutions such as schools, health facilities and religious institutions. The media, especially radio and the press; as well as videos, films and other printed materials were also pointed out as an important means currently used to communicate ASRH relevant messages. The key subjects said to be addressed in on-going IEC interventions include: contraception, protected sex, sexual abstinence and sexually transmitted infections. Issues such as making good friendships, respect and relationships with adults, and responsibilities as well as abilities to meet ones own needs were noted as addressed in general IEC but with relevance to SRH.

The main issues discussed among weaknesses and limiting factors in current IEC interventions relate to the four main components of the communication cycle: the message, the channel used, the source or sender and the target audience. However, some weaknesses were noted that are crosscutting and relate to all aspects of communication. For example, some of the on-going interventions target specific parts of the district to the exclusion of others. Community-based IEC, especially in rural areas was noted as a specific area of need; and little was discussed about IEC interventions based in health service facilities. Parents and other community-based

intermediaries pointed out weaknesses in the local leadership system, especially in the adequacy and effectiveness of their efforts in mobilising people to participate in IEC activities.

> ***"Your department is also weak somehow, I am sorry to say. When cholera broke out, a film on cleanliness was showed and people gathered to watch. That was good but as soon as cholera subsided, nothing else has been shown to this day; yet there is need to follow up these people with more films. It might be the same with this programme of yours."*** (FGD; Parents; Male)

Guidance & Counselling

The on-going interventions for guidance and counselling were recognised as focused on adolescent girls, with little coverage of the needs of adolescent boys. Guidance is provided on general issues like career, personal hygiene and menstruation, while counselling is focused on day-to-day problems encountered by adolescents (especially girls). Examples discussed in this respect include developmental problems (e.g., menstruation periods), sickness, pressure for sex or marriage, and suspected pregnancy.

The main settings where guidance and counselling are done include the schools, homes, health facilities and religious institutions. Guidance and counselling in schools was seen as an integral part of the educational system, provided by teachers on both general and SRH-specific issues.

Mothers and other older females, e.g., elder sisters and aunts provide home-based counselling for girls in and out of school. Involvement of male parents is acknowledged to be little, for both male and female adolescents. In case of grave problems, e.g., pregnancy, parents become critical actors in the home as well as school setting - for those in school.

Life skills development

Life skills development was discussed in the context of survival and coping with the challenges that adolescents face in the society where they live. Respondents also discussed the skills required by adults in order to promote safety in the environment of adolescents and encourage coping. Other skills pointed out are those needed by intermediaries, both adults and adolescents, through whom targeted young people can be reached.

Such skills include leadership skills for adolescents who are leaders in school as well as in the communities, as well as communication and counselling skills for other intermediaries such as teachers, parents and matrons.

Others include those skills traditionally passed on to children and adolescents by parents and elders, to enable them survive as well as fit in the society. Respondents in this study recognised that exposure to urban influences, the media, armed conflict and civil strife have greatly multiplied the challenges faced by adolescents. They said adolescents (both in and out of school) should be able to make informed decisions and act within the setting where they live, without undue restriction or influence by forces

around them. This calls for a wider range of skills to help them choose what to do among several courses of action before them. Examples of the main skills necessary include: self awareness skills, inter personal skills, skills in creative and critical thinking.

It is worth noting that the current ongoing intervention especially IEC are largely school-based and basically leaves out the intermediaries.

Safe and supportive environment

Consideration of the social and physical environment focused on the factors external to the person that can affect his or her behaviour. The main factors discussed in this respect include interventions such as health-care services, rules and policies that guide adolescent behaviour, and initiatives to alleviate poverty for adolescents and the households where they live. While some of these, e.g., rules and policies, can affect behaviour without the awareness of the adolescents concerned, most of them operate through guiding the thinking and behavioural decision-making of adolescents.

The health care services relevant for SRH include sexuality education, contraception and protected sex, STI screening and treatment, maternity services (pre-natal, abortion and post abortion care, delivery, and post-natal care. Respondents in this study discussed health care needs in each of these areas, and mentioned services available in some of them like contraception, maternity and STI's. Public and private health facilities, including those operated by NGO's and traditional health practitioners were noted as available for use. The services target all people that need them, including but not specifically focused on adolescents. There is no recognised participation of adolescents in the current service, beyond service use. Nearly all services present are paid for.

The confidentiality associated with such services, and their effectiveness in curing the illness were the main indicators said to be considered by adolescents in choosing where to go. Thus private practitioners were recognised as providing confidential SRH services, including abortion and STD treatment.

Policies that facilitate preventive and corrective health behaviour were noted as present and well established in the school setting, and recognised as largely lacking in the homes. They are primarily aimed at controlling the types of contact and activities between adolescents of opposite sexes; and include statements of rules and penalty if not obeyed. School authorities establish the current rules and policies, at times in consultation with parents. There is no reported involvement of adolescents, and no opportunities for their amendment in response to adolescent requests or desires.

Teachers recognised that effective enforcement of rules, even school rules, requires joint monitoring by both parents and teachers, for behaviours in and out of school. Enforcement action, even in schools is said to consistently involve parents - they are called to the school to participate in deciding on what action to take.

It can be noted therefore that current guidance and counselling services are largely reactive, focused on females and delivered by intermediaries deficient in the necessary

skills. There is limited recognition of the importance of life skills and there are no interventions in place specifically aimed at their developments in adolescents.

The health care services present are inadequate in coverage and quality and lacks specific focus on meeting ASRH needs of adolescents.

Recommendations

Considering the findings and these conclusions, it is clear that the challenges to adolescent SRH development are many; but some opportunities and resources are also recognised. The focus of KDHP in ASRH development is primarily IEC (health education) but the issues uncovered in this study are more than can be fully addressed by IEC alone. Indeed ecological thinking about behaviour development and change has underscored the reciprocity in the determinants and the need for multiple and mutually supportive interventions on the different determinants. The recommendations made in this report focus on IEC but also recognise and mention the necessity to intervene by other means.

Existing interventions - IEC and otherwise - are a great resource with more potential than is already tapped. Efforts to promote ASRH development should among other means focus on promoting and improving their effectiveness. In particular, facilitation should be considered to enable IEC programmes address the issues of concern yet to be fully addressed. Inadequate skills on the part of current and potential intermediaries in IEC interventions has been highlighted in many settings and this ought to be addressed.

There is a wide range of actors in current interventions, and many whose potential to participate is yet to be realised. Actors such as governmental agencies, NGOs and private individuals; both adults and adolescents, need to work together in participatory planning and action for SRH development. It is recommended that networking among programmes and actors be enhanced and integrated interventions be promoted. Integration of SRH concerns and IEC issues into other activities of KDHP is specifically recommended.

A number of issues do emerge which require special focus in order to enable adolescents adopt healthful behaviours.

- Every behavioural decision has potential for positive as well as negative consequences; and both aspects matter to adolescents. IEC Interventions should pay due attention to both of them in efforts to help adolescents make behavioural decisions.

- Adolescents require programmes that help them to develop self esteem and self efficacy, in order to meet with confidence the SRH challenges they face daily. However, the influence of others around them is (and probably will remain) paramount. It is critical that life skills development and working with appropriate role models are given due attention.

Media approaches that are well established and reach many people, such as Straight Talk and Young Talk (and possibly the recently introduced Ateso version of Straight Talk) and interactive programmes on radio like Capital Doctor should be explored for

extended reach and a wide content range. Approaches that are educational and also entertaining such as music, dance, drama and films ought to be promoted.

Institution-based IEC programmes, such as in schools and health units should be consolidated and strengthened for more effectiveness and wider coverage. In addition, more community-based programmes are required, not only to reach the out-of-school adolescents but also to promote linkage and mutual support between institution and home based intervention.

Many issues raised that require wider health promotion interventions beyond health education will benefit from intensive advocacy by KDHP, and efforts to recognise and utilise the non- IEC capacities and interests of other actors. For examples, organisations with strength in health service provision, guidance and counselling or the policy process can be identified and facilitated to play their roles better.

ADOLESCENT REPRODUCTIVE HEALTH IN UGANDA

Adolescent reproductive Health is high on the Ugandan Health Agenda because adolescents are the future of the nation, this group constitute 30% of the total population and are increasingly getting involved in production and reproduction. However, this is a very vulnerable group in Uganda . This is contributed to by the general lack of infrastructure, employment, high school drop out and the weakening of the traditional forms of social support at individual, community and National level . Repercussions of this has been high rates of adolescent pregnancies with the attending problems of unsafe abortions, delivery complications and a high risk of contraction of HIV and other STIs.

Given the diversity of determinants of the adolescent's reproductive health and the magnitude of their vulnerability, a lot of effort to redress their plight is being employed by both government and Non- government institutions. Grossly, different actors can be grouped, according to their areas of focus, as:

i) Character Formation e.g Scouts, Girl guides, Rotaractors
ii) Social protection and care e.g Youth Sharing
iii) Refomatory e.g Kampiringisa
iv) Rehabilitation
v) Skills training e.g Young Men's Christian Society (YMCA)
vi) Literacy Development e.g YMCA
vii) Income generating
viii) Recreational
ix) Environmental protection
x) Community Development
xi) Relief and emergency care
xii) Cultural
xiii) Health

All these actors invariably contribute to enhancing the Adolescents' reproductive Health but we'll discuss details of a few Health related actors.

BECCAD

This is a Basic Education Child Care and Adolescents Development progarmme facilitated by UNICEF/GOU initiated in 1995.

Target: Working in 10 Districts and targeting Children through to adolescence.

Objective: To promote cognitive and psychosocial development of children and adolescents within a supportive family and community envoronment that is conducive to education and prevention of STDs, HIV/AIDS. It joins Basic education, child care and adolescent health.

Activities: Sensitization of leaders at various levels and proffessionals,Development and use of materials for advocacy, capacity building through training of adolescents and community based organizations, teachers and para- legals, support establishment of counselling services and support co-ordination of related activities.

PEARL
This is a Programme for Enhancing Adolescent Reproductive Life, initiated in June 1995.
Actors: GOU/UNFPA
Target: Piloted in 4 Districts and proposed to recruit 4 additional Districts each year untill 2000. It targets people aged 10- 24 years.
Objective: To enhance adolescent reproductive life through creating a more conducive environment and providing adolescents with appropriate reproductive healt counselling and services.
Activitieas: Sensitization seminars for various cadres, rehabilitation and equipping of community centres, provision of counselling services at community centres, localized research, development of IEC messages and establishing a co-ordination mechanism.

All interventions are planned with close collaboration with the Ministry of Health and Gender and Community Development(which is responsible for the youth). The MoH has also set up an adolescent Health desk under Maternal and Child Health Division and an adolescent Health policy is being developed.

CHILD HEALTH AND DEVELOPMENT CENTER
As an inter- disciplinary and multisectoral institution fostering National Capacity building for child survival and development as well asresearch, communication and dissemination; CHDC, as far as adolescents' health is concerned is involved in:

i) Participatory Research with Adolescents on: Access to Reproductive Health Services: Participatory research with Ugandan Adolescents.

Collaborating insitutions: The Pacific Institute for Women's Health and CHDC
Objective: To respond to the need for input from adolescent and greater understanding of the context in which adolescent sexual behaviour and practices occur, as well as the need to generate more support for reproductive health services that are accessble and acceptable to adolescents.
Area of operation: Mpigi District
Target group: Adolescents age 12- 19 years who are out of school
Issues addressed: Sexual practices and perception of risk, knowledgeof and sources of reproductive health information, knowledge and attitude towards condom use, communication and sexual negotiation, adolescent service needs and recommendation for service delivery modes and strategies to increase girls' access to care.
Methodology: Initially, demographic characteristice were define quantitatively then Qualitative data was collected. Peers groups were identified and divided int three groups acording to age. Group discussions were held over time to foster confidence for them to discuss in their own words their experiences, feelings, attitudes and beliefs about sexuality and reproductive healeh

- There is remarkable understanding of adolescence and its challenges and opportunities. However, many of the facts known are not linked or associated as necessary, and some a wrongly attributed.

- Adolescence and sexual relations are perceived as one and the same; although a significant minority delay sex to later years or stop it after negative experiences or expectations.

- There is inadequate awareness among adolescents about contraception; partial information and misinformation may be contributing to current low use of contraception.

- Pregnancy is desired by and for many adolescents; it is the secondary consequences such as school drop-out and poverty challenges, and to a lesser extent STD's that are the issues of concern.

- There is low significance and functionality of traditional institutions for home and community-based child upbringing, socialisation and sex education, largely because of the social demographic transition in society.

- There are immense opportunities as well as numerous risks in the school environment with respect to adolescent SRH.

- There is a significant dichotomy in the perception of parents and adolescents with respect to the needs of adolescents and the means to meet them.

- Culture and Religion are critical institutions with significant current (and potential for more) influence on adolescent SRH behaviour.

- The current attitudes of adolescents that influence their SRH behaviour are largely based in balancing the risks and benefits they perceive in the specific behaviours. Currently, the outcome with respect to sex is more on the side of benefits, both social and material; while the balance sheet with respect to contraception is more for risks and thus non-use.

- Partners, peers and adults exert important social influences on adolescents with respect to SRH decision-making; through perceived and expressed expectations as well as modelling observed behaviours.

- A significant minority of adolescents are not involved in sexual relations (not started or stopped); primarily because of their high risk expectations in sex, based on outcomes they have heard about, observed or experienced.

- On-going interventions to promote adolescent SRH include a wide variety of programmes and actors that are often not directly linked in design, structuring or programming of delivery to the common target group - adolescents.

- Current IEC interventions are largely school-based and thus primarily reach the school going adolescents. Media interventions, especially print (Straight Talk) and radio (Capital Doctor) are reaching and popular with many adolescents.

- Critical areas of growth for current IEC interventions include the incomplete geographical coverage of the district, narrow range of methods in use, and inadequate knowledge as well as limited communication skills for the involved intermediaries.

- Current guidance and counselling is largely reactive (in response to crises), focused on females, and delivered by intermediaries deficient in the necessary skills. Some pertinent issues remain un-adressed by current guidance and counselling, largely because of common but unarticulated expectations for action in the home and/or school setting. There is limited opportunities for dialogue and consensus among the intermediaries involved in both settings.

- There is limited recognition of the importance of life skills, and no interventions in place specifically aimed at their development in adolescents.

- Health care services present are inadequate in coverage and quality,; and lack specific focus on meeting the unique SRH needs of adolescents.

- SRH-relevant rules regulations and policies are present in most schools while lacking or insignificant in many home settings. Effective enforcement of present rules and policies depends to a large extent on the opportunities for linkage between the decisions and actions of teachers and parents.

- Current poverty alleviation initiatives are limited in geographical coverage and scope of issues addressed; focused on money making as an end not a means to specific social development.