HEALTH LITERACY, HIV/AIDS, AND GENDER: A UGANDAN YOUTH LENS

By

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Abstract

Youth, the World Bank argues, need to become a constituency for reform in developing countries. This case study responds to this challenge by investigating adolescent students' understanding of the relationship between health literacy, HIV/AIDS, and gender in the context of Uganda. The four questions investigated are: (i) What kind of health literacy, HIV/AIDS, and gender-related information is accessible to Ugandan adolescent secondary school students? (ii) In the students' view, what are the factors contributing to health and HIV/AIDS related challenges faced by young people in Uganda today? (iii) According to these students, what is the impact of the debate on gender equality in the fight against health epidemics including HIV/AIDS? and (iv) What do these students consider to be the way forward for Uganda to achieve better health and improve life chances for all? The theoretical framework includes critical pedagogy and indigenous knowledge systems, as well as integrative gender frameworks. Each contributes a different but complementary understanding of adolescent students' perspectives on the issues under investigation.

Data were collected in a qualitative study from January 2005 – May, 2007. The data corpus includes: student journals, reflective reports, artifacts/documents, life history interviews, questionnaires, informal ethnographic conversations, focus group discussions and critical inquiry discussions. In response to each of the research questions, the major findings were as follows: i) The students' understanding of the relationship between health literacy, HIV/AIDS, and gender were in part influenced by the media, and in part their own experiences. ii) Poverty and peer pressure impact young people's health practices. iii) Young people want gender equality debates to have a focus on marginalized males as well

as females. iv) Youth suggest that education, fair trade, and better healthcare services are important in the attainment of the "better health for all" goal in Uganda.

The study concludes that marginalized groups, especially youth, need opportunities to develop a united voice and be active participants in reform processes. Further, new analysis frameworks are needed to understand the gender/power relations in Uganda.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral
BCC	Behavioural Change Communication
CDC	Centre for Disease Control
CIA	Central Intelligence Agency
DANIDA	Danish International Development Agency
EFA	Education for All
HIV	Human Immune Virus
IDRC	International Development Research Council
MDG	Millennium Development Goal
MGLSD	Ministry of Gender, Labour, and Social Development
MOES	Ministry of Education and Sports
MOH	Ministry of Health
NEPAD	New Economic Partnership for Development
R&D	Research and Development
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UHSBS	Uganda HIV/AIDS sero-behavioural survey
UNAIDS	United Nations [joint programme] on AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Education, Social, Culture Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Educational Fund
USAID	United States Agency for International Development
W.H.O	World Health Organization

Annotations

....	Section continues
[...]	Information omitted
[ ]	Word inserted
____	Underlined for emphasis unless indicated otherwise
Italics	Highlights a statement within a text

Definitions

Youth	People aged between 18 and 30 years
Adolescents	People within 10 – 24 age range
Teenagers	People between 13 – 19 years
Young people	People aged 10 – 30 years

These definitions are adapted from the UBOS. However in this thesis, I have used youth, adolescents, and young people interchangeably to denote people between 15 – 25 years. This is because most of the statistical data on HIV/AIDS has this age grouping.

CHAPTER I

1.0. INTRODUCTION

> Young people's lack of voice means they are a weak constituency for reform. Parents do not represent the views and aspirations of young adults like they do for younger children. Young people need to be encouraged to participate more fully in public life.
>
> (Emmanuel Jaminez, lead author World Bank Report, 2007, p. 23)

In this thesis, I take up the call made by the World Bank's Chief Economist and Senior Vice President, Emmanuel Jaminez, to provide young people with an opportunity to voice their opinions on issues that impact their lives and their society. The World Bank (2001) perceives schools as the place where this initiative should begin. It is therefore not surprising to find that in its 2007 report, the following question has been posed: "how are the schools or education systems preparing young people to participate more fully in public life?" (2007, p. 23). Such questions are not new in education as Giroux (1995) and Cochran-Smith (2004) have observed that oftentimes a crisis in the public sphere prompts stakeholders to question the kind of education young people are receiving. In this case, the crisis in the health condition of people in developing countries has led to this question.

Similar to the call by the World Bank for young people to participate in public life is a call by the World Health Organization to promote health literacy to achieve social change, especially in relation to HIV/AIDS (W.H.O 1986; 2002; 2007). The need to promote health literacy has led some researchers to focus on how young people can be pivotal to the change process (Kickbusch, Caldwell & Hartwig, 2002; Nutbeam, 2000; St. Leger, 2001). If young people begin to participate in the decision making that affects their lives, they will be guided through their transition into adulthood and be better prepared for

its responsibilities (World Bank, 2007). In accordance with the W.H.O (1986) suggestion, Nutbeam (2000) contends that schools should start promoting health literacy instead of the traditional health education. Nutbeam argues that while health education is concerned with information dissemination and individual behaviour, health literacy goes beyond such definitions and focuses on empowerment and community action. In a similar vein to the World Bank report, St. Leger (2001) suggests that young people should be active in public life issues and this can be achieved through health literacy promotion (see also Kickbusch, 2001; Kickbusch et al, 2002). All these studies argue that young people in schools should be prepared for public life by having a voice and engaging in social activism.

Therefore this interpretive case study involving adolescent students (aged 15-19 years) was designed to investigate how young people in Uganda understand issues of health literacy, HIV/AIDS, and gender. I define HIV/AIDS as distinct from health literacy because of the impact the epidemic has had on many African countries, which warrants a special focus. The assumption of this study was that having a youth lens (World Bank, 2007) would not only provide young people with an opportunity to voice their opinions, but that there would be implications for education or practice. Most important was the assumption that if young people began to understand how health literacy, HIV/AIDS, and gender are inter-related, and how these issues impact their lives and the lives of other members of the community, the youth will learn to reflect on how their actions impact both themselves and others in the community (St. Leger, 2001). Through participation in this study, which was highly reflective and iterative, the students would learn to articulate their vision of how society can be improved.

1.1. The study

According to international organizations like W.H.O, United Nations Education, Scientific, and Culture Organization (UNESCO) and World Bank, health issues in Africa have become of global concern, and immediate action needs to be undertaken (UNESCO, 2005; World Bank, 2007; W.H.O 2007). The W.H.O (2007) suggests that the major factor impeding the health and quality of life of people in developing countries and Africa in particular, is gender imbalance. This suggestion follows an observation that there appears to be more women than men impacted by most health epidemics, and in the recent past, HIV/AIDS infections (see also Baylis, 2000). This gender imbalance impacts not only the adult population but young people's health as well.

For example, the recent HIV/STI survey in Uganda revealed that women and girls are seven times more vulnerable to HIV/STI infection than men. This discrepancy is attributed to gender inequality that hinders women from accessing treatment and preventive care (Uganda AIDS Commission [UAC], 2007). In her speech at the women's summit, Dr. Margaret Chan, Director-General of W.H.O stated that, "the HIV/AIDS epidemic has put the spotlight on deep-rooted constraints that hold women back in many areas of life" (W.H.O Newsletter, July, 2007). The deep-rooted constraints were identified as poverty, gender inequality, and intimate partner violence against women. In response to the challenges faced in Africa and other developing countries, the Millennium Development Goals (MDGs) have been set up as benchmarks for promoting and ensuring the health of women and children (World Bank, 1999; 2002). These goals have led to the designing of studies that focus on the role of women in development, including advocacy for women's rights to education, better health, and employment opportunities (Robinson-Pant, 2004).

It is against such a background that the umbrella longitudinal multi-site study involving Drs. Bonny Norton and Maureen Kendrick (principal investigators), University of British Columbia (UBC), of which this sub-study is a part, sought to investigate the complex relationship between literacy, gender and sustainable development in Uganda. This larger study began in 2003. Already, sub-studies have been undertaken in North Western Uganda with a community of women in Nebbi district (Drs. Kendrick and Hissani) and in South Western Uganda with girls in a rural secondary school in Masaka district (Drs. Norton, Kendrick, and Jones). The current study, from which this thesis is developed, is located in Eastern Uganda and began under Dr. Norton's supervision in October, 2004. I have worked as a research assistant on this Mbale district research project since October, 2004.

The unique contribution of this sub-study, to the larger study, is its focus on issues of health literacy, HIV/AIDS, and gender with twelve adolescent students (6 girls & 6 boys) in an urban secondary school located in Mbale district. As mentioned in the introduction, the study was designed to provide a youth lens on discussions like health literacy, HIV/AIDS, and gender. The overarching question guiding my study is "how do Ugandan youth understand the relationship between health literacy, HIV/AIDS, and gender?" The data collection techniques included journaling, reflective reports, life history interviews, focus group discussions, and questionnaires. These methods enabled the collection of "rich" data in order to provide a "thick" description and understanding of the students' opinions on the issues under investigation. The data reported in this thesis spans over a period of two years and five months (January 2005 to May 2007).

1.1.1. Purpose of this study

The purpose of this study was to investigate and understand what youth in Uganda consider to be the relationship between health literacy, HIV/AIDS, and gender. As the World Bank (2007) report and other studies (Kickbusch et al, 2002; Nutbeam, 2000; St. Leger, 2001) have posited, it is important to engage youth in discussions on issues that impact their lives and are of public concern. These discussions have become crucial in relation to the HIV/AIDS epidemic that has impacted many young people's lives in Africa (Kickbusch, 2001). In this thesis, I contend that involving students in research provides an entry point into meaningful and critical dialogue over issues of public health and gender, so that youth can begin to articulate what possibilities of change exist in the present and the future. This sub-study therefore has implications for policy and practice if young people are to be prepared to become an active constituency for reform (Jaminez, World Bank, 2007).

1.1.2. Research questions

The designing of this sub-study was influenced by three propositions made in reports developed by World Bank (1999; 2001; 2007), UNAIDS (2001; 2005), and W.H.O (1986, 2002, 2007), which call for a renewed vigilance in the fight against global epidemics. These propositions are: having a *youth lens*; tackling *social determinants of health* and; *education for empowerment* respectively. The World Bank (2007) expands on its earlier reports (1999; 2001) by focusing on how to get a youth lens on major public life issues, and how young people can become a constituency for reform. The UNAIDS (2005) report states that although worldwide and especially in Africa the HIV prevalence levels have decreased (7 percent), they are still unacceptably high. These levels are unacceptable because there is a possibility of a resurgence of the epidemic. This report recommends that

stakeholders (especially governments) put measures into place that minimize this risk through addressing social determinants of health including gender and health inequalities. The W.H.O (2002) report proposes that health literacy be promoted so that attitude and behaviour change, especially in relation to health practices, can be attained. The promotion of health literacy would probably lead to critical literacy practices, empowerment, and social activism for the improvement of societal life chances.

Based on these propositions, youth lens, tackling social determinants of health, and education for empowerment, the research questions were designed to investigate in depth the issues raised in these three reports. The questions centered on issues of adolescence and gender with a provision for youth to articulate their vision of how society's health and life chances can be improved. Therefore, the research questions that guided this study were:

1. What kind of health literacy, HIV/AIDS, and gender-related information is accessible to Ugandan adolescent secondary school students?
2. In the students' view, what are the factors contributing to health and HIV/AIDS related challenges faced by young people in Uganda today?
3. According to these students, what is the impact of debates on gender equality in the fight against health epidemics including HIV/AIDS?
4. What do these students consider to be the way forward for Uganda to achieve better health and improve life chances for all?

1.1.3. Significance of the study

This study comes at a time when the Ugandan Ministry of Education is developing a post-primary health and HIV/AIDS[1] curriculum appropriate for adolescents. Two curricula are being designed, one for lower post-primary and the other for upper post-primary. Therefore, this study is important because it provides students' views on their health and HIV/AIDS challenges as adolescents. Recommendations can be made to curriculum developers on what information adolescents seek, which could contribute to the designing of age appropriate health and HIV/AIDS education for youth in school.

The study can also serve as feedback to stakeholders including the Ugandan Ministry of Education and Sports (MoES) and Ministry of Health (MoH), championing the health literacy, HIV/AIDS, and gender campaigns in Uganda. Stakeholders can evaluate the success of these campaigns in impacting students' health practices and determine which areas need to be strengthened to bring about the desired outcomes. The study can be used to inform policy on young people and the designing of an education curriculum suitable for adolescents. This study is relevant mainly to stakeholders interested in developing programs that incorporate youth perspectives on public life issues, because the questions used to guide the study provided the students with opportunities to articulate their views on various public life issues including adolescent and women's health.

This study is also significant because it indirectly pioneers the call by World Bank for youth involvement in public discourse as they transition into adulthood. By deliberately engaging the students to think critically about issues of health inequities, HIV/AIDS, and gender, the study encouraged their reflection process on these issues. The study provided

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[1] HIV/AIDS education has been separated from the general health curriculum in Ugandan secondary schools. This is because issues related to HIV/AIDS and youth need special attention (MoES, 2005).

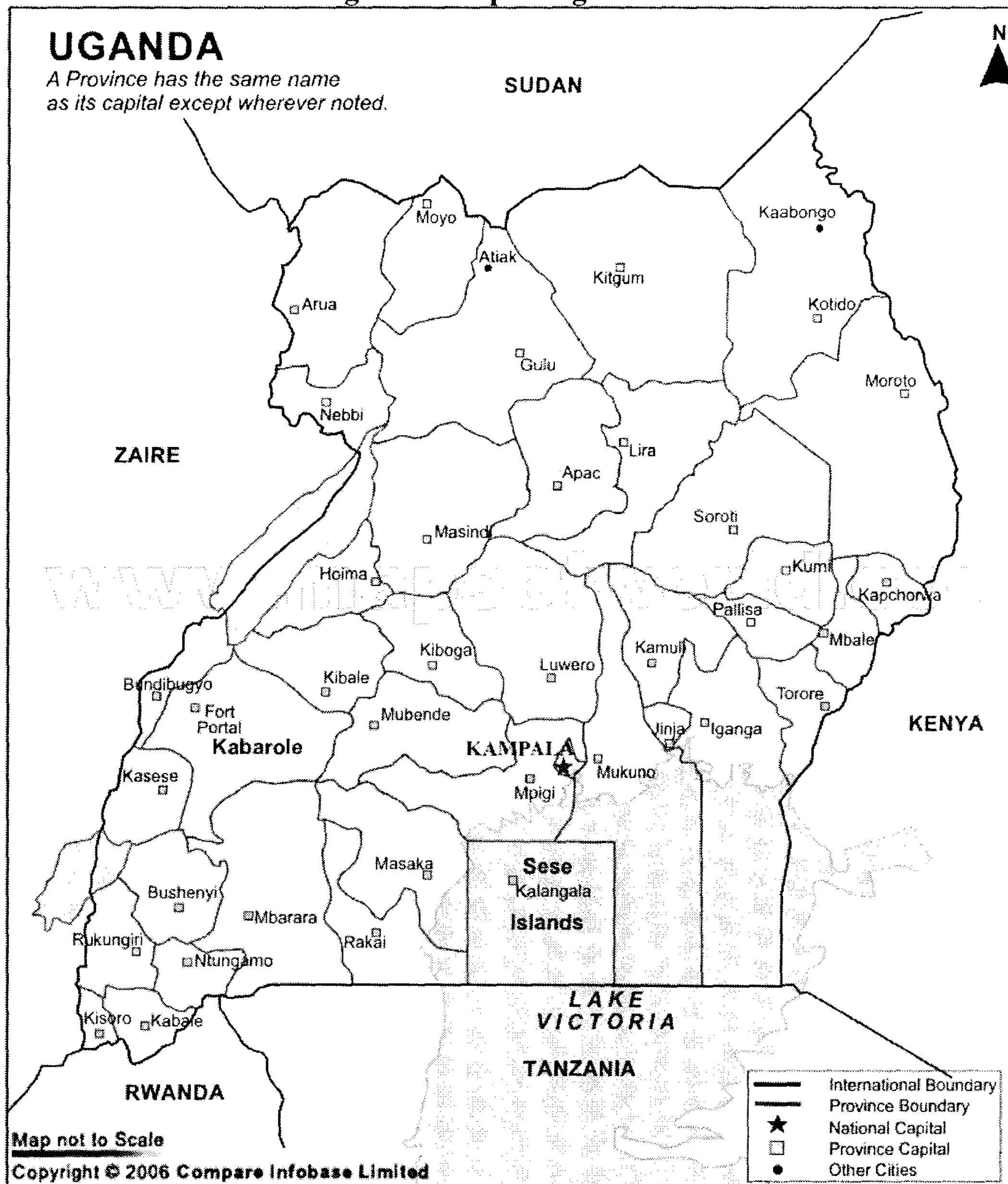
the participants with the space to reflect on their challenges, and also created awareness among the students on major public health discourses that currently impact them as boys and girls. The participating students therefore had an opportunity to provide a youth lens to the major public discussions. Through this thesis, the students' opinions can be drawn upon by researchers and other stakeholders interested in including youth in public life discourses and education for activism and social change (St. Leger, 2001; W.H.O 2002).

In relation to practice, the design of the research provides some interesting pedagogical implications for health literacy promotion in schools. The research design allowed the students to take initiative in identifying and writing in their journals the health information they readily access and that was pertinent to them. The research was student-centered and the progress of the study was guided by the emergent issues, which has practical implications for classroom instruction and health literacy education.

1.2. The Ugandan context

The Republic of Uganda is a landlocked East African country lying on the Equator - roughly two thirds of the country is north of the equator and one third south. On the banks of Lake Victoria, Uganda is bordered by Tanzania and Rwanda to the south west, the Congo to the west, the Sudan to the north, and Kenya to the east. Uganda has a current total population of 28,816,000 people (CIA databank, 2007). However, according to the 2002 census, Uganda had a total of 24,442,084 people (male: 49%, female: 51%) of which 5,299,838 people (22%) are aged between15 to 25 years (Uganda Bureau of Statistics, [UBOS], 2003). I highlight the age group 15 to 25 years, because the students who participated in this study fall into this age group.

Figure 1: Map of Uganda



Uganda has a developing, market economy based largely on agriculture. The GNP per capita is among the lowest in the world. The gross national income per capita for Uganda is $1,500 (World Health statistics, 2007). Both agricultural and industrial productions were severely curtailed from the 1970s to the mid-1980s due to political instability and civil war. However, the economy is slowly taking shape under the present government, and it is currently recognized as one of the progressive economies in Africa

(CIA World Fact Book, 2007). The study was conducted in Mbale district which is located in Eastern Uganda. Mbale lies between longitudes 34, 35E and latitudes 0045, 129N with a population of 80,000 people. According to UBOS (2005), the eastern region has high poverty levels but the particular levels for Mbale district are not known. The sections that follow will discuss issues of health, HIV/AIDS, and gender in Uganda.

1.2.1. Health Status

In relation to health, the major challenges are AIDS and malaria, which are at epidemic levels (CDC publications, 2007). In 1998, the W.H.O launched the Roll Back Malaria (RBM) campaign with Africa as its target (Muhe, 2002). Although Uganda joined the campaign, malaria still remains a major killer in the country. Transmission is high in 90% of Uganda, with 5% of the country, mainly in the highland areas, subject to unstable transmission and epidemics (MoH 2006a). It is estimated that 93% of the total population is at risk from malaria. Malaria contributes to by far the major share of the disease burden in the country; current estimated annual numbers of deaths from malaria are from 70,000 to 100,000 (W.H.O 2007).

Other common diseases include tuberculosis, venereal diseases, measles, sleeping sickness, dysentery, whooping cough, hookworm, typhoid and leprosy. The life expectancy at birth for men is 48 years and 51 years for women. The probability of dying under age five per 1000 live births is 136. The probability of dying between 15 and 60 years per 1000 population is 506 for male and 457 for women (W.H.O Statistics, 2007). The MoH is aligning its health strategic framework with the targets set by the MDGs 4, 5, 6. These goals are: to reduce child mortality by communicable diseases like measles through

immunization; to improve maternal health by increasing access to skilled health staff; and to combat HIV/AIDS, malaria, and T.B. respectively by the year 2015 (MoH, 2006a).

In relation to maternal health in Uganda, it was estimated in 1995 that between 6,500 to 13,500 women and girls die each year due to pregnancy-related complications. Additionally, another 130,000 to 405,000 women and girls will suffer from disabilities caused by complications during pregnancy and childbirth each year. These numbers are incredibly high (Futures group, Maternal and Neonatal index program [MNPI], 2003). According to MNPI, (2003), very few people access maternal care and modern family planning services. Of interest to the current research is the observation that very few (especially adolescents) have access to modern reproductive health services. The percentage of early pregnancies in Uganda is high in most parts of the country (UBOS, 2005). This reality calls for measures that can provide safe motherhood health care services, especially in rural areas, in order to curb maternal health-related challenges.

1.2.2. HIV/AIDS & STI situation

For a synopsis of the AIDS situation in Uganda, I have used an excerpt from the MoH (2006b) report (retrieved from www.health.go.ug). According to the current Uganda HIV/AIDS sero-behavioural survey (UHSBS), 91 percent of Ugandan adults are HIV negative while 6.4 percent of Ugandan adults aged 15-49 years are HIV positive. The most impacted group is the young people within the 20-25 year age range. The HIV prevalence is significantly higher among women than men and among urban residents than their rural counterparts. These statistics are summed up in Table 1 below:

Table 1: The age range of women and men who are HIV positive, Uganda 2004-05

Characteristic	HIV sero-prevalence %	
	Women (N= 10,561)	Men (N= 9,033)
Age (years)		
15-19	2.7	0.3
20-24	6.2	2.3
25-29	8.7	6.0
30-34	12.1	8.1
35-39	9.9	9.3
40-44	8.5	9.1
45-49	8.3	7.2
50-54	5.7	6.9
55-59	5.0	5.9
Residence		
Urban	12.8	6.7
Rural	6.5	4.8

Source: Uganda AIDS indicator survey 2004/2005 Data. Presentation by Ministry of Health 2006

For both sexes, rates of infection rise with age, peaking at 12% among women in their early thirties and 9% among men aged 35-44 years. HIV prevalence is substantially higher among women than men under age 35. At the ages 50-59 the pattern reverses, and prevalence among men is higher than among women. This reversal occurs because in this age group men are more sexually active than women. For both men and women, HIV infection rates are higher among those who are married, widowed, divorced or separated than among those who are not currently married or who have never married. At least 66 percent of the new infections happened among the married or co-habiting couples. In 8 percent of couples one or both partners is infected with HIV. Over half of these couples are discordant (5 percent); that is, one partner is infected and the other is not.

HIV prevalence is highest in Kampala Central (8.5 percent) and North Central (8.5 percent). These areas are followed by western regions (6.9 percent), South Eastern regions (6.5), South western (5.9 percent) and Eastern (5.3 percent). West Nile (2.3 percent) and

Northeast (3.5) have the lowest HIV prevalence. The breakdown in the social cultural norms and growing number of urban poor is attributed to the high prevalence rate in urban areas like Kampala (MoH, 2006). In Kampala, the number of new infections was reported to be high among the people in armed forces and among married or co-habiting discordant couples. However, in the North Central region, military conflict coupled with limited access to HIV preventive care and treatment, are the reasons for high rates (UAC, 2006).

Also, the age groups most affected by the epidemic have recently shifted upward (ages 35-44 years for men and 30-34 years for women). A number of people reported multiple-casual sex relationships without consistent use of condoms. At least 88 percent of men currently married have had sex with someone other than their lifetime spouses, as compared to 56 percent of the married women. These statistics indicate that continued vigilance is needed to halt HIV spread among the adult population in Uganda (UAC, 2006). The survey also indicates that infection rates among men and women in younger ages (15-19) is higher for women. According to UAC (2006), young girls aged 15-19 years are about nine times more vulnerable to HIV than their male counterparts.

Based on the UNAIDS (2007) HIV estimates for Uganda, 1,000,000 people are living with HIV/AIDS. There are 900,000 adults aged 15 to 49 years living with HIV of which 520,000 are women. AIDS has caused 91,000 deaths. There are 110,000 children aged 0 to 14 living with HIV. There are 1,000,000 children aged 0 to 17 who have been orphaned due to AIDS. The report also reveals that less than one percent of Ugandan children under 5 are HIV positive. Infection rates among children are higher in urban areas than in rural areas. Infection rates among children are the same for girls and boys. The UHSBS report supplements by stating that of the 1,000,000 people living with HIV/AIDS,

847,000 are still sexually active yet 84 percent of them do not use condoms and 79 percent did not know they were HIV- positive.

The UNIADS joint program provides a synopsis of Uganda's progress indicators, in Table 2 below:

Table 2: Country progress indicators

National programs		
Percentage of most-at-risk populations (sex workers) reached by prevention programs		10%
Percentage of pregnant women receiving treatment to reduce Mother-to-child transmission		12%
Percentage of HIV-infected women and men receiving antiretroviral therapy		56%
School attendance among orphans	88% non-orphans	93%
Knowledge and behaviour		
Percentage of young people aged 15 to 24 who had sex with casual partner in the past 12 months	**Men** 74%	**Women** 26%
Percentage of young people aged 15 to 24 who had sex before 15	16.3%	12.2%
Percentage of young people aged 15 to 24 who used a condom last time they had sex with a casual partner	55%	53%

Adopted from UNAIDS 2007 report (http://www.unaids.org./en/Regions_Countries/Countries/Uganda.asp)

Based on these statistics, sex workers are clearly still the most vulnerable group. Of great concern is the surge in numbers of people who have sex with casual partners, especially the men in the age group of 15 to 24. The UHSBS also shows a surge in the number of people with sexually transmitted diseases (UAC, 2006). Almost half of the women and over one-third of the men surveyed had herpes simplex type 2 virus. About 10 percent of both men and women had Hepatitis B and 3 percent had syphilis. Many were not aware that they had STI. Among those who reported that they had not had STI or symptoms of STI in the past year, half of the women and 40 percent of the men tested

positive for herpes. These results call for advocacy for testing if the spread of STIs is to be curbed (MoH, 2006).

The UNAIDS (2005) report states that Uganda suffered a set-back in their "success story" because of the low numbers of condoms in late 2004 to mid 2005. The *Engabo* condom brand was recalled by the Ministry of Health because of concerns of quality. However, international organizations like UNFPA (Geneva), SIDA (Sweden), DANIDA (Denmark) and DCI (Ireland) immediately stepped in and procured 94 million *Life Guard* brand condoms for distribution at no cost in the public sector. In addition, USAID procured 34 million condoms, of which 23 million were distributed to the public sectors and 11 million used for social marketing. Uganda needs about 80-100 million condoms per annum (UNAIDS statement, September, 2005). The UAC decries that although condoms are available, there is no indication of increased use of condoms among Ugandans (UAC, 2007). However, if the spread of HIV is to be halted especially among discordant couples, there is a need for sustained condom social-marketing alongside a strong emphasis of the other prevention measures (Ouma, *New Vision* July, 2007). The UN is committed to ensuring that there is a sustained and timely supply of condoms in Uganda so that the vulnerable can easily access them whenever needed (UNAIDS, 2005).

Another set back in the Ugandan campaign to curb HIV is the suspension of global funds to Uganda due to corruption and bad governance (BBC, 2007). There is dire need for renewed and continued funding to support health initiatives. However, good governance through fighting corruption should also be equally addressed in Uganda. Generally, although Uganda's HIV infection rates have plateaued in the past 5 years, there is need for constant vigilance (UNAIDS, 2007). The greatest challenge is to have a continued decrease

and to maintain the low rates of infection because currently, the vulnerability of women in all age-groups is still very high (MoH, 2006b).

The survey findings foster a different analysis of the common rhetoric surrounding the HIV epidemic in Uganda. While the literature often discusses rural girls as being vulnerable to infection because of poverty, little research exists to explain how an increase in wealth impacts the spread of HIV/AIDS among women in urban areas. Of great interest is the intricate relationship between gender and all the health situations, from maternal and neo-natal health to HIV and STI vulnerability. The Ugandan context is one of the many that led concerned stakeholders to advocate for the rights of women to better health and preventive care (W.H.O 2002; 2007). The gendered trend of HIV/STI infection among the wealthy, the poor, the older and younger women, makes the call for new strategies and the involvement of youth as a constituency of reform more urgent.

Many studies (e.g. Britzman, 1991; Kanu, 2006; Kickbusch et al, 2002; Nutbeam, 2000; St. Leger, 2001; World Bank, 2007) have called for the preparation of young people for public life responsibilities including advocacy for better life for all. The promotion of critical health literacy is believed to be the way forward in engaging young people in social activism because it makes health a political issue (Orbinksi, 2007; St. Leger, 2001). Some studies (e.g. Giroux, 1995; Sirotnik, 1988) have also suggested that young people must first understand the problem and be given all knowledge that bears upon these issues. However, the World Bank (2007) report suggests that young people are already aware of these challenges but have not been given opportunities to voice and participate in decision-making processes that affect their lives. This observation also underscores the significance of this study, which was conducted in a country considered to be a model for other

developing countries, and African ones in particular, in the fight against HIV/AIDS (UNAIDS, 2002).

1.3. The researcher

I am a Ugandan pursuing a doctorate in curriculum and instruction at the University of British Columbia, Canada. I am also a certified graduate science teacher registered with the Ugandan Ministry of Education and Sports. I therefore have first hand experience with the social and cultural settings of Uganda. Studying outside the Ugandan context has enabled me to encounter a different discourse surrounding health, HIV/AIDS, and gender involving and regarding developing countries in Africa. As a Ugandan, my interest to investigate these issues was piqued for multiple reasons as explicated below:

First of all, because I am a teacher who taught a subject (biology) that addressed health including the topic of HIV/AIDS, studies that posited that teachers in Uganda were not adequately covering these topics at secondary school level challenged me to reflect on my own practice (e.g. Burns, 2002; Kinsman & Harrison, 1999). Given the enormity of these health related challenges, I sought to understand better education practices by developing a research agenda that enabled me to learn about students' needs and how to improve my practice. This enabled me to delve into the literature on health literacy promotion and the role of schools, which became the major focus of this thesis.

Secondly, I have found that the discourse that has recently addressed issues of health, HIV/AIDS, and gender in Uganda has been mixed. The details of this discourse have been mentioned in earlier sections, but of importance were the repercussions should it be true that Uganda has relaxed in its advocacy for better health and the fight against HIV/AIDS. As the call for advocacy is sounded by international bodies like World Bank

and W.H.O, I felt it was important that I investigate these issues and be informed. I needed to have the right information to make an informed decision and contribute towards this advocacy, and to practice my civil rights to demand better public health for all genders, and an education that promotes better health for all in Uganda.

As a researcher, I seized the opportunity to do research in an area with practical implications, which is an important aspect of framing a research study. Numerous studies have investigated adolescents' health including HIV/AIDS but very few have detailed accounts of what adolescents think about their own health information needs. Given that most global health concerns impact adolescents, this was an opportunity to do research that can provide a youth lens to all these discourses concerning health literacy, HIV/AIDS, and gender in the Ugandan context.

As a female, the discourse surrounding how many global health concerns including reproductive health and HIV/AIDS impacts women in developing countries was another motivator. In other words, I was motivated to investigate the social inequities that I had not questioned before, and to think of how to open up discourse that can foster development of a critical voice to engage these inequities and perhaps ensure better health for women. This enquiry with young girls and boys became the starting point because together we began to reflect upon how we reproduce cultural inequities and to articulate or imagine possibilities for change for a better society.

Finally, I have personal experience with the health, HIV/AIDS, and gender related challenges in Uganda: first as a secondary school student when the HIV epidemic was first publicized in 1990, and secondly as a female targeted by HIV/AIDS- related information once it became apparent that girls were more vulnerable to infection. Later I worked as a

community educator on health and HIV/AIDS education programs for rural areas. The sense of the need to improve women's health is part of my self-enquiry process and impacts how I engage these issues in this thesis. My prior experience with this topic (Mutonyi, 2005) and all the factors mentioned above have driven my engagement with the topic under investigation, and provided insights on why and how I designed this study.

1.4. Thesis Layout

The thesis is composed of eight (8) chapters. Chapter one is the introduction of the study, research questions, and significance of the study. In chapter two, the theoretical framework and literature review are discussed. The theoretical framework included youth lens, indigenous knowledge, and gender frameworks. The literature review focused on studies that had highlighted the interrelationship between youth, health literacy, and HIV/AIDS, and policy and health promotion in Africa. Chapter three examines the methodology, analysis and interpretation of data and ethics issues. Chapters four, five, six and seven present findings that respond to the four research questions of this study respectively. Each of these chapters not only presents findings, but includes extensive discussion of the findings in the context of the theoretical framework and literature review.

Chapter four discusses the kinds of information youth in Uganda access. In chapter five, the factors that impact young people's lives and health are discussed, including issues of peer pressure. Chapter six examines the role of gender equality in reducing health and HIV-related challenges in Uganda. In chapter seven, the students' suggestions on the way forward are discussed including issues of corruption, parental involvement, and access to Medicare. In chapter eight, I present a summary of findings, implications for policy, theory, and practice, as well as recommendations for further research.

CHAPTER II

2.0. THEORETICAL FRAMEWORK AND LITERATURE REVIEW

This chapter presents the theoretical framework and literature review that provides perspective to issues investigated in this study. The theoretical framework is the orientation or stance one brings into the study. It is the structure, the scaffolding, the frame of one's study (Merriam, 1998). As Mills (2003) has suggested, doing a literature review helps one to "better understand the problem on which you are focusing" (p. 28). The theoretical framework I use in this thesis stems from the propositions in previous studies that advocate for new approaches or intervention strategies for challenges that impact the health of people in Africa. The study employed three broad based perspectives described in this thesis as i) Youth lens as a theoretical framework, ii) Indigenous social and communicative thought, and iii) Integrative gender frameworks. In each framework I have pointed out how the concept was developed, the underlying assumptions, and the aspects that were drawn on or extended upon during the research process of the current study.

The literature review on the other hand, aimed at understanding how previous studies have interpreted the relationship between health literacy, HIV/AIDS, and gender. This review process also informed me about the discourse surrounding health literacy, HIV/AIDS, and gender in relation to sub-Saharan Africa. Therefore in this chapter, I first present the theoretical framework, which will then be followed with the literature review.

2.1 Youth lens as a theoretical framework

As stated in the introductory chapter, I have drawn on a youth lens proposition by World Bank (2001; 2007) to investigate issues relating to health literacy, HIV/AIDS, and gender within the Ugandan context. The need for youth perspectives and involvement in critical issues impacting society has also been articulated by different critical theorists (Britzman, 1991; Giroux, 1995) and most recently, critical health literacy studies embedded in Freirean theory of critical pedagogy (Kickbusch, 2001; Nutbeam, 2000; St. Leger, 2001). The need to interpret the data through a youth lens was influenced by the suggestion by World Bank that youth should become a constituency for reform (World Bank, 2007). According to the World Bank (2001, 2007) seeking youth perspectives on matters pertaining to health literacy, HIV/AIDS, and gender allows them to not only voice their opinions, but that there are also implications for policy and education.

The need for youth involvement in re-shaping societal practices and democratic activism, for example, better health for all has been articulated (Giroux, 1995; Mitchell, 2006; St. Leger, 2001; World Bank, 2007). However, existing public policies have no provision for a conceptual framework in which youth as a group become the subjects or authors of knowledge. In this thesis I argue that if youth are to be taken seriously, then there needs to be a revisiting of existing public policies and inclusion of youth perspectives. The development of a conceptual framework that includes youth perspectives requires the designing of studies that create group consciousness and questioning how existing policies impact lives of the marginalized people within their communities, similar to Freirean educational model. The youth can come to a group consciousness of their own condition and possibilities that contrasts with the existing accounts about the plight of youth in

developing countries. In this regard, a youth lens has similarities with the standpoint theory that seeks to understand the world through the lens of women (Harding, 2004) but it is distinct because a youth lens focuses on young people as a group.

The youth in this study were given opportunities to be participants as well as authors of knowledge on issues relating to health literacy, HIV/AIDS, and gender. The analysis and interpretation of the youth accounts depended on how the participating students articulated the issues under investigation. The purpose of this study therefore was two fold: getting the perspectives of youth on issues regarding health literacy, HIV/AIDS, and gender, which is a methodological approach, and understanding how youth interpret the issues under investigation, which speaks to a conceptual framework. The details of the methodological process are detailed in Chapter three. The participants' perspectives on issues under investigation were strengthened by using existing accounts in literature on issues regarding health literacy, HIV/AIDS, and gender. The participants were given an opportunity to respond to the dominant discourses on the issues under investigation. In this regard therefore, the responses of youth to existing discourses on issues under study, is in itself a conceptual framework, which I have called a youth lens. In general, this study responds to this conceptual gap in literature on youth perspectives on existing knowledge.

2.2. Indigenous social and communicative thought

The inclusion of this framework stems from the suggestion by World Bank (1999) and other studies (Dei, 2000; Kickbusch, 2001, Majalia, 2004; McQueen, 2001; Mushengyezi, 2003; Nutbeam, 2000) that posit that African communities should come up with research agendas that address their problems. Some researchers have called for the inclusion of non-western perspectives in policies and practices largely promoted by leading

funding bodies like World Bank (Dei, 2000; McQueen, 2001; Wright, 2000). There are numerous studies that have focused on indigenous social and communicative thought especially in post-colonial and socio-cultural theory (Canagarajah, 2002; Dei, 2000, Kanu, 2006; Rogoff, 2003). Dei, Hall, & Rosenberg (2000) define indigenous knowledge as:

> The sum of the experience and knowledge of a given social group and forms the basis of decision making in the face of challenges both familiar and unfamiliar. This knowledge refers to traditional norms and social values as well as to mental constructs that guide, organize and regulate the people's way of living and making sense of their world (p.6).

However in this study, I examine African indigenous social and communicative thought as it relates to health literacy, HIV/AIDS, and gender discourse.

Numerous studies have examined African knowledge systems (Boateng, 1983; Dei, 2000; Reagan, 2005; Wright, 2000), but I draw on Kanu's (2006) work to bring into perspective how health literacy can be achieved in Africa. I must mention that although I draw on Kanu's work (situated in Sierra Leone's cultural practices), I acknowledge that each African community has its own unique history and peculiarities. However, Dei (2000) stated that African communities do share some traditional practices and "a shared history of colonial and imperial imposition of external ideas and knowledge" (p. 72). This section extends this notion to situate the studies that have proposed fresh approaches to health intervention strategies for Africa (Kickbusch, 2001). As Nutbeam (2000) stated, health intervention programs should be done *by* or *with* people not *on behalf* or *to* or *on* people. Achieving Nutbeam's goal requires having intervention strategies that are culturally and ideologically suitable for African communities (Mushengyezi, 2003).

Kanu (2006) examined African knowledge systems that could be re-appropriated for designing an education that is responsive to the challenges faced in Africa today. In this thesis, the challenges refer to the health literacy, HIV/AIDS, and gender-related issues facing Africa. Kanu identified three features of traditional knowledge systems that were not included in the processes of formal education but are still found within the communities. These features are: interwoven theory and practice; communalism; and African communicative thought (use of stories, proverbs, and anecdotes).

2.2.1. Interwoven theory and practice

Studies have shown that learning in indigenous knowledge systems often occurs through apprenticeship, as suggested by Vygotsky (1978). Such education is aimed at preparing people to be of service to the community or, as Kanu (2006) stated, preparing children for adulthood (see also Boateng, 1983; Caldwell et al, 1998; Dei, 2000). Kanu (2006) uses the following illustration:

> If the aim of the indigenous curriculum is to teach farming, for example, children do not receive elaborate theoretical discussions about farming from adults. Instead from an early age, they simply accompany adults to the farms where they participate by observing and imitating what adults do (p.208).

The central idea in this illustration is the active participation of children in the learning process. This example of an indigenous curriculum that interweaves theory and practice is used in this thesis to underscore the suggestions made by St Leger (2001) and the World Bank (2007) to provide youth with a voice in order for them to become a constituency of reform, and engage in public life issues.

2.2.2. Communalism

The idea of communalism in African traditional society was an active component of education for social development (Dei, 2000). Other studies refer to communalism as "African collectivity" (Turay, 2000; Wright, 2000) or "collective responsibility" (Dei, 2000). In communalism philosophy, the self is a product of a group or community, not an individual (Airhihenbuwa, Makinwa & Obregon, 2000). According to Kanu (2006) communalism is described as:

> The doctrine that the group (society) constitutes the main focus of the lives of individual members of the group and that an individual's involvement in the interests, aspirations, and welfare of the group is the measure of that individual's worth (p. 210).

In communalism, a person is required to contribute towards the welfare of the group. Dei (2000) stated that "Africans historically have been socialized to define themselves by their social obligations to the wider community" (p. 75). As Rogoff (2003) observed, in African American communities, people are socialized to work in collaboration rather than competition, as commonly practiced in Western communities. Any child who speaks out or is perceived as always drawing attention to self is regarded as ego-centric. According to Rogoff, this socialization explains why African American students do not speak up until asked to by teachers, as opposed to the practices of Western students.

Dei (2000) explains the effect of communalism as follows:

> In indigenous African world view, the accumulation of individual property/wealth does not automatically accord status and prestige. For the wealthy to be accorded community reverence, social prestige, and status, they must share their wealth with

> the rest of the community.... Africans reject the Hobbesian image of the competitive, isolated individual who lives in fear of others and is protected from them by the state or community (p. 75).

Kanu (2006), however, suggested that communalism as a concept has been lost in schools where students are taught to distinguish themselves from others, leading to the "rejection of communal learning values such as interdependence and cooperation" (p. 211). Therefore, the spirit of communalism needs to be revived or re-introduced as a means of dealing with the problems faced by Africans today (Dei, 2000).

In regard to current challenges like health literacy, HIV/AIDS, and gender, communalism could be central to educating people about the value of ensuring the welfare of others like women and youth. Literature shows that women and youth have poor health because they are marginalized (Baylis, 2000; Mitchell, 2006); therefore it is important to appeal to the human and humane value embedded in communalism to make the health issues of women and youth topical. This philosophy could be used in gender-equality campaigns, given that "communalism maximizes the interests of all the individual members of society" (Kanu, 2006, p. 210). In this thesis, I contend that perhaps communalism could replace the social capital approach to health promotion and community empowerment. The underlying assumptions of these approaches are the same, given that both advocate for the interests and welfare of the group (society). The difference however is that while communalism is embedded in socialist philosophies (Kanu, 2006), social capital theory is embedded in economics philosophy (Hawe & Sheill, 2004). Social capital theory and design caters to the economically wealthy and not the marginalized

(Gillies, 1998) while communalism was designed to cater for the maintenance of community wellbeing (Dei, 2000).

2. 2.3. African communicative thought

Communicative modes of story telling, anecdotes and proverbs largely characterize African traditional knowledge systems (Boateng, 1983; Kanu, 2006; Reagan, 2005; Wright, 2000). Kanu (2006) suggested that proverbs and anecdotes are powerful tools that "teach without being intrusive" (p.212). Boateng (1983) contended that proverbs and anecdotes conveyed moral lessons to youth. Rogoff (2003) stated that "stories are used to foster attention, imagination, metaphoric thinking and flexibility and fluency of thought in understanding the natural and moral world and the meaning of life" (p. 293). Kanu (2006) summed up the power of these communicative tools as follows:

> Anecdotes and proverbs can be understood as metaphors to guide moral choice and self examination because when reflected upon, these pithy sayings act as mirrors for seeing things in a particular way...they serve as important pedagogical devices because they provide experiential case material on which pedagogical reflection is possible (p. 212 emphasis mine).

The highlighted portion relates to Boateng's (1983) description of the power of stories, proverbs and anecdotes. Boateng stated that lessons drawn from these communicative tools help the child and the adult to see the world from the same view point, similar to Kanu's statement *"these pithy sayings act as mirrors for seeing things in a particular way."*

According to Kanu (2006), these tools can be used to address "the problem of separation between school and the community that was introduced during colonial

administration" (p.213). Wright (2000) also suggested that the use of these communicative tools would introduce the community into the school and the school into the community because students and elders would both be involved in story gathering. This would re-establish the links between school and community that once existed in indigenous education systems. The use of stories, proverbs and anecdotes would resurrect both in the school setting and in the general community some of the content of indigenous education, and some of the reverence for the wisdom of elders and traditional performers that existed in traditional society. These thoughts are developed in this thesis to provide the possible anti-dote to the policy issues that led to the separation of communities and schools, and parents and youth.

However, one cannot focus on the use of stories, anecdotes and proverbs without mentioning the role of music, poetry and drama as a means of teaching in African education systems (Kendrick & Mutonyi, 2007; Morrison, 2003; Mushengyezi, 2003; Norton & Mutonyi, 2007; Silver, 2001; Singhal, 2004; Singhal & Rogers, 2003). Boateng (1983) posited that African education systems boast of their entertainment nature. For example, storytelling was often characterized by periodic singing, which kept listeners awake, interested and involved. In contemporary literature, the inclusion of entertainment in educating communities about health issues is referred to as Education-Entertainment (Singhal, Cody, Rogers & Sabido, 2004). The entertainment aspect of the traditional education system has already been used in health promotion, especially in educating people about social issues relating to HIV/AIDS. Numerous studies have documented the use of education-entertainment or a confluence of performances (story, song, drama, poetry) to educate youth, women, and communities, about malaria, HIV/AIDS and gender (Kendrick

& Mutonyi, 2007; Kickbusch et al, 2002; Majalia, 2004; Morrison, 2003; Mushengyezi, 2003; Norton & Mutonyi, 2007; Silver, 2001; Singhal, 2004; Singhal & Rogers, 2003). Other studies have reported that the use of stories, proverbs and anecdotes has been harnessed to promote health literacy through the media (Gupta, Katende & Bessinger, 2003; Singhal et al, 2002; Valente et al, 1994).

All the studies that have reported on the power of indigenous communicative tools in health literacy promotion have concluded that they have numerous advantages. The advantages include: engaging with the audience; developing messages from what people know (Silver, 2001); making people own the story as they apply it to their own lives (Majalia, 2004); giving people voice, especially women, who would otherwise not have participated (Kendrick & Mutonyi, 2007; Morrison, 2003); using repetition, which helps people remember the message (Norton & Mutonyi, 2007); intergenerational communication in which older people learn from the youth and vice versa (Boateng, 1983; Wright, 2000); utilizing local resources and so are inexpensive (Mushengyezi, 2003); and the messages are relevant to the lives of the communities and foster discussions for social change (Kickbusch et al, 2002; Morrison, 2003; Singhal, 2004). These studies have concluded that traditional modes of communication can be used in health promotion.

In general, I contend in this thesis that African traditional knowledge systems could make a significant contribution to designing a curriculum that promotes health literacy. The different aspects of the indigenous knowledge systems could be linked to policy issues like involving youth (World Bank, 2007), tackling social determinants of health (UNAIDS, 2005), and educating for attitude and behaviour change (W.H.O 2002; 2007). The knowledge gaps in reproductive health issues (Burns, 2002) could be overcome with the

adaptation of indigenous sex education institutions like *senga* (Muyinda et al, 2004), and the issues of community empowerment could be promoted through the concept of communalism (Dei, 2000; Kanu, 2006). The involvement of youth in public life issues (Mitchell, Stuart, Moletsane & Nkwanyana 2006; St. Leger, 2001) could be promoted through drawing upon the idea of communalism and interweaving theory and practice (Kanu, 2006). These are some examples of the propositions made in this thesis regarding health literacy promotion in Uganda. The next section discusses gender equality frameworks and how these were conceptualized to inform the designing of this study.

2.3. Integration of gender frameworks

In this study, I advocate for the integration of existing gender frameworks if gender equality campaigns are to be effective in Uganda. Recent studies done in Uganda have advocated for a particular framework for gender equality promotion, including the capabilities approach (Jones, 2008; Kakuru, 2006) or the Gender and Development approach (Mirembe & Davies, 2001). However before I discuss gender frameworks, it is important to establish my definition of gender. In this thesis, I have adopted Mendoza's (1997) definition, which is:

> Gender is what it means to be a male or a female and how that defines a person's opportunities, roles, responsibilities, and relationships. Gender is a sociocultural variable and refers to roles, behavior, and personal identities that the society or culture prescribes as proper for women and men. These attributes, opportunities and relationships are socially constructed and learnt through socialization processes. Gender roles vary across determinants such as race, culture, community, time, ethnicity, occupation, age, and level of education (p. 1, emphasis mine).

This definition was comprehensive and could easily be translated to the students who took part in this study. The definition enabled the students to understand the difference between gender and sex (biological differences). Also, the definition, especially the highlighted portion, allows room for representing different kinds of gender relations across cultures and contexts. Lastly, the term gender is used inclusively in this thesis; that is, it refers to males and females, not males alone or females alone. The participants in this study were male and female students. Next, I discuss the gender frameworks.

2.3.1. Gender frameworks

I particularly draw upon Unterhalter's (2005) work to situate the discussion in this section. Unterhalter identifies four approaches to gender equality in education (see Table 3 below) and analyses them to provide an understanding of their strengths and limitations.

Table 3: Contrasting gender frameworks

Framework	Linked theory	Understanding of gender	Understanding of equality
Women in development (WID): from 1970s to the present	Modernization; human capital theory	Gender= women, girls	Equality of resources. Sometimes termed parity
Gender and Development (GAD): from 1980s to the present	Structuralism; Marxism	Constructed social relations, power	Redistribution of power. Sometimes termed equity
Post-structuralism (from 1990s to the present)	Pre-colonial theory	Shifting identities	Stress on difference
Human development (from 1990s to the present)	The capability approach	Inequality and capability denial	Equality of rights and capabilities

Source: Modified and adapted from Unterhalter (2005) page 16.

As shown in table 3 above, each framework has a different interpretation of the concept of gender and equality, and as a result, each has a particular focus or audience. For

example, the WID approach is concerned with issues relating to women and girls. This approach underscores the social benefits of educating women and girls and how their education impacts development and family healthcare. In this approach, equality is about numbers; that is, how many women or girls are in schools, how many are employed, how many are in leadership positions and how many are involved in decision-making. This approach has been instrumental in advocating for girls' education through giving stipends and scholarships to needy and yet astute female students, and providing feeding programs in schools. The WID approach is popular among policy-makers and aid agencies like the World Bank because it uses economic analyses, an approach that "speaks the same language" as that of these leading funding bodies (Robeyns, 2006; Robinson-Pant, 2004). The MDG 3 understands gender equality as parity, and underscores instrumental gains associated with girls' education. As shown in table 3 above, WID is still used today and has become a major accountability tool in representing gender equality for many governments (Leach, 1998; Leach, Fiscian, Kadzamira, Lemani & Machakanya, 2003). Governments use enrolment numbers to argue that gender equality is being achieved (Robeyns, 2006).

The limitation of the WID approach lies in the fact that it does not address questions of exploitation, subordination and social division. In addition, in this approach the education of women and girls "is for others not for themselves" (Unterhalter, 2005, p. 18). Robeyns (2006) suggested that in the WID approach, education is seen as an investment, and so communities that view boys as having more productive potential will still not invest in girls' education. Generally, the women are still left to shoulder all the responsibilities for the unpaid work in the household, caring for the children and family members as it usually was. In regard to women's and girls' health, therefore, this approach cannot adequately

address the systemic inequalities like domestic violence that are seen as major contributors to high HIV/AIDS prevalence rates among women and girls. In addition, this approach can lead to unintended consequences like blaming women for the poor health of the children or family (Baylis, 2000; Longwe, 1998).

The GAD approach, on the other hand, is interested in highlighting the social dimension of gender inequality (Longwe, 1998; Unterhalter, 2005). The focus is on "the sexual division of labour inside and outside the household, forms of political mobilization, and changing gendered structures of power" (Unterhalter, p. 21). In the GAD approach, the analyses of gender make a distinction between practical gender needs like food, water, and shelter, and strategic gender interests like addressing deeply entrenched forms of gender discrimination, sexual violence, political representation and workplace policies. Equality concerns the removal of structural barriers to gender equality like unfair laws, labour market practices, and management regimes in institutions. This approach uses the philosophy of empowerment and is concerned with equity or fairness of resource distribution. This approach has been instrumental in making topical issues of women's oppression and in the enactment of policies that take into account the gendered processes of decision making. It also led to the development of the concept gender-mainstreaming in policy issues. GAD has not been used by leading aid agencies but it has been drawn upon by Non-Government Organizations (NGOs) that are interested in addressing gender-relations in developing countries. It is popular in academic circles as well, especially in studies focusing on gender (see Longwe, 1998; Mirembe & Davies, 2001).

The limitation of the GAD approach is the universal categories associated with it; that is, it does not recognize the different gender relations across races, and so promotes a

Western and Eurocentric understanding of gender equality. Robeyns (2006) posited that the overemphasis of legal and moral rights associated with GAD makes governments execute agreements with precise stipulations without adequate measures for policy implementation. For example, governments will make public proclamation of equal rights, but once granted, no further claims on social change can be made. Therefore, although the rhetoric on protecting people's rights becomes common, in reality, social oppression and gender imbalance will still exist (see Mirembe & Davies, 2001).

According to Unterhalter (2003), the post-structuralist approach to gender equality centres on questions of identity. It advocates for the recognition of difference and has been highly used in the discourse on sexual orientation, especially in light of the HIV/AIDS epidemic. This approach is common in academic publications and is popular in North America, Western Europe and Australia. However, this approach has not had an impact in African communities, with the exception of South Africa. The framework is used by academics interested in issues of identity and sexuality, especially in critiquing the process of marginalization of non-mainstream identities like gays and lesbians.

The fourth approach is the rights and capabilities framework. Capabilities are seen as "the various functionings that a person can attain-- where functionings are the constitutive elements of living, that is doing and being" (Robeyns, 2006, p.78). Capabilities are the opportunities someone has to attain states of being and doing. In this approach, "equality needs to be based on an understanding of human capabilities, that is what it is that each individual has reason to value" (Unterhalter, 2005, p. 28). Therefore, something must matter intrinsically whether or not it additionally also matters instrumentally. The rights and capabilities approach contains an ethical injunction with regard to formulating policy

for change. Therefore, it is concerned with not just the provision of education facilities but ensuring that the children get quality education, a concern that comes from a moral duty not a legal duty. The parents ensure that children stay in school by providing an enabling environment. This approach therefore is concerned with the inner transformation of individuals, resulting in the tackling of external oppressions (Sen, 1999). The approach offers a language and framework (Robeyns, 2006) that groups and individuals can use to formulate their assessments and proposals for change. The limitation of this approach is that it is relatively new and is common in academic and think tank circles only.

2.3.2. A case for the integration of frameworks

Based on the discussion of the different frameworks used in gender equality promotion, I argue for integration rather than fragmentation of frameworks. As Unterhalter (2005) noted, a closer analysis of these frameworks will show both some commonalities and also the individual importance of each approach. In this thesis I argue that WID and GAD frameworks can be instrumental in making women's and girls' issues topical and political. This is important as one cannot deny the benefits of educating women. Robeyns (2006) wrote in relation to the WID approach: "this is important as having some basic skills or having a decent education can make all the difference between starving and surviving and between merely surviving and having a decent life" (p. 72).

The post-structuralist approach and the rights and capabilities approach can both be instrumental in enacting policies that take into account the differences and individual circumstances of women, men and children. These approaches provide a multidimensional investigation of gender issues, which are currently lacking in existing policies. Both approaches are concerned with the diverse social settings that impact equality. For

example, the capabilities approach highlights the importance of securing the social settings where the capabilities will be articulated. The social setting could be within a household or within the larger community. In contrast to the WID and GAD approaches, the important aspect of this approach lies in its providing the tools with which an individual can begin to articulate what is of value, without trying to fit into existing universal categories of the roles and responsibilities of women and men.

As regards health literacy, HIV/AIDS, and gender, all these approaches are important for enacting policies that protect women from domestic violence, and girls from molestation. The capabilities approach, which concerns itself with inner transformation, could be used in dealing with issues of attitude and behavioural change in relation to the HIV/AIDS discourse in developing countries. The post-structuralist approach can be used to make topical issues of marginalized identities not only as they relate to HIV/AIDS but as they relate to issues of gender and health as well. This approach is inclusive because the challenges experienced by men that are not highlighted in WID and GAD, can be investigated under the post-structuralist and the capabilities approaches. The integration of frameworks is crucial given that Uganda, like many other developing countries, is dependent on foreign aid and follows international policies (e.g. the MDGs) that are embedded in different theoretical perspectives regarding the promotion of gender equality. In summary, these theories can each make unique contributions to the gender and equality discourse, and therefore in this thesis, where opportunities arose, a particular approach was used to interpret or understand students' responses provided in this study.

Next I discuss the literature review of this study. First, I have framed the issues by presenting studies that highlight the need for health literacy promotion. Then, why focus on

women and youth. The section concludes with previous studies that were used to situate the current study in the larger discourses on health literacy, HIV/AIDS, and gender.

2.4. Health literacy: beyond traditional health education

Although the term health literacy has been in use for over thirty years, the concept has yet to gain prominence in health promotion discourse worldwide (Bernhardt, Brownfield & Parker, 2005; Nutbeam, 2000). Bernhardt et al (2005) posited that for decades, health literacy and health education have been used interchangeably in many studies, but it is actually important to make a distinction between them. Health education is defined as the ability to apply literacy skills to health related materials such as prescriptions, appointment cards, medicine labels and directions to healthcare services (Bernhardt et al, 2005). This explains why literacy was promoted alongside health programs because the assumption was literacy had a direct impact on people's health practices (Nutbeam, 2000). However, over the years, it has become apparent that literacy in itself does not lead to better health practices (Kickbusch, 2001; Nutbeam, 2000).

For example, a study found that in America, although 90 percent of the people are literate, not all have good health practices (Bernhardt et al, 2005). The functional understanding of the relationship between literacy and health was inadequate for educating patients with chronic illnesses because it missed much of the deeper meaning and purpose of health literacy (Nutbeam & Kickbusch, 2000). Within developing countries however, researchers found that the relationship made between health and literacy neglected the social dimensions that are important in people's decision-making processes (Airhihenbuwa et al, 2000; Kickbusch, 2001) Therefore, some studies have suggested that a distinction should be made between literacy and health practices, leading to the development of the

term health literacy (Kickbusch, 2001). According to Nutbeam (2000) "health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (p.264: citing W.H.O 1986). Kerka (2000) and Ratzan (2001) have suggested that the cognitive skills include accurately interpreting and evaluating media reports, navigating healthcare systems, and effectively accessing and using health information. The social skills include self-confidence, negotiation and assertiveness, and the resulting individual health-related behaviours associated with these attributes (Kickbusch et al, 2002). The purpose of health literacy is empowerment (W.H.O 1986).

St. Leger (2001) has suggested that in health literacy promotion, women and youth should be given opportunities to develop skills in advocacy and to achieve a sense of empowerment through social activism. This is crucial today because the fight against HIV/AIDS in Africa needs collective action against social and economic inequalities that impact people's health (Kickbusch et al, 2002). Kickbusch (2001) posited that a Freirean model or critical conscientization should be used as the tool for empowerment. Also, St. Leger (2001) suggested that young people be given audience and opportunities to articulate their visions of how people's health can be improved. In this thesis, the suggestion made by St. Leger (2001) to empower youth was drawn on and related to the call made by the World Bank (2007) report to make young people a constituency of reform by encouraging them to participate in public life issues. In addition to the call for youth empowerment was the suggestion that youth be given audience and opportunities to articulate their views (St. Leger, 2001). In this thesis, the proposition was extended to the observation made by Emmanuel Jaminez that "*parents do not represent the views and aspirations of young*

adults like they do for younger children" (World Bank Report, 2007; p. 25). This suggestion culminated in the focus on having a youth lens on issues pertaining to health literacy, HIV/AIDS, and gender within the Ugandan context.

Generally in this thesis, I posit that Uganda's health intervention strategies should move beyond traditional health education (provision of health facts to individuals) to health literacy, which includes individual and community activism. Furthermore, I argue that promoting health literacy will lead to collaborative action between communities and governments, as opposed to the current situation where people think they have no role to play (Nutbeam & Kickbusch, 2000). As Nutbeam (2000) observed, previous educational programs may have had the unintended consequence of leading to intervention strategies done *on behalf* of the people through their governments. Kickbusch et al (2002) suggested that health literacy programs therefore should be culturally relevant.

2.5. The context and focus: women, youth and life chances in Africa

The studies presented in this section situate the discourse on health literacy and HIV/AIDS on the plight of women and youth. According to UNAIDS (2006), and the W.H.O (2005) HIV/AIDS reports, of the estimated 34 million people living with HIV/AIDS, 24.7 million are in sub-Saharan Africa. This disease has claimed the lives of many teachers and people of considerable wealth in sub-Saharan Africa, leading to the growth of poverty in many parts of the continent (Bennel, Hyde & Swainson, 2002; Kickbusch, 2001). The number of orphans and child-headed households (UNAIDS, 2005) and grandparent-headed households (Lewis, 2006) increased. HIV/AIDS has impacted school attendance levels for many orphaned children, even in light of free education (Bennel et al, 2002; Kakuru, 2006; Mitchell, 2006; UNESCO, 2002). Numerous studies

have posited that although everybody in Africa has been impacted by HIV/AIDS, women and youth have borne the brunt of the epidemic (Baylis, 2000; Gillies, 1998; IDRC, 1997; Kickbusch, 2001; Mohga, 2001; UNAIDS, 2005; World Bank, 2002, 2007; W.H.O 2007).

As mentioned in the introduction, the current statistics on HIV prevalence rates in Africa show a drastic decline of the disease, and yet the plight of women and youth and their life chances remains precarious (UNAIDS, 2005, 2007). In East Africa, which includes seven countries (Burundi, Eritrea, Ethiopia, Kenya, Rwanda, Uganda and Tanzania), the prevalence rate remains at a high of around 7 percent. In West and Central Africa, the prevalence rate is at 5 percent, and in Southern Africa (Lesotho, Swaziland, Mozambique, Malawi, South Africa and Zimbabwe), the prevalence rates are as high as 23 percent (W.H.O 2005). However, the W.H.O (2007) report draws our attention to the fact that social determinants of health like poverty and gender imbalance have not been adequately addressed although these factors were responsible for the rapid spread of HIV/AIDS in Africa.

The most affected groups are women, children (through mother-to-child transmission), and youth (W.H.O 2007). The prevalence rates between men and women in all age groups differ, with women being 2 to 5 times more vulnerable to infection compared to their male counterparts (UNAIDS, 2006; W.H.O 2005). Chan (2007) posits that many women infected with HIV/STI do not access treatment and preventive care, making their life chances minimal. In order to put the challenges in perspective, the next sub-section focuses on which factors enhance the vulnerability of women as discussed in the literature. Later, the factors that impact the health of young people are also discussed.

2.5.1. Women, HIV/AIDS and life chances

Gender-power relationships and socio-cultural practices that impact women's health are the main focus of the discussion in this section.

a) Gender-power relationships

Some studies have suggested that African women have limited negotiating power in their sexual relationships (UNESCO, 2001). The reason is that most African communities are partrilineal, making women submissive to their male counterparts. This submissiveness is extended into marriage and is fostered by the practice of paying bride price (Castle & Kiggundu, 2007; Lewis, 2005; Mirembe & Davies, 2002). Also some women experience domestic violence, or abusive relationships, and yet the women have no power for negotiation. Many women think domestic violence is normal or expected and will not challenge their husbands or boyfriends over such matters (Chan, 2007). In relation to HIV/STI prevention, many women who face this violence will not insist on condom use in fear the request will result in a beating (Chan, 2007; HRW, 2002).

Furthermore, because of this low social status, women are also denied access both to health and HIV-related information because they are burdened with household chores and have limited time to listen to health programs (Castle & Kiggundu, 2007; Mohga, 2001). Mohga (2001) has stated that low social status also contributes greatly to general health inequalities experienced by women, ranging from access to STI treatment to maternal health care, like ante-natal check-ups or family planning. Furthermore, because of their low status, many infected women do not know about the ARVs, and that mother-to-child HIV transmissions can be controlled (Kickbusch et al, 2002). Some studies have also reported that many women fear to get diagnosed for HIV/AIDS because of the

repercussions should they find themselves to be positive (W.H.O, 2005). These repercussions include abandonment and stigmatization, which affects women who are economically dependent on their husbands. Therefore women engage in unprotected sex and get exposed to possible HIV/STD infection (Baylis, 2000).

Therefore, although the number of HIV infections among pregnant women is seen to be decreasing in many parts of Africa (UNAIDS/W.H.O 2005), the factors, like the gender-power imbalance, which make women vulnerable to infection are still not addressed (W.H.O 2007). Furthermore, while Chan (2007) noted that more women are now receiving ARV treatment because women advocacy groups have raised awareness, she cautions that *the epidemic gives us no luxury of time for slow change processes* (W.H.O July 2007 newsletter). Governments need to tackle gender inequalities that lead to intimate partner violence. In Uganda, the Ministry of Health is calling on the government and other stakeholders to focus on married people because statistics show that the number of new infections is higher among married people (Ouma, New Vision report, July, 2007). Kickbusch (2001) observes that the numbers of educated women dying from HIV-related illnesses are high although in theory, these women are perceived to be empowered. Kickbusch associates this trend with the low social status women hold in society.

Generally, gender-power imbalance coupled with poverty and poor healthcare services puts women at a greater disadvantage compared to their male counterparts, and affects their life chances (Chan, 2007; Mohga, 2001). As a result, their children's health is also put in jeopardy as evidenced in high child mortality rates. Because of these reasons, the call for social activism and advocacy for gender equality for better health for all is now deemed to be critical (Nutbeam, 2000, St. Leger, 2001). However, some researchers

caution that the focus on women's empowerment can lead to a negative result because the burden of responsibility is placed on the shoulders of the women with little support from their male counterparts (Baylis, 2000; Leach, 1998; Mohga, 2001).

b) Social and cultural practices

The social and cultural factors that contribute to poor health practices include the attitude towards illness (Hobcraft, 1993; Kickbusch et al, 2002). Hobcraft (1993) has observed that many communities in Africa have a fatalistic view of illness especially because most epidemics are so overwhelming with no hope for reprieve. Other studies have noted that the same attitude is extended to HIV-related deaths, as many accept the disease as another part of their life (Kickbusch et al 2002; UNAIDS, 2002)

Coupled with the resigned attitude toward illness are the superstitious practices common in some communities in sub-Saharan Africa (UNESCO, 2001). These superstitious practices have resulted in misconceptions causing many people to not readily seek medical care but rather to visit traditional healers (Obbo, 1996). The growth of stigma against HIV-infected persons is attributed to the belief that the disease is a curse. The stigma makes infected persons fear to declare their status which in turn creates a high risk for possible infection should the person still be sexually active (Kickbusch et al, 2002; UNESCO, 2001). Although campaigns have been done to encourage people to get tested for HIV, so that statistics on how many people need ARVs are established, many people do not want to know their status (W.H.O 2005). The negative effect is that people in discordant relationships and especially women, expose themselves to possible infection as the couples will most likely not have protected sex.

Other cultural practices that create an environment of vulnerability are wife inheritance, polygamy and the participation in several sexual networks (Pool et al, 2000). These practices when combined with the low social status of women and children provide a dangerous environment for women's health especially in relation to HIV and STI infections, and access to treatment (Lawson, 1999; Mohga, 2001). Given that most of these diseases are associated with sexual promiscuity, many infected persons fear to know their HIV/STI status. Men who learn they are infected secretly seek medical attention without realizing the possibility of re-infection if their spouses are not treated as well (Mohga, 2001). This observation is true for the Ugandan situation where the survey revealed that many people who have STIs either were unaware of it or did not truthfully declare their sexual history (UAC, 2005). As observed by UNAIDS/W.H.O (2005), an STD infection increases the chances of possible HIV infection.

Culture is also seen to play a role in the practice of condom use among sexually active men. In Uganda, for example, few men are using condoms because they think it is not culturally appropriate. This belief that condoms are not culturally appropriate coupled with the fact that condoms are also associated with sexual unfaithfulness is the reason sexual transmission of HIV remains high (Kickbusch et al, 2002; MoH, 2006). Chan (2007) and Lewis (2006) caution women that marriage is not a safe haven as many more infections are occurring among intimate or married partners.

Comment

If these practices are put in the larger perspective, the environment does not provide room for better health practices. The fact that few people in remote communities access clean drinking water has continued to impact the number of children dying due to diarrhea

or cholera and general water-borne diseases (UNICEF, 1999). These people may be living in a poverty environment; that is, their children may be malnourished and the women themselves may be in such poor health that they cannot adequately breastfeed (Ahmed et al, 2000). The fact that HIV and malaria are also claiming so many lives also compounds the situation and life chances of women (Muhe, 2002).

However, with the investments made over time, there is improvement in the health trends in sub-Saharan Africa. For example, there are declines in the number of HIV related-deaths due to the use of ARVs, and there are declines in child-related deaths due to improved sanitation practices and increased access to safe drinking water (UNICEF, 1999). Notable increases in the number of people seeking medical care compared to those using traditional medicine, with many changing their views towards illness, have also been reported (Cocks & Dold, 2000; Juntunen, 2001; Konde-Lule, Tumwesigye & Lubanga, 1997). In relation to bride price, the Ugandan constitution has given provision for each community to revisit the practice. The government did not ban the practice because of its place in people's cultures. Bride price was considered by most African communities as a form of cementing relationship between families, an appreciation to the girls' family for bringing her up and in recognition of the fact that her labour will benefit the bridegroom's family (Fuglesang, 1997). Byamukama (Sept. 2006) reports that there are increasingly more families which do not demand bride price in Uganda. Reasons for this vary, but include religion as Christians do not consider payment of bride price as being in consonance with their religion. Other families have begun equating the practice to purchase of their daughter. Byamukama argues that although Article 37 of the constitution provides for the right to practice and promote one's culture, this right is not absolute. Article 32

provides that laws, cultures or traditions which are against the dignity, welfare or interest of women or which undermine their status are prohibited by the constitution. This provides the basis for critical examination of how bride price contributes to the commercialization of girls, domestic violence, and cohabitation where the intending groom's family may not have resources to foot such an expensive venture (Allafrica.com, 2007).

However, population explosion is becoming another looming threat. If the population explosion is not controlled, it will strain the available resources leading to a resurgence of poor healthcare services (UNDP, 1999). Uganda is said to have one of the fastest growing populations and yet it lacks the resources to cater for such a growth rate (United Nations Population Fund, UNFPA, 2007). The UNFPA (2007) has suggested that there is need for advocates to understand the cultures in which they are working, and then to determine how they can partner with communities to bring about required changes like gender equality, and better health practices. Generally, tackling gender-power imbalance and negative socio-cultural practices, alongside fighting poverty and providing good healthcare services are all seen as crucial in curbing the health challenges in sub-Saharan Africa (Orbinksi, 2007). The success of these efforts will take a longer time than anticipated by aid agencies because cultures change but at a slow rate. Chan (2007) has pointed out that an epidemic like HIV gives us no luxury of time, and so fast action is required especially in ensuring women's health. Significant gains have been reported in some areas, yet the role of social norms in impacting the health practices of communities especially in relation to HIV/STI remain a challenge (UNAIDS, 2006). Some studies have focused on the plight of women and advocate for the protection of women's rights to better health and life, especially in relation to HIV/AIDS (Chan, 2007; Leach, 1998).

2.5.2. Young people, health, and HIV/AIDS

In this thesis, the terms "young people" and "youth" are used interchangeably, but I provide some clarification of these terms of reference in this section. Clarification is provided because the terms are understood differently in various communities. In Uganda for example, the term "young people" refers to those in the stage of transition from childhood to adulthood, and encompasses adolescents (10-24 years), teenagers (13-19 years) and youth (18-30 years). Thus, young people are all those in the age range of 10-30 years (UBOS, 2006). Therefore, data from Uganda on young people may include an age group that is identified differently in other communities with different bracketing of ages. However, most of the studies cited in this study use the term "youth," described as those who are 15-24 years old. The term "youth" is used for consistency but where I need to expand the concept to accommodate different age ranges, "young people" is used.

As mentioned in earlier sections of this thesis, the number of young people living with HIV or who have died of HIV in sub-Saharan Africa has been very high (UNAIDS, 2001). The trend of prevalence has risen above the teenage years (13-19 years) for most of the communities of sub-Saharan Africa, and noticeably so in Uganda and Burundi (UAC, 2005; UNAIDS/W.H.O, 2005). The current rates of prevalence reveal that the most vulnerable are those within the 20-25 years range (W.H.O, 2005). According to this W.H.O report, the reason for this high prevalence is the increasing number of youth having pre-marital sex with fewer using condoms or contraceptives. The success in reducing the infection rates among 15 – 19-year-olds is attributed to a reported change in behaviour of many teenagers. In recent years, especially for those in school, the average age of first

sexual encounter has increased from 15 years to 19 years for boys and 18 years for girls (UNAIDS/W.H.O, 2007).

However, taking the general population of young people into account (both those in school and not in school), the first sexual encounter for most young people still remains at 15 years (below the age of consent which is 18 years). The 2002 census revealed that about 60 percent of the girls had a baby by the age of 15, with many already married (UBOS, 2005). Some communities in sub-Saharan Africa are still battling the challenges of early pregnancy and other reproductive health related issues. As MNPI (2003) observed, reproductive health services in many sub-Saharan countries are not adequate, and these centres have few skilled birth attendants. In addition, these statistics reveal that few people are adhering to the defilement law that calls upon parents and communities to report any man who has sex with a girl below the age of 18 years.

Some studies (e.g. Burns, 2002; Kakuru, 2006) have provided some understanding of why youth engage in early sex or remain vulnerable to possible HIV/STI infections, and early pregnancy in case of the girls. The factors selected for elaboration below apply to the youth within schools or unmarried because the previous section focused on married women. Like in the previous section, these factors include poverty, gender relations, social and cultural practices. But the way these factors impact unmarried young people differs from the way they impact married people. The impact of each factor is detailed below:

a) Poverty

For young people, poverty drives them to migrate into urban areas with the hope of overcoming the desperation experienced in the rural areas (UNFPA, 2007). Many of these young people, however, end up living in slum areas which have poor hygiene and

sanitation services, making the young people vulnerable to deaths from diseases like cholera. When cholera outbreaks occur, the majority of the people affected are those living in urban slum areas (Orbinksi, 2007). Some youth end up practicing prostitution as a means of earning money. The young women also fall prey to older men soliciting sexual favors in exchange for expensive material goods such as cell phones and clothes, or for basic needs like food and rent money (Kickbusch et al, 2002). Intergenerational sexual relationships are common in African communities, a practice that has to be discouraged to protect young people against HIV/STD infections and unplanned pregnancy (UNAIDS, 2007). These cross-generational relationships perhaps explain why a larger proportion of people living with HIV/AIDS in this region are female.

As a result, the number of unplanned pregnancies keeps growing, with many young people unable to attend ante-natal care or to afford the cost of a skilled birth attendant (Kyomuhendo, 2003; Nutbeam, 1998). There are growing numbers of abandoned children in urban areas because the parents cannot afford to take care of them (Cohen, 2002). There are people with either HIV or an STI who will not access treatment or complete treatment because they cannot afford healthcare fees. Many girls do not use contraceptives as they are not in control of when they have sex (Mohga, 2001). Fighting poverty remains the first priority for most development-oriented aid agencies, as the effects are far-reaching in relation to health and quality of life (World Bank, 2002). The UNFPA (2007) calls upon funding bodies to develop projects for the urban poor. UNFPA posits that most funding bodies design rural-oriented projects forgetting the urban poor. However, based on the current trend of urban migration, there will be more poor people living in urban areas than in rural areas. Interestingly, Madizingira (2001) has observed that although the funding

bodies design programs for rural areas, the implementation criteria are designed for urban areas. These programs can therefore be used in urban areas.

b) Gender inequalities

Coupled with poverty are the gender inequalities that place girls at a lower social status than boys. For decades, it has been noted that many African communities do not value girls as productive members of the society, so that when it comes to education, the boys will have school fees while the girls are left to do household chores (Leach, 1998; Leach et al, 2003; UNESCO, 2001). Furthermore, because of their low social status, young girls are vulnerable to sexual harassment by older men especially, but also by boys their own age (Kickbusch et al, 2002). In some communities, sexual status and masculinity are largely defined by numbers of sexual partners, and femininity by desirability as a girlfriend (Gupta, 2000). The process can be intensely competitive, making it socially taboo for boys not to have a girlfriend and for girls to reject sexual advances (Mirembe & Davies, 2001). Therefore, even as young people are encouraged to abstain from sex as a means of avoiding HIV/STI and early pregnancy (UAC, 2004), the social and gender norms apply a different pressure on these youth.

According to UNESCO (2001), some African communities feed girls with less nutritional food than they feed boys because of the belief that boys are more valuable or more prone to early death, especially as children. Given that it is more prestigious to have a son than a daughter, special care is more frequently accorded to the boys than to the girls (Singhal, 2004). As a result, many girls grow up with lower self-esteem, which draws them into abusive relationships in their adult lives. The boys also face the pressure of living up to community expectations, and many leave home when they fail to meet these expectations

(Gupta, 2000). There are many unemployed young people living in urban areas who could have prospered in the rural areas, but because of community expectations were driven away from home (UNFPA, 2007).

Therefore UNAIDS and UNESCO have developed a life-skills curriculum which has a strong emphasis on self-esteem (Norton & Mutonyi, 2007; UNAIDS, 2004). In addition to the life-skills curriculum, UNICEF developed the *Sara* animation film series to educate communities about the value of girls and the need for good nutrition for both girls and boys. This series also promotes gender equality through advocating for equal opportunities for education (Singhal & Rogers, 2003). These series were aired in eastern and southern African communities and within schools where such gender norms were practiced. However, when Kakuru (2006) studied teachers' competency in dealing with youth who have been impacted by HIV/AIDS, she found that gender inequalities and lack of support for girls and vulnerable children still existed in rural Ugandan schools. Similar findings were reported by Mirembe and Davies (2001) and Mirembe (2002). Therefore, although some studies have reported some change (Norton & Mutonyi, 2007; Singhal & Rogers, 2003), more needs to be done to ensure that gender equality is attained for vulnerable girls and boys (Hawkes & Hart, 2000).

c) Socio-cultural practices

The first socio-cultural practice to be discussed relates to the position of youth in the social structure of many African communities. The youth are the lowest in the social structure and so are taught to respond to authority (Jegede, 1997; Kanu, 2006; Obbo, 1995). According to Obbo (1995), many African communities train youth to be obedient to those who are older, with the notion that older people are more knowledgeable, and are always in

the right. Therefore, youth have no safe haven for sharing their experiences, especially in incidences of harassment because the verdict is often against the younger person. Jegede (1997) has observed that this practice is carried over into schooling where students are submissive to their teachers and many are not trained to challenge authority (see also Kanu, 2006). In the area of sexual harassment, young people, especially girls, will therefore not readily defend themselves against abuse; many silently endure molestation from teachers (Jones & Norton, 2007). The Ugandan Ministry of Education and Sports (MoES, 2005) posits that young people rarely get molested by outsiders or people not known to them, but many endure abuse from intimate friends and teachers, those whom they should be able to turn to for help. The low social status of youth makes the curbing of molestation more challenging as many girls will not come out and report the abuse for fear of punishment.

Even with defilement laws put in place, this sexual abuse is still difficult to overcome because it involves intimate members of the communities. Within schools, teachers who are caught molesting girls are dismissed from service (MoES, 2006). However, this rule does not negate the fact that some are not caught. In relation to HIV/STI young people, especially girls, are therefore vulnerable to infection should their molester be infected. Furthermore, the belief of some people that having sex with a virgin cures HIV makes the low status of youth even more dangerous as they become easy prey for people with such beliefs (UNAIDS, 2001). Also, not many molesters take responsibility should the girl become pregnant. In the end, many girls end up dropping out of school, with some having illegal abortions and dying in the process (Bennel et al, 2002). There is need for the improvement of the status of youth within African communities. World Bank (2007) is

proposing that a youth lens be provided on all public life issues so that youth can become a constituency for reform by being a part of the decision-making process.

In addition to youth having a lower social status, they are generally considered children until they are either initiated into adulthood through ritualistic rights or preparing to get married (C. Caldwell, P. Caldwell, K. Caldwell & Pieris, 1998). Because youth are perceived to be children, it is culturally taboo to provide them with certain kinds of sex education (Caldwell et al, 1998; Nakazinga, 2004). According to Caldwell et al (1998), sex education had a particular purpose in African communities; that is, initiating young people into adulthood. The education included teaching young men adult chores and the nature of their role in the family, while young girls were taught hygiene during menstruation and the codes of conduct associated with it (Fuglesang, 1997). In addition, young girls were given information about pregnancy, traditional methods of birth control, and the role of breast-feeding. The education also took into account the potential for sexual behaviour to cause harm—through jealousy, emotional discord and infection – as well as good, in areas like social cohesion and responsible social behaviour (Fuglesang, 1997; Runganga & Aggleton, 1998). This knowledge was provided with the understanding that sex should happen within a marriage setting as opposed to current sexual practices (Caldwell et al, 1998).

Because of the place of sex education within the communities, talking about sex publicly was also considered taboo. It was relegated to its proper place: done by special people during the initiation and marriage preparation ceremonies (Caldwell et al, 1998). However, some studies show that with sex being a taboo topic, many sexually active young people have no sexual health knowledge and are therefore at risk of HIV/STI infection and/or early pregnancy (Burns, 2002; Singhal, 2004). Some studies have reported that

many teachers fear to transgress these cultural barriers and provide sex education even though they are mandated to do so (Kinsman et al, 2001). Furthermore, very few parents are said to be in support of sex education for their children (Asera, Bagarukayo, Shuey & Barton, 1997; Nakazinga, 2004; UNAIDS/W.H.O, 1994).

In light of the campaign to fight HIV/STI and early pregnancy, these attitudes are seen as problematic and a hindrance to effective sexual health education for young people (Asera et al, 1997; Burns, 2002; Kinsman et al, 2001). In order to ensure and reduce high-risk behaviour, there is a need to overcome the socio-cultural practices that prevent holistic sex education for young people, including the lack of parental support and involvement. With evidence that many young people are sexually active (UNAIDS/W.H.O 2005), the knowledge gaps on preventive methods (Das, 2005), places the youth at a high risk of infection with HIV/STI (Burns, 2002). The repercussions are higher for girls who also run the risk of early pregnancy and with it the possibility of dropping out of school or being married off at an early age (Leach, 1998; Mohga, 2001).

2.5.3. Summary

The studies cited above helped to underscore the need to pay special attention to the health of women and youth. The empowerment of women and youth is not only crucial but critical. Both women and youth have information gaps on key issues like their rights to better health and a better life, and the way to maintain their sexual health (Kickbusch et al, 2002). For older or married women, the knowledge gaps exist because of their low status in society (Castle & Kiggundu, 2007; Kakuru, 2006). For youth on the other hand, knowledge gaps exist because of the taboos surrounding sex education for young people, which hinder them from accessing critical sexual health information (Burns, 2002; Kinsman, et al, 2001;

Muyinda et al, 2004). However, the risk of infection due to insufficient knowledge has greater repercussions for girls than boys (Baylis, 2000).

Furthermore, apart from the gender-power relations both women and youth face, their low social status puts them at greater risk of HIV/STD infection. For married women, the domestic violence they suffer stops them from advocating for protected sex or even disclosing their health status (UAC, 2006; UNAIDS/W.H.O 2005). For youth, especially girls, low social status hinders them from reporting incidences of rape or sexual molestation from older men and even peers (Kickbusch et al, 2002). Therefore it is not coincidental that the call for a focus on women (Chan, W.H.O 2007) and provision for a youth lens (Jaminez, World Bank, 2007) has been made simultaneously. Although the women and youth face different challenges, the effect is the same and therefore it is important that they are empowered to overcome these health challenges.

The cited studies impacted how I framed the questions of this study, and how I analysed and interpreted the data collected. I paid special attention to gendered discourses, youth challenges and the kinds of information young people accessed. The studies also enabled me to understand how complex the issues surrounding women's and young people's health are. The next section (2.6) will expand on the areas discussed in section 2.4 but will also focus on studies that have called for the examination of current policies that impact the health of people in developing countries. These studies make a case for fresh approaches to health intervention strategies for developing countries.

2.6. Policy issues: examining current health strategies for Africa

This section draws on studies that stimulated debate and critical thought on the policies used, especially by aid agencies, to promote health in Africa. These studies argue

that these policies are economically, ideologically, and culturally incompatible with those of participating African countries (Airhihenbuwa et al, 2000; Kerka, 2003; Kickbusch et al; 2002; McQueen, 2001; Mohga, 2001; Nutbeam, 2000; Okuonzi & Birungi, 2001; Orbinksi, 2007; Robinson-Pant, 2004). These research studies take issue with the models, theoretical perspectives, and implementation strategies used in health promotion. The researchers invite scholars, educators, and policy makers to critically examine some of the policies and advocate fresh approaches to health promotion strategies for Africa. In this section, I present their critical arguments against policies, common assumptions in policies, and implementation strategies respectively.

2.6.1. Models used for health promotion

Some studies have pointed out that the models used for health promotion do not take into account the economic status of the participating developing countries in Africa (Kickbusch et al, 2002). Three models, the social capital, the health reform model, and the best practice and evaluation model, along with their shortcomings, are discussed below:

a) The social capital model

The leading funding bodies use the social capital empowerment model to deal with the broader determinants of health and well-being (Gillies, 1998; Hawe & Shiell, 2004; World Bank, 2002). The model aims at promoting health by tackling the broader social, economic and environmental determinants of health, given the compelling evidence that some factors that impact health decisions are beyond the control of the individual (Gillies, 1998). Gillies points out that the social capital approach ensures that local and national agendas are taken seriously and not in a merely tokenistic approach. The aid agencies

therefore are eager to ensure that their suggestions are adhered to, given that funding to these developing countries depends on how well the suggested health programs are implemented.

The criticism of this approach centres on areas of methodological and economic inequalities that were not regarded when the approach was promoted. Some studies take issue with the fact that this model is based on economic and scientific approaches that promote understanding of issues in cause– effect relationships (Leach, 1998; Robinson-Pant, 2004). Leach (1998) has posited that because the principles used in this model are generalized, aid agencies find the approach easier for designing policies. For example, the World Bank might argue that if all people access an education, it will lead to gender equality, and subsequently better health practices and life chances for all. However such an argument does not take into account the social context in which the health-decisions will be made (Kickbusch et al, 2002). As a result, under a social capital model of empowerment, women who are not in power positions still bear the brunt of the inequalities that have put them in poor health (Mohga, 2001). The shortcoming therefore is that the over-arching problems like gender-power relations are not addressed, meaning that marginalized communities do not benefit from this approach (Leach, 1998).

In addition to overlooking oppressive practices, this model has only achieved success in countries that are economically powerful like Britain, Canada, Australia and Italy (Gillies, 1998; Hawe & Shiell, 2004). The resources and economic status of African countries are not commensurate with these countries. Because of this economic inequality, the social capital model has created class differences and health gaps within societies in Africa (Kickbusch et al, 2002; Nutbeam, 2000). Only gainfully employed and educated

people are able to pay the medical fees and to access better healthcare services (Mohga, 2001). Therefore, in Africa, there exists a health gap between rural and urban communities, men and women, and educated and uneducated people (Mohga, 2001). Mohga has suggested that because funding is dependent on the donors' agendas, many African countries have resorted to providing reports that follow the stipulations to ensure sustained funding, even though not many people are benefiting from these health programs.

Robinson-Pant (2004) has argued that these funding bodies or policy makers depend on quantitative studies steeped in science and development economics. These case studies will, for example, provide evidence for a causal relationship between education and health, especially in relation to women's roles, without examining the social practices of the communities. However, any indication of non-attainment of results is interpreted as a problem of participating countries' non-compliance with set goals. In general, many developing countries have fallen short of the goals set for them, and even recently, the Human Development Report (2007) is already indicating that the MDGs will not be adequately achieved in many African countries because of resource and economic inequalities. This observation underscores the limitations of the social capital model in health promotion.

b) Health reform model

The healthcare systems and models promoted in many developing countries were designed for economically stable countries (Ahmed, Lopez and Inoue, 2000). Unfortunately, many African countries do not have the resources to maintain these healthcare services (Kickbusch, 2001). For example, in Uganda, the healthcare system was modeled on the National Health Service (NHS) of Britain, which required resources

beyond those available in Uganda (Okuonzi & Birungi, 2001). Therefore, the healthcare system in Uganda could not sustainably function and has broken down.

In addition, the healthcare reforms suggested by the World Bank (1987, 1993), embedded in liberal market theory, and successful in Western and European countries, caused many problems for the economically poor people in Africa. These policies introduced user-fees for healthcare and therefore those who were not gainfully employed could not access good medical care (Mohga, 2001; Okounzi & Birungi, 2001). As a consequence, poor and marginalized women were again put in the disadvantage of neither accessing nor receiving medical treatment (Mohga, 2001). Okuonzi and Birungi (2001) have concluded that these reforms modeled for economically rich countries have led to the growth of health inequalities, and produced further health gaps between developed and developing countries. Like the social capital model, the healthcare systems are also not suitable for developing countries, yet the policies like user-fees and privatization are still being promoted by leading funding agencies (Mohga, 2001).

c) Best practice models of evaluation

Another model that has caused debate and critical argument includes issues of how progress in Africa is evaluated and reported. According to the leading agencies' evaluation model of best practice, constant data entry and reports that show progress each year are required (Ahmed et al, 2000). McQueen (2001) has stated that this demand for continuous data was made without taking into account the resource inequalities in developing countries. Whereas many developed countries have the luxury of technology and resources, the same is not true for African countries (see also Cohen, 2002; Orbinksi, 2007). McQueen (2001) has argued further that the terms 'evidence', 'effectiveness' and

'investment' are Western-derived and are in many ways Euro-centric. McQueen suggests that the model for best practice should be critically examined in relation to how it impacts resource allocation for purchase of technologies, which often occurs at the expense of investing in services that cater to the poor.

These studies call upon the funding bodies to recognize disparities, and develop approaches that are friendly to the conditions of the participating developing countries. The most important observation is that the inappropriate models for health promotion, coupled with economic inequalities, have impacted the health of youth, women, and children generally, and the rural and urban poor in particular. Moreover, most of the initiatives were designed for this population group (Airhihenbuwa et al 2000; Cohen, 2002; Kickbusch et al 2002; Madzingira, 2004; Mohga, 2001). The poor in sub-Saharan Africa have always been identified as facing severe health challenges (Cohen, 2002). It is important to highlight the negative impact of some of the policies designed with the intention of improving the life chances of poor and marginalized people (Leach, 1998).

2.6.2. Common assumptions in health promotion policies

As with the models used in health promotion, some researchers question and invite debate on the common assumptions in health promotion policies used in Africa. Some studies have focused on the ideological underpinnings of health promotion programs (Cohen, 2002; Kerka, 2003; Nutbeam, 2000; Orbinksi, 2007). The common assumptions and programs that have drawn debate and critical arguments include: (i) the unexamined assumption that literacy and education are the panacea for all problems in Africa, (ii) the behaviour and communication change (BCC) approach to community education; and (iii) Research and Development (R&D).

a) The literacy and education myth

For decades, health promotion in Africa has been in conjunction with the promotion of literacy and education (Nutbeam, 2000). The main assumption is that through literacy and education, women will be empowered and health practices will improve (Robinson-Pant, 2004). Therefore, leading funding bodies promote adult literacy education programs and the construction of schools as important to health improvement (Leach, 1998). These policies are informed by the argument that health practices in developed countries are effective because people are literate (Majalia, 2004). Therefore, by extension, the aid agencies assume that for people in Africa to have better health practices, literacy through formal education should be promoted. The main criticism against this approach is the fact that it does not take into account how social factors like emotions, culture, and environment impact people's decision-making process (Kickbusch et al, 2002). For example, Zimbabwe has high literacy levels and yet many people, including educated and gainfully employed women, are dying of HIV/AIDS (Kickbusch, 2001).

Therefore, it is important to constantly point out that literacy and education alone do not necessarily lead to empowerment, emancipation, and better health, as is often perceived (Nutbeam, 2000). Furthermore, literacy, commonly understood as the ability to read and write in English, imposes Western ideologies onto African communities without recognizing the socio-cultural differences (Kerka, 2003; Majalia, 2004). These studies have posited that the ideological underpinnings in these literacy and education programs should be critically examined by researchers, educators, and policy makers.

b) Behaviour change and communication approach (BCC)

The BCC operates on the theory of "logical persuasion," which is a common approach in the West (Kickbusch et al, 2002). This theory therefore focuses on influencing individual attitudes through information giving and logical persuasion. The criticism of this approach has centered on the fact that it is not suitable for African communities, which have a theory of communalism (Airhihenbuwa et al, 2000; Dei, 2000; Kanu, 2006). Communalism requires one to put the welfare of others above self, although not exclusively at the expense of the individual (Kanu, 2006). Airhihenbuwa et al (2000) have observed that the BCC approach focuses on individual empowerment without paying attention to the fact that the African and Western view of self are different. The self in Africa is a product of the community rather than an individual, as it is in the West (see Dei, 2000). Also, like the literacy and education myth, the BCC approach with its theory of logical persuasion does not take into account the role of emotions, culture and environment on people's decision-making on health issues. Health advocates need to take into account the role communalism plays in decision-making in African communities if attitude and behavioral change promotion is to be effective. As stated in the introduction, the UNAIDS (2007) has set change of behaviour as one of the central goals in the fight against HIV/AIDS in Africa.

c) Research and Development approach (R&D)

Like the other two theoretical approaches, R&D is one of the cornerstones for health advances in Western countries (Orbinksi, 2007). This approach has been imported into developing countries that do not have a long history of research (Cohen, 2002). In fact, the World Bank (1999) decried the lack of a research culture in Africa and suggested R&D

be encouraged. Cohen (2002) has observed that R&D is the reason Western countries have developed drugs that ensure the health of their people. Cohen observes that over 90 percent of drugs needed by the rich are continuously funded, and are being developed by pharmaceutical companies. However, because the medicinal needs of African communities do not constitute a 'valuable enough market,' few drugs that address tropical diseases such as malaria were being funded or developed by pharmaceutical companies. This perhaps explains why, most drugs in developing countries are out-dated, and most diseases have now become drug-resistant (Jong-wook, 2003; Orbinksi, 2007). Furthermore, most of the hospitals in developing countries have no drug supply, making people resort to over-the counter drug purchases (Witter & Osige, 2004). In general, Aikenhead (2006) invites us to critically analyse the R&D approach because it is based on Western practice and science that are not commensurate with the way other communities come to learn about their environment. Some studies have suggested that traditional herbalists should be consulted to provide some background to non-western approaches to science (Omaswa, 2006; Teh 1998). Other studies have proposed that traditional medicine should become a major healthcare service in Africa along with the modern medical practices (Juntunen, 2001; Leonard, 2001).

2.6.3. Implementation strategies used in health promotion in Africa

Some studies focus on how the implementation strategies used in health promotion need to be revisited. The major criticisms centre on modes used for communicating health-related information that are not commensurate with cultural ideologies of the communities (Kickbusch, 2001; Madzingira, 2001; Majalia, 2004; Mushengyezi, 2003; Nutbeam, 2000). Other criticisms concern the replacement of traditional practices with modern healthcare

systems that do not take into account the social practices of the people (Geest, 1997), and the introduction of formal education health programs, which alienate people from their communities (Nutbeam, 2000).

a). The modes of communication

The criticism of the strategy used for communication was that it did not utilize the local resources and practices of the people (Silver, 2001). Kickbusch (2001) has suggested that because the models and theoretical perspectives were designed for a literate population, most health information was presented in written form, already a disadvantage to African communities which are largely oral cultures. Public health promotion relied heavily on information dissemination through pamphlets, internet, radio and other modern media that are readily accessible to many people in developed countries. Extending these approaches to developing countries is not ideal given the limited number of people who access these media. For example, in Uganda, the 2002 census revealed that out of the 28 million people, 2.4 million people identified *radio* as their main source of information. However, 2.5 million rely on *word of mouth* for information. The least used or accessed sources are post mail (7,319), print media (36,804), hand mail (39,504) and television (31,807), three of which require one to be able to read and write. This means that oral modes of communication (radios) are used and preferred by most communities in Uganda. The result of using modes that are suitable for literate and affluent communities is information and health gaps between the educated and the uneducated; the rural and urban; the young and old; and the men and women within African communities (Madzingira, 2001; Majalia, 2004; Morrison, 2003).

b). Modern healthcare systems

The studies that have examined the traditional health practices in Africa invite a critical analysis of how commensurate these modern healthcare systems are with people's social practices (Cocks & Dold, 2000; Diallo & Paulsen, 2000; Geest, 1997). These researchers have argued that most African people find the modern healthcare providers impersonal and uncaring when compared to traditional practitioners. For example, Glasser et al (1995) found that many people felt that their consultations with doctors were too brief. Geest (1997) found that in African traditional practices, the practitioners often took almost two hours with patients. Furthermore, because every illness is believed to have a social or religious origin, prayer or spiritual guidance plays a big part in African engagement with disease (Cocks & Dold, 2000; Diallo & Paulsen, 2000). This spiritual aspect is not usually a part of the modern healthcare system, which is slowly replacing the traditional practices (W.H.O 2002). Geest (1997) however observed that in many African hospitals, there were as many pastors and priests visiting patients as there were doctors (see also Juntunen, 2001; Leonard, 2001; Teh 1998). The persistence and number of people consulting traditional practitioners in rural Africa have led W.H.O to reconsider the place of traditional practitioners in healthcare provision (Omaswa, 2006; W.H.O 2000, 2002). This observation makes a case for why the social and traditional practices must be considered when introducing the modern healthcare systems as a replacement for traditional healthcare practices (Tsey, 1997).

c). Formal health education programs

The criticism of the formal health education system centres mainly on the end product of the implementation. Nutbeam (2000) has observed that policies like building

schools and other health education programs, aimed at providing a supportive environment for health, may have led to unintended consequences. Some of the unintended consequences include the growth of a class system because only those with formal education were gainfully employed and therefore, could access medical care since they could afford the user-fees. The educated happened to be mostly men and so schools fostered gender-health imbalances (Nutbeam & Kickbusch, 2000). Kanu (2006) has observed that many communities felt alienated from their children in schools because schools did not incorporate traditional knowledge but promoted Western knowledge systems. Therefore, many children viewed their traditions as primitive, leading to a breakdown in parental involvement in their learning process. Schools rendered the elders and indigenous education systems useless (Dei, 2000)

Caldwell et al (1998) have provided some understanding of why parents are not involved in the sex education of their children. They stated that sex education was traditionally carried out by experts in the communities, and since schools and teachers replaced this system, many parents have left the teachers to provide this information to their adolescent children. The problem, however, is that many teachers also feel culturally bound, and reluctant to transcend these cultural barriers, they do not provide sex education as assumed by the parents (Asera et al, 1997; Burns, 2002; Kinsman et al, 2001; UNAIDS, 2001). Muyinda et al (2004) have added that with the introduction of schools the traditional sex education institutions broke down, so that those who were not attending school did not have an avenue for accessing health information. Therefore, many sexually active young people have limited or no sexual health knowledge. They engage in risky behaviour, which exposes them to HIV/STD infection and early pregnancy (see Burns, 2002).

Because of the replacement of indigenous knowledge systems with modern systems, including schools and women-targeted health programs, many traditional health providers were also rendered useless (Caldwell et al, 1998). The result was a health education that was limited to inter-personal communication, and media campaigns directed towards individual outcomes and health service use, as opposed to the holistic approach common in many traditional systems (Geest, 1997; Nutbeam, 2000). The schools did not use indigenous ways of communication, so the health information students received was 'foreign' in the sense that it contained Latinized scientific names of illnesses that they could not easily translate into their mother tongue (Nutbeam, 2000). The health experts became the information providers, further alienating the people (Morrison, 2003).

Another unintended outcome relates to how the women-oriented health education programs impacted the lives of the communities. Baylis (2000) observed that many women in African communities were blamed for the spread of HIV/STIs, and many men were not taking an active role in the healthcare provision for their families. One reason women fear to know their HIV/STI status is because they will be blamed for being the "vectors" and victimized in society. Mohga (2001) noted that because many reproductive health and HIV/STI programs focused on women, they had the unintended outcome of causing women to be viewed as the problem (see also Castle & Kiggundu, 2007). The programs were designed to highlight the plight or health challenges of women and provide an environment of support, but instead the women became portrayed as either victims (powerless) or vectors, both negative outcomes of well-intentioned programs (Mogha, 2001).

Some studies have critiqued the use of Western worldviews of sexuality in African communities, stating that the depiction of women as powerless has not taken into account

the agency women in Africa exercise to protect their reproductive health (Castle & Kiggundu, 2007; Reid & Walker, 2005). The agency includes seeking pertinent information and treatment from healthcare centres (Castle & Kiggundu, 2007; Mohga, 2001). Other researchers have focused on the way women-oriented health programs and advocacy groups have led to the portrayal of African men as uninterested in women's health issues (Hawkes & Hart, 2000; Wegner, Landry, Wilkinson & Tzanis, 1998; White, Greene & Murphy, 2004). The main argument is that with the unquestioned assumption that men all have good health and that African men are uncaring or abusive, the men who are supportive of women-oriented programs are not recognized (Desai & Alva, 1998; White et al, 2004). Therefore, attention should be paid to how the health literacy, HIV/AIDS, and gender programs depict African women and men, and how the depiction impacts society's health practices.

2.7. Conclusion

This chapter dealt with the theoretical perspectives and literature that influenced the design of this study. The theoretical perspectives were instrumental in the analysis, interpretation, and discussion of the data. These perspectives (youth lens, indigenous social and communicative thought and integrative gender frameworks) were important in the progressive contextualization (Kakuru, 2006) of the findings. That is, these theories were used to extend the data to speak to larger issues, those that transcend the particulars of the context of the study. The contemporary discourses on health literacy, HIV/AIDS education, and gender that hinged on the findings were also used in the analysis and interpretation.

The review of literature was important in situating the current study within the existing discourse on health literacy, HIV/AIDS, and gender. These studies were

instrumental especially in the design of research questions and choice of methodology used in this study. The importance of including a gender dimension in this study was underscored by the studies that highlighted the challenges of women and youth as regards to maintaining their health and well-being. For example, the questionnaires were designed with the purpose of investigating the issues relating to adolescent health and gender.

Not only was the review of literature instrumental in the research design process, it also impacted how the data was analysed and interpreted. The studies that dealt with the policy issues vis-à-vis social and cultural ideologies provided a lens through which the data could be understood. For example, the data was analysed in terms of unintended consequences (Nutbeam, 2000) resulting from health and gender equality intervention strategies currently used in Uganda. The data was also analysed for examples of transcendence, especially in regard to the provision of sexual health information to youth that facilitates their ability to maintain their HIV free status. In addition, doing a review of the literature provided an understanding of what propositions were confirmed or disconfirmed by the extrapolation of these findings to such over-arching issues as health literacy, HIV/AIDS, and gender. Through this process, it was possible to establish the research gaps and to underscore the significance of the current study, and the contributions of the study to existing literature and theories on health literacy, HIV/AIDS, and gender.

The studies cited under section 2.6 provided different lenses for looking at the data collected in the current study. Highlighting the policy issues provided an understanding of how policies used in health interventions might have unintended consequences (Nutbeam, 2000), as discussed above. Besides looking at the data through a lens of policy, the studies also helped to provide a socio-historical perspective (Caldwell et al, 1998; Kanu, 2006),

especially in understanding why change in health practices has been slow or why communities in Africa have not adopted some interventions (Leach, 1998, Mohga, 2001). Generally, the studies were instrumental in pointing out the tensions and complexities that a researcher investigating issues on health promotion would encounter. These different lenses were influential during data collection and analysis in this study. Special attention was paid to how policies impacted students' views and daily lives, as well as how the social and cultural practices informed the way the participants engaged with the health-related issues under investigation in this study. I watched out for those unintended consequences in the health policies or programs and in students' responses to questions on health literacy, HIV/AIDS, and gender, during data analysis and interpretation.

Of great importance to this study was the emphasis on how cultural practices and ideologies from one community cannot uncritically be translated into new communities (Kerka, 2003). The critique was useful during data collection and analysis because I paid special attention to students' understandings of concepts like health literacy, and gender equality, which are thought to be situated in Western cultural ideologies (Leach, 1998). Furthermore, although the studies cited above were meant to invite debate and critical analysis of the intervention programs, I found them informative, especially in relation to understanding contemporary discourses on health issues and Africa. In addition, the studies demonstrated how health policies and programs impact individuals and societies (Nutbeam, 2000). Therefore, it is important to focus not only on the negative impact of health programs, but also on the intended outcomes, especially with regard to ensuring women's and young people's health. As Carlisle (2001) points out, it is always important to make

sure the health issues of the voiceless or marginalized in communities are greatly emphasized. This suggestion was important to this study with young women and men.

Doing a literature review helped situate the current study within contemporary literature. The three sections (2.4, 2.5, & 2.6) were instrumental in the development of investigative tools like questionnaires and also during the data analysis process. The sections provided different lenses through which I could examine the data I had collected. The review also helped me to understand why new approaches to the health situation and intervention programs for Africa are being suggested. Nutbeam (2000) has posited that currently, health and structural interventions are done *on behalf of* or *to* or *on* people and not *by* or *with* people. It is time to have strategies that not only work with governments but include the African people as well. Most of the studies have recommended that adding or taking seriously the socio-cultural dimensions of health will enhance better understanding between the people involved (as opposed to only governments), will create a more comprehensive unity among Africans, and will enhance possibilities for a collective desire for change (Caldwell et al, 1998; Kickbusch, 2001; Kickbusch et al, 2002; Mohga, 2001).

Generally, the need for multilevel partnerships and advocacies became apparent, given the diversity and immensity of the needs that have to be met if the quality of life in developing countries is to be improved. These include: global partnerships between developed and developing countries; government and local community partnerships; and individual and community partnerships and advocacies all geared towards dealing with the social determinants of health like poverty, social status and gender relations.

The next chapter discusses the methodology and methods of data collection.

CHAPTER III

3.0 METHODOLOGY AND RESEARCH DESIGN

In this chapter, I present the methodological and epistemological considerations guiding the study, the sources of data, and a description of the research process. Merriam (1998) suggests that it is important to select a methodology that allows a researcher to get as close as possible to the problem under investigation. The study investigated the relationship between health literacy, HIV/AIDS, and gender as understood and interpreted by youth in Uganda. The particular research questions as already mentioned in the introduction are: 1) What kinds of health literacy, HIV/AIDS, and gender related information is accessible to Ugandan adolescent secondary school students? 2) In these students' view, what are the factors contributing to health literacy and HIV/AIDS related challenges faced by young people in Uganda today? 3) According to these students, what is the impact of the debates on gender equality in the fight against health epidemics including HIV/AIDS? 4) What do the students consider to be the way forward for Uganda to achieve better health and improve life chances for all? The methodology is discussed next.

3. 1. Methodological considerations

In designing a research study, one has to consider the ontology, epistemology and axiology of a given methodology (Creswell, 1998; Denzin & Lincoln, 1998, 2000; Glesne, 2006; Merriam, 1998). Ontology refers to the nature of reality (what), epistemology is how knowledge is constructed (relationship between knower and known) and axiology refers to the ethical and philosophical view points (Denzin & Lincoln, 1998). Merriam (1998) has pointed out that there are two competing paradigms in research which have opposing

perspectives on their views of reality, epistemology and axiology. Ontological position in quantitative research is that reality is stable and fixed, and that knowledge is outside the knower and is measurable. Their axiology is objectivity and detachment (Denzin & Lincoln, 1998). In qualitative research, the ontological position is that reality is unstable and interpretive. The epistemology is that knowledge construction is mediated by people's experiences, context and the meanings people bring into their interaction with the world. Its axiological position is that knowledge constructed is impacted by beliefs, values and politics of an individual, therefore highly subjective (Denzin & Lincoln, 1998, 2000). Merriam (1998) adds that qualitative studies aim at investigating the "how" "what" and "why" questions, with an aim of making sense of, or interpreting phenomena in terms of the meanings people bring to them. Merriam states that the role of the researcher is to provide an understanding of the participants' perspectives of a given phenomenon.

Therefore these methodological "positionings and tensions" in research ontologies, epistemologies, and axiologies (Merriam, 1998) were all taken into consideration when choosing the design of the current study. I ascribe to qualitative epistemological and ontological worldviews as reported findings are my interpretations of the meanings students' brought to the issues under investigation. The study is also constructivist in design (Schwandt, 1998) because primacy is given to human agency and imagination. In this thesis, I acknowledge that participants' views are mediated by their lived experiences and interactions with the social world.

In constructivism, the process of knowledge development and the manner in which the material world shapes and is shaped by human action and interaction depends on dynamic normative and epistemic interpretations of the material world (Posner, 2004).

Therefore there is a social and cognate dynamic in this approach to research. The constructivist approaches (cognitive and social) to knowing, parallels the epistemological and ontological underpinnings of the current study. The analysis is rooted in an interpretivist framework (Gallagher & Tobin, 1991; Schwandt, 1998) which recognizes the role played by human action and consciousness in knowledge construction when humans engage with new experiences in their social world (Duit & Treagust, 2003).

However, the focus on the human agency does not mean that I ignored the role of the environment on the knowledge construction process of the participants. I have already demonstrated in the literature review the role environment plays in the knowledge construction and use of information relating to health literacy, HIV/AIDS, and gender. Therefore, efforts were made to investigate how the participants' environment impacts their actions and how they relate health literacy, HIV/AIDS, and gender, through using investigative tools that provide a holistic understanding of context and social structures that govern the participants' lives. The ability to provide a holistic and in-depth understanding places immediate requirements on the choice of tradition (nature of design), methods and choices explained in the next section.

3.2. Research design

The current study is an interpretive multi-case study (Merriam, 1998). There are varied definitions of case studies ranging from looking at them in terms of the research process (Yin 1994, 2003), pinpointing the *unit* of study (Stake, 1995; 1998) to its end product (Merriam, 1988, 1998). According to Merriam (1998), case studies can also be described by the overall intent of the study. Is it intended to be largely descriptive? Is it interpretive? Is it meant to build theory? Is it intended to present judgments about the worth

of a program? I therefore chose to define the case study in terms of pinpointing a *unit* (Stake, 1995) and overall intent of the study (Merriam, 1998). Stake (1995) stated that a case study is an integrated system in which there are boundaries. The case then can be a person, a program, a class, a school and so on. In this thesis, the tradition is a multi-case study because of the number of individuals participating in the study. It is bounded by the individuals being the only informants, belonging to the same age group, attending the same school and being at the same grade and level of education (secondary school level).

According to Merriam (1998) case studies can be interpretive because of the level of analysis done on data collected. Interpretive case studies contain rich, thick descriptions and the researcher gathers as much information about the problem as possible with the intent of illustrating, supporting or challenging theoretical assumptions held prior to the data gathering. In this study the data was collected over time and this provided for a comprehensive analysis of adolescent students' views on the topic under investigation. As a researcher, I made efforts to analyze and interpret the data collected from the participants' perspectives on concepts under investigation (Gallagher & Tobin, 1991). Therefore the knowledge produced is contextual as described by those who provide it (Schwandt, 1998). The final report is understood as "a text that is itself a second-or-third order interpretation of respondents' interpretations" (1998; p. 232). According to Schwandt, meaning attached to a given experience is a constellation of what the participants and the researcher mean it to be at that moment. What is "written up" is not an objective representation of participants' perspectives but rather a combination of the researcher's interpretation of their responses (Olsen, 2000). However, the researcher can extend the interpretation into a wider context like relating the findings with the existing literature (Merriam, 1998; Mills,

2003). In this thesis, the participants' perspectives are constantly related with findings in existing literature on health literacy, HIV/AIDS, and gender in developing countries.

In order to have rich and in-depth data, careful selection of data collection techniques was done. Yin (1994) suggests that case studies are advantageous in that they get as close to the subject of interest as they possibly can, partly by means of direct observation in natural settings, and partly by their access to subjective factors (thoughts, feelings and desires). The methods used for data gathering included questionnaires, interviewing, conducting document analysis, examining life histories, focus and whole group discussions, creating researcher's diaries and observing participants. Getting rich data also involved careful selection of the research site and participants as detailed below.

3.3. Research site

In research, the means of site selection and sampling of participants is essential especially if the researcher wants to get an in-depth understanding of the problem under investigation (Glesne, 2006; Merriam, 1998). The choice of site therefore should reflect the purpose of the research (Glesne, 2006). The research site for the current study was selected because of a pre- existing research relationship (Mutonyi, 2005) and because it fit the interests of the larger research project.

The research site is a secondary school located in the eastern region of Uganda. In October 2004, Dr. Norton (Principal investigator of larger study) sought permission to have a continued research relationship with the study site (school). The school pseudonymously called Mulembe High School (MHS) is one of the largest urban public secondary schools in Uganda and Mbale in particular. Mulembe High is a co-educational school with a large student body. Being an urban public school, MHS does not only serve the Mbale area but

the whole country because students are centrally selected. At the end of the primary, secondary and advanced education phases, students take national examinations. The Uganda Primary Leaving Certificate (PLC), Uganda Certificate of Education (UCE), and Uganda Advanced Certificate of Education (UACE) are awarded following national examinations taken after seven years of primary, four years of secondary and two years of advanced level education respectively.

Performance in PLC determines which secondary school one will attend. As part of their primary school exercise, students fill out national forms for secondary schools of their choice. The public schools base their selection on a grading system and admit students from all over the country. The grading system is supposed to give the students from different socio-economic backgrounds equal opportunities for admission in any given school of their choice. This gives public schools a relatively national outlook in terms of ethnic (tribal) and socio-economic composition. Also because Mbale district borders Kenya, schools within the district are steadily attracting students from Kenya and thus developing an international outlook.

Given that MHS is a non-residential school it attracts more students from Mbale and neighbouring districts but there are hostels for students to rent within the neighbourhood for those living outside Mbale. The school had a total of 3,500 students by the time this study was conducted and 141 teaching staff (101 males and 40 females). The school head was a female and was supported by two male deputies. The school academic programs run from 8:00 a.m. to 4:40 p.m. (except on Mondays and Fridays when student assemblies are held). After 4:40 p.m. the students leave for co-curricular activities like

sports and clubs including the health and HIV/AIDS clubs[2]. It is a reasonably resourced school with a computer laboratory and libraries and has both O' level and A' level status. It has school partnerships with Britain and South Africa and visitors from Sweden. Therefore students in this school are used to seeing international scholars and visitors.

The site was ideal for the current study because most of the students in the school come from the rural areas where they live with family, and are now living in the hostels, which are in the urban areas. It was useful to get students' perspectives on both the rural and urban health literacy practices as regards to HIV/AIDS, and gender. This in a way required an understanding of how these students are living without the social fabric said to be responsible for the low numbers of HIV cases in rural areas (UAC, 2005; MoH, 2006). In order to get a comprehensive understanding of how the students' experiences contribute to their knowledge construction process, great importance was placed on sample selection of the participants. The sample selection process of the participants is discussed below.

3.4. The participants

The selection of participants in research is as critical as the selection of the study site (Creswell, 1998; Glesne, 2006). The researcher has to get participants with a "rich knowledge base" from which the problem under study can be understood (Merriam, 1998). In order to have rich and thick descriptive data for the current study, purposeful sampling strategy (Glesne, 2006) was used. Merriam (1998 citing Patton 1990) suggested that

> The logic and power of purposeful sampling lies in selecting *information-rich cases* for study in depth. Information-rich cases are those from which one can learn a

[2] Health and HIV/AIDS clubs are student led organizations whose purpose is to carry out peer education on issues relating to adolescent health like HIV/AIDS. Details on the activities of the clubs are in an article by Norton and Mutonyi, (2007). The publication details are in the reference section of this thesis.

great deal about issues of central importance to the purpose of the research, thus the term *purposeful* sampling (p. 61, emphasis original).

Therefore, the choice of purposeful sampling strategy aimed at having information-rich cases from which the researcher would get an in-depth understanding of the relationship health literacy, HIV/AIDS, and gender, from a youth lens. Merriam (1998) has suggested that in purposeful sampling, one should have criteria for selecting people or cases.

The criteria for sample selection included: i) the ability of participants to take part in the study for four years (the participants were participating in the larger study, see Ch. 1). ii) The participants should comprise both boys and girls to have gendered perspectives. iii) They should be active members of the health and HIV/AIDS clubs in order for the researcher to have an "expert's" opinion (Merriam, 1998) of students' experiences and literacy practices within health and HIV/AIDS school clubs. iv) The participants had to be at the same grade level as this counted for the boundedness of this case study (Stake 1995).

Based on the criteria of sample selection attributes (Merriam, 1998), a total of twelve (12) students were selected; six boys and six girls, as shown in Table 4 below:

Table 4: Participants in this study

Name	Gender	Class level (at start)	Age (at start)	Class level (at end of this study)	Age
Barasa Donald	Male	Senior Three	17 years	Senior Five	19 years
Boogere Maureen	Female	Senior Three	15 years	Senior Five	17 years
Masibo Sarah	Female	Senior Three	17 years	Senior Five	19 years
Massa James	Male	Senior Three	16 years	Senior Five	18 years
Mugide Flavia	Female	Senior Three	16 years	Senior Five	18 years
Mukite Tracy	Female	Senior Three	15 years	Senior Five	17 years
Mutenyo Phillip	Male	Senior Three	16 years	Senior Five	18 years
Nabulo Rose	Female	Senior Three	16 years	Dropped out*	
Nakuti Gina	Female	Senior Three	16 years	Senior Five	18 years
Waison Timothy	Male	Senior Three	15 years	Senior Five	17 years
Wambwa Joshua	Male	Senior Three	16 years	Senior Five	18 years
Wesubalah Petero	Male	Senior Three	17 years	Senior Five	19 years

* Nabulo Rose was replaced by Karen Stacie who is currently in Senior Five and is 19 years old. Karen participated in the on-site data collection period between January to April of 2007. Note that all these are pseudonyms (see section on ethics). I will be identified as INT = Interviewer

The selected students were then informed of the research project and asked if they were interested in taking part in the study. However their participation was only guaranteed when permission was granted by their parents. The details of consent are discussed under ethical procedures. I learned that there were four groups of students with different personalities represented in this study. These groups and personalities included:

a) The Scribes: Tracy, Flavia, Maureen, Phillip and Gina

It was often hard to get an input from this group of students during focus and whole group discussions. These students revealed that it is in their nature to be silent because even at home, that is required of them. Therefore this group of students preferred writing or responding to the questionnaires rather than the other data collection methods. The students were comfortable with writing or written text because it is a private practice. This is what transpired when I asked which mode (method) they preferred:

INT: Which mode of expression do you prefer?

Phillip: For me I think newspapers are a good form of getting information. It can help you make reference and to have conversation.

INT: So you prefer written. What about the others?

Tracy: I prefer to write.

Gina: For me I fear talking in a large group so I write.

Maureen: I also write

Flavia: For me I don't like writing but between talking and writing, I will write.

INT: What do you really prefer to do?

Flavia: To draw

[Informal ethnographic interview, January, 31st 2007]

For Flavia though, she would rather draw and her journal sometimes had pictorial representations supporting the text. However, because of the limited opportunities to draw, she chose writing over the choice of having group discussions or oral expression. This group of students underscored the importance of having questionnaires alongside focus group discussions if I was to get their honest opinion about something. However, it was clear that they were articulate speakers and during group discussions, it was often better to directly ask them to respond so that they could feel included and that their opinion counted. I should mention that due to the large data corpus, visual data is not included in this thesis but will be analysed in conjunction with Drs Norton and Kendrick for the larger study.

b) The Debaters: Timothy, Petero and Donald

This group of boys appeared to be on the quiet side but often very vocal on given issues. I called this group the debaters because they always brought out provocative views to get the others talking. It was also apparent that they were the leaders of the group because of their personalities. Their views were often accepted by the other members as representative of a given view. This could have been because Timothy and Petero were the top students in their class. Timothy, Petero and Donald liked to access information through a medium that allows for dialogue and discussion. This is what they said:

INT: What is your preferred communication mode? Is it oral, written, dramatized etc? What do you prefer?

Petero: Oral is better because you can ask any question of the person who is speaking to you. For written, you can read and remain with question marks.

INT: So you like to interact?

Petero: It is better to interact than just reading.

Timothy: The only good thing with written is you can keep the information but it is better to interact and ask questions.

Donald: Yeah like for me I like the radio talk shows where you call in and ask questions.

[Informal ethnographic interview, January, 31st 2007]

Although this group of students would easily settle for written text, they preferred interactive modes of communication. It was therefore not surprising that these students considered the focus group discussions as the most important. As Timothy said "it is better to have this group discussions compared to writing. Now I can ask you a question and also get the others to respond." The students stated that they often listened to radio talk shows because it allowed for interaction. But because of being on the shy side, they fear to participate in drama representations, unlike the next group.

c) The Performers: James, Karen and Sarah

This group of students was more expressive and quite vocal in group discussions. They seemed unthreatened by an audience and so I called them the Performers. It was this group that helped counter most of the points raised by Timothy and team, which often led to a debate during the whole group discussions. So this group and the second group worked well and seemed to feed off each other's energy. This is what these students said:

James: If I am given an option, oral information and then writing, I will choose oral.

Karen: I am in the interact and Straight talk club so I like oral

Sarah: I like drama like in the ACYC [AIDS Challenge Youth Club].

James: Yes drama is very good and I like being a part of it.

[Informal ethnographic interview, January, 31st 2007]

This group was on a mission to share information with others so they chose drama because it is a common method youth use to share knowledge on HIV/AIDS within school and their

communities at large (Norton & Mutonyi, 2007). James adds that he loves drama because "it is lively and you do so many things like poetry, singing, and dancing, which are different from just reading." James is on the executive committee of the HIV/AIDS club.

d) The Lone Ranger: Joshua

Joshua is a lone ranger in many ways and very confident of his opinions. He has a strong sense of who he is and is not hesitant to let people notice this. This is what he said about which mode of communication he prefers: "I enjoy when written is balanced with oral." He likes written because it enables him to prepare beforehand if he is to engage in a discussion. During the life-history interview, and follow-up discussion of the students' profiles, he stated his interest in politics and how much he liked engaging people in, or following political debates. This is what he said "I have a collection of newspapers even those from 1980 and during my leisure time, I read the political pages. They are in my file at home." That is why he prefers to have written text then followed with oral, mainly discussion based communication. He liked the critical inquiry discussion and provided the challenge for the other participants to read carefully what the articles had stated.

Generally the different methods used for data collection resonated with different participants as presented above. The data collection methods are discussed next.

3. 5. Methods

In most cases, the data collection methods should be commensurate with the paradigm and tradition chosen by the researcher (Merriam, 1998). In qualitative studies, the methods of data collection selected should be adequate for an in-depth investigation of the problem and enable the researcher to have rich data (Merriam, 1998). Rich data is important because in qualitative studies the researcher should provide a rich and thick

description of the context and understanding of the relational aspects of the problem under study (Denzin & Lincoln, 1998, 2000; Glesne 2006). For this thesis, there were several methods used for data collection that suited the qualitative study framework. These methods included:

a) Journaling and reflective reports

Journaling and reflective reports are often used in ethnographic studies to provide an immediate reaction to a given event or experience in the field (Glesne, 2006). In this study however, the participants were requested to journal all the information relating to health, HIV/AIDS, and gender that they accessed within the school and larger community. The students were also required to read through their journals and come up with monthly and quarterly reflective reports on what they had written. These reports detailed why the information was important to them and students' immediate thoughts on how this information impacted their lives. The reflective reports were quarterly (4 months) while the journals were collected at the end of each year. The journals gave me an opportunity to explore what information regarding health literacy, HIV/AIDS, and gender the participants' accessed through the public media. The reports also provided me with the opportunity to determine what information was readily available and what sources of information were easily accessible to the participants.

The reflective quarterly reports were instrumental in the design of other research methods like questionnaires and interviews. The reports were useful in detailing what the participants found interesting, did not find interesting, and what motivated them to seek the information they had written down. The reports also provided an opportunity to follow participants' knowledge development on issues pertaining to adolescence, health,

HIV/AIDS, and gender. This knowledge provided entry points for engaging the participants in a discussion of matters of public concern.

b) Artifacts and document collection

Besides journaling, the participants were requested to collect some articles (written or visual) that had information on health, HIV/AIDS, and gender that contributed to my understanding of the findings. These articles were considered as artifacts (Creswell, 1998) because they were locally produced. These artifacts were sent along with the quarterly reports if the participants had collected any. The artifacts turned out to be adolescent-oriented newspapers like *Young Talk* and *Straight Talk* and adolescent magazines on health and HIV/AIDS. The participants also clipped articles on health related information from the national newspaper *The New Vision* that provided insight into what material on health is available for the general public in Uganda. These artifacts were important in assessing what kinds of information the participants were being exposed to.

Documents that had information pertinent to the current study were also collected. Documents are differentiated from artifacts because the former have official information and sometimes one needs to get permission to access the documents (Creswell, 1998). I attained a copy of the HIV/AIDS curriculum for secondary schools from the research site. These documents were drafts of the HIV/AIDS curriculum that was being tested in selected schools (MoES, 2006). Mulembe High School (research site) was participating in this test curriculum. This document was collected to provide an understanding of what is in the curriculum, especially information that was of interest to this study. This document enabled me to understand how the curriculum shaped the participants' engagement with the issues under investigation in the current study. Generally, the artifacts and documents were also

instrumental in the development of the other methods of data collection especially the focus group discussions and refining the questions to be used in the questionnaires.

c) Questionnaires

Questionnaires were also used for data collection to supplement the information received through the other methods of data collection. The specially designed questionnaires (Anderson, 1990; Gay & Airasian, 2003) collected information ranging from background information on each participant to their understandings of the concepts like health literacy and gender equality. The questionnaires were administered at different times during the research process. The participants completed a total of five take home open-ended questionnaires, which are identified as Q1, Q2, Q3, Q4 and Q5 respectively (see appendix 2). Some of the students' questionnaire responses were used as cues for life history interviews and focus group discussions (see timeline at end of section).

d) Life history interviews

Life history interviews (meant for the larger study) were conducted within the school by Dr. Norton in February 2006. I therefore co-opted the findings of these interviews in this study. Life histories are used to understand individual-community relations and to solicit information on people's backgrounds, interests and thoughts on issues under study (Denzin & Lincoln, 2000; Hatch, 2003; Tierney, 2000). According to Tierney (2000), life history is "any retrospective account by the individual of his life in whole or part, in written or oral form, that has been elicited or prompted by another person" (p. 539). The account can be an analysis of the social, historical, political and economic contexts of an individual's life story by the researcher (Tierney, 2000). Stephens (2000) suggests that life history research "concerns the relationship between two inter-dependent

worlds: that of the individual with their unique life story and that of the past, present and future contextual world through which the individual travels" (p. 32). Life history data enabled the researcher to understand the inter-relationships between the participants' past, present and future worlds and how these worlds impacted their perspectives on issues regarding health literacy, HIV/AIDS, and gender.

The life history interview questions prompted the participants to give an account of their personal experiences with health challenges, family history, their social practices and future dreams. I then interpreted these accounts as providing the life history (Tierney, 2000) of the participants. The life history interviews were conducted for two days and were audio recorded with the permission of the participants.

e) Focus and whole group discussions

Focus group discussions (FGDs) are valuable interview techniques that can lead to a better and shared understanding of given issues under study (Mills, 2003). Focus groups are particularly important because they provide an opportunity to gauge the persistence of a given view. It also helps in determining how many people hold a given view from the sample participating in the study (Creswell, 1998; 2002). In the current study, focus group discussions were used for multiple purposes including getting clarification on certain responses and information in the participants' journals and questionnaires. The FGDs were also used as an opportunity for the researcher to observe participants' interaction in order to understand how gender impacted levels of participation. The FGDs re-enacted a classroom scenario for the researcher given that the participants were in the same grade and the school is co-ed. I wanted a better understanding of how these students might relate within the classroom and gauge the level of participation for both the boys and girls. The FGDs were

also used for gaining insight into how widespread the participants' views on gender equality, HIV/AIDS and health practices were. Focus group discussions helped me to determine participants' shared understanding of concepts like gender equality and health literacy from the conversations that ensued during these interactions.

Another advantage of focus group discussions is that they provoke greater spontaneity and candor than can be expected in an individual interview and follow-up questionnaires (Goldman, 1962). During the FGDs, I observed that the participants were often able to extend their arguments or views a little further and each built on the point raised by another or sometimes countered others' views. The group dynamic also influenced how the participants engaged with the issues under discussion. If the energy of the group was high, the participants contributed more but if the energy was low, the discussions were also not very deep. It was important to have these discussions earlier in the day compared to after school when the participants had had a long day. Most of the discussions during the months of January and February of 2007, held within the school, were done earlier in the day, because the students were on holiday. But when the school term began, I held FGDs at the end of the school day. I had to ensure the discussions were engaging and motivating to the participants in March and April 2007.

Focus group discussions were also used because they minimize power relations between researcher and participant and offer peer support for participants who might be on the shy side (Fontana & Frey, 1998; Madriz, 2000). The peer support seemed to be particularly important for the female participants in this study. This observation was also made by Fontana and Frey (1998) during their research discussions with women. The one-on-one interviews with the female participants had many silences and the girls-only FGDs

done in February 2006 had more participation although the participants tended to agree with one another's opinion. To overcome this, I used whole group discussions (WGDs) and observed that the boys' opinions tended to 'spark off' responses from the girls on a given issue and vice-versa. In total we had 2 FGDs and 6 WGDs and these conversations were audio taped. Participant observation was done during the WGDs and this helped me understand the gendered perspectives that became evident during some discussions.

f) Informal ethnographic interview

My technique for informal ethnographic interview drew upon Mills' (2003) understanding of the term. According to Mills, "the informal ethnographic interview is little more than casual conversation that allows the researcher in a conversational style, to inquire into something as an opportunity to learn" (2003, p. 58). These informal ethnographic interviews take place within the research site but in a place where the participant is comfortable. I conducted these informal interviews within the school at the time when we were having soft drinks together and chatting about the research process and the participant's lifestyles. I tried to make them as informal as possible.

In this study, I also used informal ethnographic interviews to hold one-on-one conversations with the female participants who were less active in the WGDs. This was an opportunity to ask a set of questions in a casual manner to get information that I thought would be helpful to the study. I particularly wanted to find out why these selected participants were silent during the FGDs. These conversations took about 10-15 minutes while we are standing under a tree or sitting in a classroom before scheduled research times. I asked some questions like "are you intimidated by the set-up of the FGDs?" "What makes a bright young girl grow-up to be so quiet?" "What should I do to get more input

from the less talkative participants?" I tried to use indirect questions because I did not want to make the selected participants feel they were being interrogated or reprimanded. It was easier to get the participants talking by sharing my own experiences with group discussions and asking if any of my experiences resonated with their own experiences.

Through these informal ethnographic conversations, I got to know the participants better and to understand that some girls have no "voice" in their families and this has impacted how they relate in the public arena. In their homes "children are to be seen but not heard" and this has translated into their school life. Through this select group of participants, I realized that I needed to use more of the questionnaire technique to solicit more information from the quiet yet information rich participants. These conversations were later recorded as anecdotes in my journal and became part of the data corpus.

g) Critical inquiry discussion

My technique for using critical inquiry discussion draws on Sirotnik's (1988) work with students in a classroom. This technique is often used to get students to understand the socio-historical context of given issues with the aim of equipping students for democratic duties. Sirotnik stated that the critical inquiry process is rigorous, time consuming, collaborative, informed, school-based and dialectic around generic questions like: a) What is going on in the name of X (X being the problem) b) How did it come to be that way? c) Whose interests are being served or not being served by the way things are? d) What information and knowledge do we have, and need to get that bear upon these issues? e) Is this the way we want it to be? f) What are we going to do about all this? (p. 64).

Sirotnik (1988; see pp. 64 & 65) suggested that the first two questions (a & b) remind the participants that problems have a present and historical context and that the

problems must be situated in these contexts in order to be understood. The third question (c) demands of participants that they confront constructively the political reality of significant educational issues; that they recognize and contend with embedded values and human interests. The fourth question (d) demands of participants that the inquiry be informed—that knowledge of all types relevant to the discussion be brought to bear upon the issues. The last two questions (e & f) remind participants that all is not talk; notwithstanding the omnipresent ambiguity in educational organizations or community social structure, action can and must be taken, reviewed, revised, retaken and so forth.

During the data collection process, it became clear to me that this inquiry technique would be appropriate in engaging students on selected issues on traditional African practices that perhaps escalate the rate of HIV/AIDS infection, especially among the youth and women. In my initial analysis of the participants' FGDs, I realized the need to engage the participants in a deeper discussion on certain issues in order to understand their standpoint on some issues. According to Merriam (1998), the advantage of doing a qualitative study is the ability for the researcher to develop new inquiry techniques that pursue issues of interest to the study, at any time of data collection process. Merriam states that this results in a better understanding of a given phenomenon and rich in-depth data.

I selected four articles that discussed HIV/AIDS in Africa, three of which focused on Uganda. The first article was written by Gupta (2000) titled "Gender, sexuality and HIV/AIDS, the what, the why and the how". This article was chosen because it discusses the complex relationship between gender and HIV/AIDS. The second article is by Burns (2002) titled "Sexuality education in girls' school in Eastern Uganda". This article was selected because it argues that gender roles hinder sexuality education for girls in Uganda.

The third article is by S. Nyanzi, B. Nyanzi, and Kalina (2005) titled "Contemporary myths, sexuality misconceptions, information sources and risk perceptions of bodaboda men in South West Uganda." This article was selected because it points out how myths impact sexual health practices with direct implications for women and girls' health. The fourth article was by Muyinda, Nakuya, Whitworth, and Pool (2004) titled "Community sex education among adolescents in rural Uganda: Utilizing indigenous institutions." These authors argue for the inclusion of indigenous institutions in HIV/AIDS education.

Generally the articles provided the opportunity for engaging students in discussions on health literacy, HIV/AIDS, and gender from an etic (outsider's) perspective. Gupta (2000) and Burns (2002) are not Ugandans and so their views were etic while Nyanzi et al (2005) and Muyinda et al (2004) are Ugandans and therefore had emic insights on some issues, but etic to this study, because they were not a direct part of the research. The articles set-up the discussions as the students grappled with how the authors had interpreted African and Ugandan cultural practices and its relationship to health literacy, HIV/AIDS, and gender. The articles also provided lenses through which the participants would engage in the discussions, and minimized my personal interpretations and opinions on issues under discussion. The participants were divided into groups of three (self selected) and each group chose an article, developed a commentary or critique of the article. After two weeks, each group shared what the article was about, highlighted the key issues, and provided a commentary or critique of the article. At the end of each group presentation, we entered into a discussion and this generated lots of feedback from the other members who had not read the particular article. I used the template provided by Sirotnik (1988) as my guideline to framing key questions for engaging participants during discussions. These discussions

resulted into 2 hours and 30 minutes of audio-recorded data. Youth and gender issues generated many viewpoints.

The timeline for the data collection is presented in Table 5 below:

Table 5: Timeline of data collection

Method	Dates	Time
Journaling, reflective reports, artifact collection	Began Jan 2005	Ended May 2007
Questionnaires		All these were take home questionnaires.
Q1	Feb 12th 2006	2 days
Q2	Jan 25th 2007	1 week
Q3	Feb 16th 2007	2 weeks
Q4	Feb 26th 2007	2 weeks
Q5	May 28th 2007	2 weeks
Life History Interviews*	Feb 13th 2006 (Boys only)	30-45 minutes with each student
	Feb 14th 2006 (Girls only)	30-45 minutes with each student
Focus group discussions*	Feb 15th 2006 (Boys only)	1 hour
	Feb 16th 2006 (girls only)	1 hour
Whole group discussion	August 29 2005	1 hour
	Jan 25th 2007	1½
	Jan 31st 2007	1½ hours
	Feb 16th 2007	2 hours
	March 26th 2007	2 hours
	April 8th 2007	1 hour
Critical inquiry discussion	March 14th 2007**	2½ hours. Each group took about 30-35 minutes
Informal ethnographic conversations	Feb 16th 2007	10-15 minutes

* The life history interviews and focus group discussions were adopted from the umbrella study. These were conducted by Dr. Norton.

**The articles used for the critical inquiry discussion were distributed on Feb 26th 2007.

It must be stated that although the data collection process is detailed linearly above, the procedures were not fixed. All the techniques for data collection were used simultaneously during all on-site field visit intervals. For example, during the on-site visit in February 2006 questionnaires, ethnographic interviews and focus group discussions were used to collect data; yet the participants were still journaling and collecting artifacts. The techniques have been discussed linearly to capture the range of methods used and not a step-by-step description of the data collection process. It was important to have a hybrid of methods, because the informal ethnographic conversations with the students revealed the need to have written and oral representations of information.

As mentioned earlier, some students were not comfortable with group discussions and preferred written, but I learned that the quiet girls needed to be encouraged to speak up because they are socialized to speak when spoken to. It was easy to use a hybrid of communicative modes because the participants are students. Uganda's education system is based on the British model of education and therefore the participants are exposed to, and are working with Western ways of communication, such as writing. This explains why the quieter female participants chose writing as a better compromise to breaking the social rule of not speaking up unless asked to speak (see Rogoff 2003).

3.6. Data Management, Analysis, and Interpretation

In this thesis, data management started as early as 2005 with the first set of quarterly reports and participant journals. The questionnaire responses were scanned into the computer files but the hard copies were stored with the participant journals and quarterly reports. The audio recorded interviews and FGDs were transcribed verbatim and also stored in the computer files demarcated for the research project until data analysis

commenced. However, the data was constantly coded with dates and other identifiers for each participant to ease the process of data analysis.

There is an initial and ongoing analysis of data before the intensive analysis that leads to writing up (Merriam, 1998). The first sets of data (quarterly reports and journals) underwent initial analysis so that I could get an understanding of what the participants were focusing on and to see what areas needed pursuing. According to Mills (2003), initial data analysis enables one to identify any gaps in the data and allows one to develop the correct data collection techniques for a complete study. The other data collection techniques especially the questionnaires were developed because the initial analysis of the data pointed out areas that needed further exploration. In summary, data analysis was an ongoing process throughout the data collection and the data management period (Creswell, 1998; Denzin & Lincoln, 1998; Glesne, 2006; Mills, 2003).

After the completion of data collection in May 2007, I commenced the rigorous process of data analysis. Mills (2004) suggests that "data analysis is an attempt by the researcher to summarize the data that have been collected in a dependable, accurate, reliable and correct manner" (p. 104). In order to achieve the goal of making the data dependable, I read and re-read the journals, quarterly reports and questionnaires searching for different ways of reporting the data that these sources were providing. I used Erickson's (1986) data analysis template in search of emergent themes during the process of reading and re-reading of the data. The same intensive analysis was subjected to the interviews and focus group discussions through listening and re-listening of the audio recorded data. I then read and re-read the transcribed interviews and focus group discussions in search of recurrent themes and patterns (Erickson, 1986). The interviews, discussions and focus

group data was then entered into Atlas ti qualitative data analysis software and coded (Mills, 2003; Denzin & Lincoln, 2000). The data management and analysis process was therefore a mix of manual and computer enhanced management (Merriam, 1998).

Each data source was therefore analysed individually and co-concurrently for complementarity and difference. For example, the student journals and quarterly reports were analysed in conjunction with the life history interviews and researcher's initial analysis notes. The questionnaires, researcher's reflective journal and subsequent focus group discussions were also analysed concurrently as they complemented each other. Later on, the entire data corpus was then analysed for intersectionality of the themes and patterns. The entire data corpus was read and re-read and then sorted into categories and themes (Erickson, 1986). I was carefully looking at areas highlighted in each data set, comparing patterns developed when the data was analysed concurrently and the new patterns and categories identified in this next level of analysis (Creswell, 1998). After the analysis, which aimed at reporting the outcomes of the data collected as accurately as possible (Mills, 2003), I commenced the process of data interpretation (Denzin & Lincoln, 1998).

According to Mills (2003), data interpretation focuses on the implications or meaning of the reported data. In this process, I embarked on searching the data for intersectionality with the concepts under study in this thesis. This is what Kakuru (2006) calls progressive contextualization. Progressive contextualization involves focusing on a specific activity and then explaining it in progressively wider or denser contexts. For example, in order to understand the participants' conceptualization of gender equality as related to questions of health literacy and HIV/AIDS, the students' accounts on family-gender relationships were drawn upon. These accounts of family-gender relationships were

then extrapolated into the larger discourses on health literacy, HIV/AIDS, and gender within the larger discourses in public media and the literature reviewed in this thesis.

Mills (2003) suggests that one can interpret data by either connecting findings with personal experience, seeking advice of "critical" friends, contextualizing findings in the literature or turning to theory. In this study, the data interpretation included contextualizing the data within the literature in order to find confirming and un-confirming opinions that provide a unique contribution of the study. The data were also interpreted through looking at given theories on health literacy promotion and the gender frameworks used for equality advocacy that influenced the designing of the study. The data were also related to the personal experiences of the participants' and researcher's perspectives on the data collection process. Throughout the data collection process, I asked the participants to give feedback to my interpretations of their responses. Advice from critical friends was also sought especially from the research team and thesis committee members who gave insightful comments of some of the interpretations I had made. This process enabled me to connect my interpretation closely to the data and analysis and to avoid an inaccurate representation of available data.

3.7. Trustworthiness/ credibility of the data and conclusions

Trustworthiness and credibility are used in naturalistic qualitative studies to describe in quantitative terms what is called validity (Lincoln & Guba 1985). Validity, generally, is conceived as the trustworthiness of a research study and has been defined in terms of the logic and technical adequacy of the process used to conduct a study (Eisenhart & Howe, 1992). Conventional validity (Eisenhart & Borko, 1993) refers specifically to a level of confidence in the accuracy and appropriateness of the methods used in an

investigation. Lincoln and Guba (1985) propose four alternative constructs that more accurately reflect the assumptions of the qualitative paradigm. These are credibility, transferability, dependability and conformity. The paradigms are each addressed here.

a) Credibility

According to Lincoln and Guba (1985), credibility demonstrates that the inquiry was conducted in such a manner that the subject was identified and studied. Researchers need to pay careful attention to a study's conceptualization and the way in which the data were collected, analysed and interpreted and the way in which the findings are presented (Merriam, 1998). Credibility is thus judged on how dependable and believable the findings are (Lincoln & Guba, 1985). In the current study, the methodology, methods, process of data analysis and interpretation have been detailed. The theoretical framework that influenced the conceptualization of the study and interpretation of the data has been detailed in Chapter 2 of the thesis. Particular effort has been made to ensure that what was discussed and written is as factual as possible through providing thick descriptions (Erickson, 1986). The researcher further established credibility through triangulation (Mathison, 1988) member checks with participating students, peer debriefing and critical friends in attempt to judge, make claims, draw conclusions or interpret the data (Merriam, 1998; Mills, 2003). Triangulation was particularly achieved through use of multiple data sources and collection techniques already discussed in section 3.2.2 above.

Credibility or validity of this current study was also achieved through long-term observation and study of phenomena (Merriam, 1998). The study is multi-case which allows for cross-case analysis in search of consistency and comparisons within case and outside a particular case (Stake, 1998). All these provided for a holistic understanding of

the situation to construct "plausible explanations about the phenomenon being studied" (Mathison, 1988; p. 17). That is, to provide students' perspectives on health literacy, HIV/AIDS, and gender within the context of Uganda.

b) Transferability

Transferability also relates to issues of validity of findings. Lincoln and Guba (1985) suggest transferability as a second paradigm for establishing validity in qualitative research. Here, the research has to demonstrate that the findings can be replicated in a setting similar to the one designed by the researcher. However, Lather (1994) has argued that making such generalization is problematic given the unique nature of each setting. Rather, the researchers in other areas with similar settings should look for the issues that resonate (Newman, 1999) with them. In Chapter 2, I have outlined the theoretical framework that guided the study in terms of data collection and analysis. The study was designed as a case study to capture and understand in-depth the perspectives of the participants. It is therefore inappropriate to transfer the conclusions to another setting as that was not the intent of the study. I however agree with Newman's (1999) suggestion of resonance. The readers of this thesis can decide if the findings apply to their contexts.

However, Stake (1995) suggests that there can be a naturalistic generalization where details on a particular case allow one to see similarities in "new and foreign contexts." In this regard, I have detailed the research site and criteria for site selection, used multiple sources of data, that is, twelve participants and different data collection methods to ensure corroboration. Triangulation of different data through different methods of data collection and sources was done to reduce researcher bias or limitations of a particular

method. This process was to ensure that the data is reported in a dependable, accurate, reliable and correct manner in the findings chapter (Mills, 2003).

c) Dependability

Another criterion for addressing quality issues in research is the issue of dependability, in which the researcher attempts to account for changing conditions of the aspect chosen for study and changes in design based on new understanding of the setting. For the current study, a coding of the data was done to deepen layers of analysis culminating in the creation of themes (Erickson, 1986). The most encompassing process of coding was used to compare data and interpretations as reported in section 3.3 of this chapter. This ensured dependability of the research as all responses fit into the categories developed and used in writing up Chapters on findings of the study. I have provided an audit trail (Merriam, 1998) of how I arrived at the results through using both descriptive and interpretive commentaries of findings in Chapter 4, 5, 6 and 7. An attempt has been made to detail how the categories were developed and how the findings answer the research questions (Erickson, 1986). The findings are supported by direct quotes and vignettes where necessary to guide the reader to follow the analytic path taken.

d) Confirmability

Do the data help confirm the general findings and lead to the implications? This is what the last criterion addresses. Given the same set of data, would the same conclusions be drawn by a different person? In some ways, the data speaks for itself, although in other aspects it is probable that different conclusions could be made. The framework impacts the way one reports the findings (Mills, 2003). The theoretical framework discussed in Chapter 2 acted as the lens for data analysis and reporting, hence the data confirms the general

findings, which lead then to the implications. However, Merriam (1998) has suggested that one can strengthen the confirmability of the findings by explaining: the position of the researcher vis-à-vis the group being studied; the basis for selecting informants; and description of them and the social context from which data were collected. My background and interests in the study has been detailed in Chapter 1 (section 1.3). The criterion for research site and participant selection has been detailed in section 3.5 above.

3.8. Ethical procedures

Permission was sought and granted by the Ethical Review Board of UBC under the umbrella research project conducted. Permission was sought by Dr. Norton from the relevant authorities in Uganda in October 2004. The head teacher of the school participating in the study gave permission to have the study done and then the participants filled consent/assent forms and got their parents permission to take part in the study. It was important to have the parents' consent because according to UBC ethical procedures, all those below 18 years are to have parental consent. The participants were informed of their right to withdraw from the study at any time and that this would incur no punitive measures. This was also explained to the head teacher and the parents.

The participants' permission was sought before information was audio-recorded. I explained to the participants that only the research team would have access to the raw data and that their privacy would be protected. The participants were also informed about possible publication of findings and were assured of their privacy. The issue of anonymity and protection of the participants' identity was discussed again in April 2007 and I asked each participant to suggest a pseudonym for him or her self. The school was also given a pseudonym to protect its identity. The selected pseudonyms are used throughout the thesis.

As relates to remuneration the participants worked as mini-research assistant positions for the umbrella project. The participants therefore received an agreed upon honorarium for their participation in this study. In spite of the added incentives for participating in the study, I constantly reminded the participants of their freedom to withdraw from the study at any time. Each year, permission was sought from parents to ensure that their child's continued participation was still agreeable to them and this also served as a reminder to the participants that their participation was voluntary. Whenever the discussions extended beyond the agreed upon time, I compensated the participants for the extra time. I paid the students' transport costs during the data collection months of January and February 2007 when the students were on holiday. I also made sure each student received money for a meal whenever we went over time during the discussions.

The final form of remuneration is related to the role of the researcher as explained by Schwandt (1998). According to Schwandt, the researcher "rescues the activity of participants' meaning- making, changing it from a passing event, which exists only in its own moment of occurrence into an account, which exists in its inscriptions and can be consulted" (p. 231). This thesis is therefore an inscription that can be consulted to get the accounts of Ugandan students on issues of health literacy, HIV/AIDS, and gender. The research findings will also be published in local and international journals, thus giving the participants' views a larger audience. Also, the Ugandan Ministry of Education and Research Council have requested copies of the thesis, indicating that the students' views will be read by key authorities in Uganda.

3.9. Summary of research process

This current study was conducted in three major phases. The first phase was the preparation which included writing the research proposal and conducting an extensive literature review, which impacted the selection of research design. The preparation phase also involved getting ethical clearance from both UBC and the research site. The second phase included the process of data collection, which involved journaling, artifact and document collection, questionnaires, interviews, critical and focus group discussions, and participant observation. The research process phase also involved data management, analysis and interpretation of the data collected. This included transcribing, scanning of questionnaire responses into computer files, typing, coding and interpretation of the data corpus. It also involved constant feedback between participants and researcher over the on-site field visits that ensured that respondents had an opportunity to clarify or confirm if the analysis was representative of their views on the concepts under investigation. This process then led to the third phase.

The third phase was writing up the thesis which included intensive and comprehensive data analysis and interpretation based on what emerged and what exists in the literature. Themes and categories that portray the perspectives of the participants on the concepts under study were developed to enable the reader to understand the path of analysis. This process concludes with reporting of findings as accurately as possible and drawing conclusions, which is the focus of the next four thesis chapters (4, 5, 6, & 7). The layout will include a complete thematic representation of the findings relating to a particular question interwoven with the analysis and interpretation.

Therefore the next four chapters will present the data that centered around the research questions. Chapter four focuses on the 1st research question, chapter five, the 2nd research question, chapter six the 3rd research question and chapter seven, the 4th research question. As mentioned in the introductory chapter, the findings are extensively discussed in relation to the theoretical frameworks and literature review. These chapters will then be followed by chapter eight which has a summary of findings, implications for policy, theory, and practice, limitations, and recommendations for further research.

CHAPTER IV

4.0. INFORMATION ON HEALTH LITERACY, HIV/AIDS, AND GENDER

This chapter presents the findings that responded to the first research question, which is: *What kinds of health literacy, HIV/AIDS, and gender related information is accessible to Ugandan adolescent secondary school students*? The purpose of the question was to investigate what kinds of information on health literacy, HIV/AIDS, and gender, adolescents can access. As stated in the introductory chapter (Ch. 1), the study was designed to investigate what information adolescents in Uganda search for, in order to maintain their health and well-being. The question therefore allowed the participants to provide an understanding of what health, HIV/AIDS, and gender information is accessible to young adolescents in Uganda.

As explained in the methodology chapter (Ch. 3), the students were asked to keep a journal and write quarterly reports on the health literacy, HIV/AIDS, and gender information they would access over the data collection process. The journals and reports were to contain the date the students made an entry, the source of information, the language in which the information was provided, and the reasons the participants selected to report on a certain issue. This chapter therefore draws on the data from the students' journals, reflective quarterly reports, the artifacts and documents collected. These are supported by excerpts from FDGs, WGDs, and interviews that had pertinent information and responded to question 1 of this study.

Based on the data corpus, the health literacy, HIV/AIDS, and gender related information students accessed was varied. The students had information on both neglected

diseases[3] (see Cohen, 2002; Orbinksi, 2007) and prominent health concerns like malaria, T.B. and HIV/AIDS, with a gender and youth dimension. The information was targeting both the adult and young populations of Uganda. In this chapter, I have selected to present only the data on prominent health issues that had a youth dimension because of the prominence of the information in the students' journals and reflective reports. I must mention that the initial analysis of the data done at the beginning of the study in 2005 showed that the students were journaling similar information. During an on-site visit in August 2005, I asked the students why the information was similar. Joshua said "we all get the same copy of the newspapers like *Straight Talk* and you find that each one has written the same information." This perspective was reiterated by the others during this discussion.

The chapter is organized as follows: 4.1 presents the findings on the kinds of adolescent-targeted information students accessed. 4.2 focuses on methods used for dissemination of the information the students reported. It is important to reiterate that the focus on language and methods used for health literacy, HIV/AIDS, and gender information dissemination was influenced by the literature that critiqued the current approaches to health education in developing countries (see 2.5). 4.3 will be the discussion, followed by conclusion, 4.4, of the chapter.

4.1. Adolescent-friendly information accessed by students

Three sub-themes emerged from the analysis of the adolescent-friendly information the participants' accessed. These are 1) self esteem and adolescence, 2) youth empowerment, and 3) vulnerability of youth. I must state that because the students had

[3] Cohen (2002) defines neglected diseases as the illnesses that are impacting lives of people in developing countries and Africa in particular and yet have not captured global attention. These diseases include river blindness, Leshimiasis and other water-borne diseases.

similar information, my choice of whose journal to use under each sub-theme does not indicate that only that student had the information. I decided as a matter of representation that each participant appeared at least once in this chapter. Furthermore, close analysis of the data, especially after checking it against the collected artifacts, revealed that the students were copying the information verbatim into their journals. Therefore, excerpts and format of the journal entries are direct representations of how the information was conveyed to the youth, and not how the student chose to represent it. Variations in the information provided by the participants' occurred only in the quarterly reflective reports.

4.1.1. Self esteem and adolescence

Self esteem emerged as an area of focus in the kind of information the students accessed. The information was associated with growth and development in the adolescent stage, and gendered experiences. The information was mainly accessed through the adolescent newspaper called *Straight Talk,* produced and sent to participating schools every month. The information was on expected experiences during adolescence, menstruation, wet dreams, and advice to adolescents. Excerpts in journals from Sarah, Maureen, Flavia, Petero, and James, are used to illustrate the content under this sub-theme.

An excerpt from Sarah's journal is used to provide an example of the content of the information on changes adolescents are to expect:

These are some of the changes the adolescents face during transition from childhood to adulthood:

- The body changes and their effects (psychological and physiological)
- Confusion about what is right or wrong
- Peer pressure

- Social changes i.e. uncensored exposure to various social activities/objects
- Lack of assertiveness on the part of the girls which to some extent is influenced by cultural beliefs e.g. society's expectations of subjective obedience from the girls/woman when approached for sex [Excerpt from Sarah's journal, January, 2005].

The other participants included: the breaking/deepening voice for boys and pitched/softer voice for girls, the boys experiencing wet dreams and girls undergoing menstruation, the adolescents dealing with pimples, and how to shave the armpits and pubic hairs, the attraction to the opposite sex and dealing with crushes, and how the adolescents can maintain a slim and attractive body through exercise.

The data also revealed that the purpose of providing information on expected body changes was to help young people to deal with the low-self esteem that adolescents experience. An excerpt from Maureen's journal is used to illustrate the message:

> Girls you are special. Accept what you cannot change. Self esteem means feeling good about yourself. When you have low esteem, you become vulnerable and people tend to use you. You lose focus on what matters to you. While you may think you have many challenges because you are a girl, know that it is a blessing for each of us to be what we are. You are the only one of your kind and there is no other person like you. Learn to celebrate your womanhood. Whether you are boy or a girl, there are challenges. It is how you deal with them that matters.
>
> [Excerpt from Maureen's journal, May, 2005].

These words of advice are meant to make girls feel valuable to society as well as feel proud of who they are. The female participants in this study all documented this piece of advice, indicating that it was important to them.

Furthermore, the participants also accessed information on self-esteem, menstruation, and school absenteeism among girls. As mentioned in the introduction, because the students were citing the same source, the information was the same. I use Petero's and Flavia's journal entries to illustrate the issue of menstruation and self esteem. Petero wrote:

> Menstruation is the monthly flow of blood from the girls/ woman's vagina. It is one of the changes experienced by girls during adolescence….some of the girls say that they feel terrible pain during their menstruation and also brings about laziness, stomach and breast pain….<u>it also causes girls the girls not to settle because they think people can realize that she is in her menstruation period. Girls are advised that people cannot know just by looking at you. Menstruation is not shameful but a part of growing up</u>.
>
> [Excerpt from Petero's journal, May 2005; emphasis mine].

The highlighted portion illustrates how menstruation was related to the issue of self-esteem. An excerpt from Flavia's journal builds on this. Flavia wrote the following in her journal:

> How do I avoid staining my clothes?
>
> Make sure you wear a pad. Have pants that fit in order to hold the pad in place. Change your pad at least three times a day. Always have extra pads. If you stain your clothes get help from a teacher or friend.
>
> Can I attend school when I am in my periods?

Menstruation does not stop you from doing your daily activities. You can go to school, dance, and do sports during your periods. Menstruation is not shameful or dirty. It is a part of growing up. Burn the used pads or throw them in a pit latrine. If you use pieces of cloth, wash and dry them in the sun in a private place. Do not dry them under your mattress.

[Flavia's journal entry, May 2005; emphasis mine].

This excerpt contains information that educates girls about menstruation and how to use pads. The highlighted portion however captures the information that was of interest to the participants, that is, it deals with self-esteem and how it affects the school attendance of some girls. The fear of staining their clothes during menstruation appeared to be of concern to the female students participating in this study. Rose and Sarah reported that they feel stressed during menstruation because they fear staining their uniforms.

For the male participants however, it was the experience of one of their female classmates that prompted them to write about menstruation and bad odour. During the life history interview held in February, 2006, Petero said the following:

There is a girl in our class, for her, even people have neglected to sit with her because of that bad smell. The girl says that even if she bathes 100 times, the smell does not go away. People used to think she doesn't bathe but the girl bathes and she said even if I bathe 100 times, this smell will not go away. They said that why don't you apply perfume? She said applying perfume or deodorant no problem, but when I sweat, I will smell the more.

[Excerpt from life history interview, February, 13, 2006]

The male students used the plight of their classmate to explain some of the challenges faced by girls. In their journals however, the male students wrote that the solution to bad odour

for girls is to bathe regularly during their menstrual periods. It became apparent that these male students assumed their female classmate had perhaps not bathed during her menstrual period, and that it resulted in bad odour. This assumption might have been fostered by the piece of advice on menstruation reported by Flavia and used above.

However, the male students also accessed information relating to ejaculation and wet dreams. The information assured them that it is a normal experience. James wrote:

> Dear boys who are 15 above. It is normal whenever whitish fluids come out of your penis when the penis erects. Some boys have been worried whenever they would see such thinking that it could be a sign for STDs. This whitish fluid we call it "ejaculate." [Excerpt from James's journal, January 2005).

This particular piece of information was reported by the male participants only. This indicated that this information was important to the boys but not to the girls in this study.

In summary, the students accessed and reported information that addressed particular questions that they might have had. For example, Rose was struggling with issues of menstrual cramps because she often missed school during her periods. When she accessed information that educated her about use of hot bottles and painkillers, she was able to regularly attend school. Tracy found the information on menstruation useful because she is the elder sibling and so she had no one to talk to and ask about menstruation and proper use of pads. Generally, the issue of self-esteem was important to both genders as some of the information male students included in their journals had issues on erections, penis sizes, and use of public washrooms. This compares to the information for the girls on growth, menstruation, and their low-self esteem as detailed above. Given that most of the participants were in their early adolescence, this information was crucial and critical as it

provided the necessary answers to their unasked questions. The next section presents the information that was designed for youth empowerment.

4.1.2. Youth empowerment

The information that the students documented centered on the rights of adolescents to education and to sexual health information. Excerpts from Donald's, Flavia's and Timothy's journals will be used to provide examples of the information that spoke to youth empowerment. Donald copied into his journal points on adolescents' rights to health and education from the proposed HIV/AIDS curriculum. These rights included the following:

- Pregnant schoolgirls to continue with education after they have delivered
- Girl-child environment and retention in schools to match that of boys
- Protecting the rights of adolescents to health information and services
- Strengthening and utilizing existing peer to peer networks to facilitate the sharing of accurate information on adolescent health.
- Sensitizing policy makers, leaders, parents, young people and the community on adolescent health, its special needs, rights and responsibilities.
- Sensitizing law enforcement organs about the rights of adolescents and their responsibilities in protecting adolescents from exploitation. (Excerpt from Donald's Journal, June, 2005).

The analysis of these excerpted data revealed that the adolescents were being empowered to demand for their rights to good health and education. The first two points

concern themselves with girls' rights to education. All of the participants reported knowing someone who dropped out of school due to pregnancy and thought many adolescents do not know that they have a right to come back to school if they so choose. For example, Petero's sister got pregnant while she was in Senior Three (16 years) and because he was informed of the rights to education, in his reflective report he wondered if the sister would like to return to school after she had delivered.

Additional data in the participants' journals that spoke to youth empowerment focused on the importance of providing adolescents with sexual and reproductive health information. An excerpt from Flavia's journal is used here:

> Adolescent sexual and reproductive health refers to the physical and emotional well-being of an adolescent and includes their ability to remain free from unwanted pregnancy, unsafe abortion, sexually transmitted diseases including HIV/AIDS, and all forms of sexual violence [Excerpt from Flavia's journal, June 2005].

Timothy also wrote down the following on reproductive rights:

> Know your reproductive health rights and defend them. The Ugandan law protects children against forced marriage. If you are above 18 years, you have a right to choose your own partner. If you are being forced to marry, report this to the Local Council leader or police in your area. [Excerpt from Timothy's journal, Jan., 2006).

When these statements are taken together with the information on adolescents' rights to education and health, it could be concluded that the *Straight Talk* paper aims at empowering youth through knowledge provision. To these participating students, there was need to know what the government was doing to protect their rights and generally be informed of their rights so that they could pass on this information to friends or peers. Each

participant reported performing the role of peer educator to their school friends. The analysis of the *Straight Talk* papers sent in February, June, and July of 2006 revealed that the information is geared towards individual empowerment. For example, the July 2006 *Straight Talk* topic (see www.straight-talk.or.ug) focused on creative ways young people can earn a living.

4.1.3. Vulnerability of youth

Students documented and reported various kinds of information that highlighted the vulnerability of youth especially to HIV/AIDS, and strategies for protection. The data, revealed that the information on sexual health and HIV/AIDS the students accessed was in keeping with the goal of providing young people with the necessary knowledge to ensure their health and well-being, as well as ensure that there is behavioural change among adolescents. The information was also aimed at breaking the cultural barriers and providing youth with the necessary sex education.

The boys and girls had noted down in their journals the factors that make youth, especially girls, vulnerable. In June 2005, Donald recorded the following points:

- The failure of some parents to meet the financial needs of their children especially the girls has driven some of them into the act of sex misuse so as to find a living.
- Some girls give themselves for sex because they fear to be rejected by what they call future husbands who may be demanding for sex.
- Some girls do not have protected sex and rely on menstruation cycles which they do not understand properly and even then it is not a guarantee.
- Some the girls become pregnant out of rape.

- Some of the school girls are tired of schooling and they think that becoming pregnant automatically pushes them out of school.
- Others look for favour from teachers like additional marks in exchange for sex which results into pregnancy.

[Excerpt from Donald's journal, June 2005].

The points highlighted the factors that lead to risk of HIV/STD infection, and pregnancy for young girls. It is important to note that some of the girls are depicted as deliberately engaging in risky behaviour, for example, the last two points. However the other points provide an understanding of why some girls might engage in a sexual relationship in exchange for money.

In addition to data on vulnerability of girls, the students documented the challenges faced by young boys and girls in Uganda. Phillip and Gina's journal entries are used:

Phillip wrote the following about challenges faced by boys:

- Not given attention by parents compared to girls.
- Family responsibilities are taken up by older boys which is a burden.
- Heavy workload especially manual labour.
- Sex demands especially in relationships where he is supposed to demonstrate love.
- Imprisonment for defilement
- Forced marriage
- Abduction especially during wars
- Low knowledge levels on sexual health due to no parental and community guidance.

[Excerpt from Phillip's Journal July, 2006).

Gina documented the following as challenges faced by girls:

- Girls are undervalued and denied education.
- Culturally a girl is not supposed to inherit property which makes them vulnerable.
- Too much domestic workload.
- Disturbance from boys and men for sex even when not in a relationship.
- Defiled or even raped by boys or men.
- Forced marriage.
- Displacement and abduction in war time.
- Low knowledge levels because of high drop out levels and early marriages.

[Excerpt from Gina's journal, July, 2006].

Some of the challenges are similar. For example the issue of forced marriage was expressed by both genders as a cultural pressure. Youth (especially the girls) who are not in school are often advised to marry even though the same pressure is extended to the young people in school. Other similar challenges related to workload, with the boys writing about manual labour and the girls writing about domestic work. It was interesting to see that both boys and girls have low knowledge levels on reproductive health matters, but the reasons for this differed. For the boys, knowledge gaps existed because of no parental or community guidance while for the girls the reason was dropping out of school early before they began to understand their body changes. In general, both genders experience challenges and the participants cited the "Straight Talk" newspaper as their source for this information. If extended to the topics on youth empowerment, it could be concluded that highlighting the low-knowledge levels on reproduction and sexuality was meant to challenge young people to seek these kinds of information.

The students' journals also had information on safer sex and the importance of abstinence. The information on condoms that was given to young people addressed the myths and misconceptions associated with condom use. This information was followed with proper instructions on how to use condoms effectively. Tracy's journal entry is used for illustration:

> The theoretical basis for condom protection is that the male latex condom covers the penis. When used every time and correctly, the condom provides a barrier to semen and vaginal fluids and blocks the sexual transmission of HIV. Electron microscopy of latex condoms reveals pits and imperforations but no pores that penetrate the entire membrane. Condoms offer a high degree of protection about 80-90%. It is safe to use condoms to avoid contracting HIV/AIDS.
>
> [Excerpt from Tracy's journal, April, 2006; emphasis mine].

The common myth surrounding condom use concerns pores that allow fluid exchange. The highlighted portion captures the scientific evidence that addresses the issue of safety of condoms, and counters the myth that condoms have "holes." Given that literature suggests that young people do not know how to use condoms (Kinsman et al, 2001), the students accessed a visual representation of how to use a condom. This is included below:

Figure 2 Illustration of how to wear a condom

This figure was extracted from Sarah's journal. The analysis of the June 2006 *Straight Talk* issue (sent as an artifact), revealed students accessed information on the various brands of condoms available in Uganda, and the importance of safer-sex practices.

However, the students were not only taught about safer-sex practices or condoms, there was information on the importance of abstinence. An example is below:

> Abstaining is the best way to protect your present and future reproductive health. Reproductive health refers to the health of the reproductive tract. <u>When someone is in good reproductive health, they are able to have a satisfying and safe sex life and are capable of reproducing</u>. Not abstaining has very serious consequences, including HIV/STD infection, early and unwanted pregnancy, dropping out of school and poverty.
>
> [Excerpt from Rose's journal January, 2006; emphasis mine]

The report ends with a plea to students to think about their future and wait to have sex when married. The highlighted portion also countered the myth that suggest that virgin boys and girls have a higher chance for becoming barren or impotent (Nyanzi et al, 2005).

The promotion of abstinence for youth is in keeping with the Ugandan HIV/AIDS communication strategy, which is Abstinence, Be faithful to one sexual partner, and Condom use (ABC). The ABC should be given equal emphasis in the media (UAC, 2007).

In general, the data revealed that the adolescent-friendly information that the students' accessed, indicated that there are deliberate efforts to address the needs of young people through information provision. Straight Talk is the medium through which the cultural barriers or taboos regarding sex education are being transcended. Therefore young people in school are able to get sexual health education that is critical to maintaining their health and well-being. However, the Ugandan policy on condoms for youth has been a major discussion in recent studies (e.g. Blum, 2004). So I pursued this issue with the students during the whole group discussion in February 2007. This is what ensued:

> **INT:** Research shows that many young people in Uganda are sexually active and yet Uganda does not encourage condom use. What do you think should be done to help these young people?
>
> **Petero:** First of all it is not young people like us; many of us are abstaining, especially the boys.
>
> **Gina:** Even some of the girls.
>
> **Phillip:** The HIV statistics show that those above 19 are the ones getting infected. Like those thirty and above in Uganda.
>
> **INT:** That is statistically correct. But why not promote condom use then for those who are at risk?
>
> **Sarah:** Actually they promote condom use for these people. They know that people above 18 find it hard to abstain, especially those at campus or other colleges.
>
> **Phillip:** Nowadays even the campaigns have changed from ABC to CBA.
>
> **INT:** Really? I have been hearing the opposite.
>
> **All:** Yes.
>
> **Timothy:** There is lots of talk on condoms.
>
> **INT:** What about among people your age, are condoms promoted?

James: Now when it comes to our age, the first thing is abstinence and then maybe condom use.

INT: So what you are saying is that adolescents in school are encouraged to abstain, while the older people are told to use condoms. Is that so?

All: Yes.

[Excerpt from FGD: Feb. 16, 2007].

From this focus group discussion, it was apparent that different kinds of messages are designed for different age groups in Uganda. The students confirmed that condom use promotion is still a part of the Ugandan HIV campaign strategy. I also analysed the proposed HIV/AIDS education curriculum that formed part of the data corpus of this study. Indeed, although the students will be taught about condoms and their safety, the sub-text encourages them to abstain, hence confirming James's statement: "now when it comes to our age, the first thing is abstinence and then maybe condom use". The Minister of Education has posited that abstinence is encouraged but the office recognizes that some adolescents are sexually active and need to know about condoms (MOES /PIASCY, 2005).

In general the students accessed information predominantly from *Straight Talk.* The students found the newspaper a very central source of information for adolescents. The students also indicated during the group discussion in August 2005 that easy access to other sources of information was not possible. This is exemplified in this excerpt below:

The challenging thing is that we are at school, we don't have enough time to maybe listen to radios and T.V. and yet they have lots of programs teaching about issues we are interested in. In addition to not having enough time, some of us don't have access to such facilities because we are living in the hostels. [Maureen's comment during the WGD, Aug, 29th 2005].

It is important to mention that students made an effort to access information from radios, televisions and healthcare centres as outside sources to school-related information access points. The information the students accessed was conveyed in English although there are some radio programmes that communicate health related information in local languages. The next theme discusses the communicative modes used in conveying health related information the participants in this study accessed.

4.2. Modes and motivation for accessing information

In examining the kinds of information concerning health literacy, HIV/AIDS and gender that students in this study accessed, the style in which the information was presented caught my attention. The manner in which the students noted the information demanded an understanding of the methods of knowledge communication. The students had accessed information through stories, a proverb, or an anecdote. The stories and anecdotes were common in all the students' journals but a comment on one proverb appeared only in Phillip's journal.

a) Use of stories to communicate health-related information

The participants had written stories on various health related topics in their journals. This demonstrated that these students were accessing media that used stories to discuss pertinent health and HIV/AIDS issues. Stories extracted from Gina's and Tracy's journals are used to illustrate how people in Uganda were taught about tuberculosis and antiretroviral drugs (ARVs) respectively. The story on T.B. was as follows:

TB had eaten some of Andrew's bones and they had to be removed

I made the call to Gulu after a long time and Andrew answered the phone. "Jackie is at the hospital, I am here with Daniella," he

said. In the background, I could hear the three year old Daniella happily rhyming away. Under normal circumstances, Andrew would also be away at Gulu independent hospital working on dental patients. But for 18 months, he had experienced a near to death brush with tuberculosis of the bones and was forced to stay at home in a wheelchair babysitting Daniella. Jackie says it is a miracle that Andrew is able to move his limbs again [...]

Eighteen months ago, I received a desperate SMS [phone text message] soliciting for prayers: "please pray for Andrew, he cannot move, he is in hospital." Jackie remembers Andrew returning from work and complaining of serious chest pain [...]. The next morning, Jackie rushed off to work and left Andrew in bed since it was a Saturday. When I returned home, I found the house still a mess [...] I knew something was very wrong with Andrew. They rushed to Lacor hospital where some tests were done and they were referred to Mulago [...] Dr. Naddumba, a bone specialist at Mulago put Andrew on three weeks treatment to stop the spread of T.B. and recommended an operation. "He told me that T.B had eaten some of Andrew's bones to powder and they had to remove the affected bones," Jackie says [...]

The story continues for a while and Gina mentions that the story was adopted from the *New Vision* newspaper. After the story, there is a discussion on the facts about T.B. presented by one of the doctors from Mulago hospital in Uganda. The doctor talks about symptoms, and who is at risk of T.B. infection, and then discusses the types of treatment. The doctor's (Beyeza) dialogue on treatment in response to the story, is worth mentioning.

Beyeza says T.B. of the bones can be treated with antibacterial drugs like isoniazid, rifampin, pyrazinamide, ethambutal and streptomycin or surgery. Drugs are prescribed for between six and eight months. "T.B. does not eat up bones. It is cancer. In most

cases, a combination of medication and surgery will lead to over 98% of cure," says Beyeza. In Uganda, T.B. treatment is free.

[Excerpt from Gina's journal, Jan, 2007; emphasis mine].

What was significant in this excerpt is the underlined statement "T.B. does not eat up bones. It is cancer." It was significant because the title of the story was "TB had eaten some of Andrew's bones and they had to be removed." Obviously the doctor intended to make sure he corrects the misconception communicated in the story. In general, the story was used to educate people about T.B. and to remind them that treatment is free.

The story on ARVs as extracted from Tracy's journal was as follows:

Proscovia's mother died when she was 13. She was the one in the hospital washing and taking care of her. Her mother didn't tell her that she had HIV but she found out from her dad. Her mother died when she was doing P.7 in 2000. In those days we did not have ARVs. Proscovia's brother died when he was 8 in 2001 and her sister died when she was 6 in 2002.

Proscovia was born with the virus but she lived without falling sick until she reached S.2. She got very sick. She had T.B. and malaria. Boys started calling her "sick girl". She took it simple but reported to a teacher and this teacher talked to them and they stopped…. She has then been talking to straight talk to help others in her situation. When boys come to her, she tells them that I am not ready for a relationship but she can still chat with them.

[Extract from Tracy's journal notes, Feb, 2006]

The above story was copied from the February, 2006 *Straight Talk* newspaper, which was sent by the participants as an artifact for the study. The story was followed with some factual points presented in question and answer format as shown below:

Q: What are ARVs?

A: ARVs are a combination of usually three drugs. The different drugs attack the virus at different points.

Q: When should you start?

A: When your CD4 count is below 200. If your immunity is still high, you do not need them.

Q: What happens if you take ARVs before your CD4 count drops to 200?

A: You increase risks of poisonous side effects and resistance to ARVs. You also waste your money on these drugs.

Q: How much do ARVs cost?

A: The cheapest one 55,000 Ug. Shs a month [$ 40 US p.a.]. Some centres have free ARVs.

It was evident that the information providers were underscoring the information that the adolescents were supposed to understand from the story by including this Q and A section. The questions were not from the participants but from the information providers.

b) Using a proverb

Phillip writes about a proverb he heard while young and how it had made him develop a misconception about Parkinson's disease. This is what he wrote in his report:

After a long time of unknowing, I have finally found it to be Parkinson's disease. When I was young, I was made to believe that trembling of hands in some old people is because that person has ever touched his mother-in-law, which is a taboo in the African culture (Bugisu). I was made to believe that it attacked in most cases only men. Contrary to what I had believed, in my research, I have come to know that it is a disease of the nerves. It is due to lack of a transmitter chemical called dopamine which helps transmit signals from one nerve cell to another at a junction. This results

into failure of the nerves which move muscles to function well. It is also said that it is brought about by drug abuse.

[Excerpt from Phillip's December 2005 report].

The information on Parkinson's disease was adapted from the "New Vision" March 2nd 2005; under the health column. The proverb in this case concerns the relationship between son-in-law and mother-in-law. In my experience, and as one coming from Bugisu, it was easy to identify which proverb Phillip was referring to. As children, we were cautioned never to get close to an in-law because it is an abomination. We were also told that whoever breaks this law will be found out because there would be involuntary muscle movement (trembling hands). So people were careful not to break this moral law. The *New Vision* however used the proverb to educate people about Parkinson's and Phillip gained from this method.

c) Communicating through anecdotes

Sometimes the information the students accessed was in anecdotal form. I use Karen's journal entry for illustration.

There is a common belief that too much shopping before the baby is born is not good, yet expectant mothers need to plan and stock up on their baby's requirements before hand as they will be too busy. The truth is there is no bad luck attached to shopping for all your baby things before you give birth. I know many people, including yours truly who have done all their shopping and survived to tell the tale after childbirth. It is just that in the olden days when infant and maternal mortality were rampant, expectant mothers did not want to raise their hopes too high just in case the mother or baby didn't make it home from the delivery room.

[Excerpt from Karen's journal, January 2007].

In general, the media from which the students are accessing this information is enabling those with a reading culture to stay in touch with traditional learning approaches like story telling, use of proverbs, and anecdotes. As Kanu (2006) observed, anecdotes are used to promote appropriate behaviour without directly criticizing the individual. This seemed to be the intent of the anecdotes used and noted by the students. Although the author is attacking a traditional belief, he/she is doing so in a covert manner and this is demonstrated through an explanation of why shopping for babies was not done in olden days. In other words, the author of the article acknowledges that the anecdote had merit in a particular context but in the present, there is a need to revisit its purpose. In modern times, there are more live births compared to what used to be in the past; time is of essence because many people are living and working in urban areas, away from their extended families; and other family members are also busy. Therefore parents need to prepare early.

The fact that students copied these stories and anecdotes required investigation into their motivation for accessing information through these modes. During group discussions held on the 31st of January 2007, the students commented generally on the power of traditional communicative modes and this is what they said:

> **INT:** I am interested in understanding whether using traditional modes like drama, singing, stories, are good for educating people on health related issues. What do you think about this?
>
> **Tracy:** Traditional communication like drama is good because it teaches you a lot of things. For example, you learn about AIDS and then also other things at the same time. For example, how people are suffering and why it is good to abstain.
>
> **Sarah:** Me I like traditional communication especially singing, dancing, and drama because it makes learning lively.

James: O.k. me I found drama. At school we have that club that is called ACYC and there is also straight talk. You find that in drama, there are some things you laugh at maybe demonstrating some behaviour. There are some things that are educative and funny.

Karen: I also like drama and singing because it is lively.

Flavia: I like singing and stories because they make it easy to understand the information, not like in text books.

INT: Oh really? Flavia you hardly talk. Can you really perform?

Flavia: Yes. I like singing those traditional songs. Besides we do it in a group and others sing with you.

Timothy: I agree with Flavia. Stories are easy to follow.

Petero: Even me I find stories interesting.

Phillip: I like drama and stories because they are entertaining.

Donald: Just what the others have said. I also like traditional ways because the information is like entertainment.

Gina: I like drama and stories. The information is interesting.

Maureen: I also like singing and stories because they are entertaining.

Joshua: Girls usually like traditional ways like dancing and so they go for drama. For me, I can read anything but I like when stories are written, for example in newspapers.

INT: What do the others think of Joshua's comment?

Timothy: Boys are just shy, but also boys are active like in the AIDS club. So it is not just the girls.

Karen: Maybe that is where girls find they can be a part of the educative process because in drama, you are teaching others.

All: Yeah, maybe that is also a factor.

Sarah: It [performance] perfects our body and English.

[Excerpt from group discussion, January 31st 2007].

The common theme in all the students' responses spoke to the entertaining and yet educative power of traditional modes of communication. Through this discussion, I deduced that students' copied down the stories because they found them interesting, lively and educative. Analysis of the proposed HIV/AIDS curriculum revealed that each topic will be either preceded by a story or concluded by an anecdote. This suggests that the curriculum developers recognize the power of stories in knowledge development. Although Joshua brought up a gender dimension, it was apparent that many of the participants had not thought about gendered preferences although Karen had a plausible explanation.

4.3. Discussion

This section extends the findings into larger discourses on health literacy, HIV/AIDS, and gender, embedded in existing literature. The findings revealed that the students accessed and reported information on health literacy, HIV/AIDS, and gender that were relevant to them as adolescents. The information that related to self-esteem, empowerment, and sexual health responded to particular social needs of the students. For example, the female participants reported that information on menstruation was timely because some of them (especially Rose and Flavia) had questions on the subject. The male students also learned about wet dreams and related myths, which enabled them to understand their own challenges and experiences as boys. The content of the information also addressed a cultural and social problem – knowledge gaps among youth that put them at risk (Burns, 2002). As reported in the findings section, the students learned about their rights and accessed pertinent information on sexual health, a topic that is highly taboo (Burns, 2002; Kinsman et al, 2001). There is evidence of transcendence of this cultural barrier although it is the media and not the teachers that are providing the information.

The findings in this study have indicated that students in Uganda access information on health literacy, HIV/AIDS, and gender predominantly through print media in the form of "Straight Talk", "New Vision", or "Monitor" newspapers. The school purchases the national newspapers and also receives *Straight Talk* every month. These papers are printed in English, the official language for public communication in Uganda. In addition to these newspapers, the students accessed information from their school-health and HIV/AIDS curriculum, radios, televisions, occasionally from computers, and healthcare centres. The information from these other sources complemented what the students had accessed through print media although the healthcare centres provided details on HIV/STDs.

The literature has suggested that the media and language used for disseminating health, HIV/AIDS, and gender-related information in Africa has led to knowledge gaps especially among unschooled women and youth (Kendrick & Mutonyi, 2007; Kickbusch et al, 2002; Majalia, 2004; Morrison, 2003). The gaps occurred because information dissemination has been done through schools (curricular and non-curricular sources), print media, and ICT, and communicated in English (Madzingira, 2001; Nutbeam, 2000). This approach to information dissemination favored the rich, the schooled, and those who can read and write in English (Madzingira, 2001). Uganda, like any other developing country, has embraced the technology-age and therefore dissemination of information on health literacy, HIV/AIDS, and gender has utilized these modern media (Edejer, 2000; Mayanja, 2002; Mushengyezi, 2003; Mutonyi & Norton, 2007; Pillsbury & Mayer, 2005). In addition, schools still remain a major avenue through which people access information, and English remains the official language of Uganda, and therefore most of the communication on health, HIV/AIDS, and gender issues uses English.

However, even with the advent of technologically-based information communication, traditional methods of teaching can be used to promote better health practices. As illustrated in the findings, there are leading examples of how traditional methods like story telling, proverbs, or anecdotes can be used to scaffold people's learning process. This is similar to what Kickbusch (2001) observed as the purpose of communication in health literacy promotion. Kickbusch argues that the communication mode should be able to utilize traditional methods of education that communities readily identify with, and therefore can take ownership of. From the data, it can be argued that the media is attempting to ensure that traditional practices are not discarded in favour of modern methods but are used alongside or are appropriated to promote health literacy.

The findings also reveal that Straight Talk is ensuring that young people access accurate information through using experts to build on what had been discussed. The concern with accuracy of the information relates to studies that have highlighted the misconceptions and beliefs that have contributed to the spread of the HIV/AIDS epidemic. The beliefs like having sex with a young virgin will cure one from HIV/AIDS (UNESCO, 2001) and the myths surrounding condom use (Kickbusch et al, 2002), have contributed to the vulnerability of women and girls to HIV/STD infection. Therefore, the international funding agencies have demanded that governments in developing countries provide accurate information and educate communities on better health practices (IDRC, 1997; UNAIDS, 2005; World Bank, 2002). The argument is that people have knowledge gaps because they do not access accurate information, so governments should increase access to, and use trained personnel like doctors to provide health and related information to communities (World Bank, 1999, 2002).

The study findings indicate that Uganda is responding to this assertion by World Bank (1999, 2002) because most of the information that the students accessed was provided by medical personnel (see 4.2.1) and by experts on adolescent health matters. In addition, the information on condoms addressed the common myths surrounding their safety against HIV/AIDS infection as reported above. The section on sexual health information (figure 2) provides an example of how young people were taught visually how to wear a condom. The information on T.B. (Andrew's story) and ART (Proscovia's story) were very detailed. In general, students accessed health literacy, HIV/AIDS, and gender-related information aimed at educating young people in Uganda so that their health practices are improved. The information was disseminated in such a way that it catered for the interests of young people like questions on adolescent body changes including menstruation, wet dreams, and sexual health related issues.

Not only was the media providing taboo knowledge, the young boys and girls were also being taught how to challenge gender stereotypes. The stories used for communicating health information, coupled with a special focus on girls as valuable to society, provides such an example. Gender stereotypes have been reported as one of the major contributors to young girls' knowledge gaps and vulnerability to HIV/STD infection (Kakuru, 2006; Mirembe & Davies, 2001). As highlighted in chapter 2 (see 2.4.2), the low status of women in society impacts lives of young girls who face the danger of being molested, raped or married off at a young age. Therefore any information that focuses on girls and their challenges is of cultural and social relevance as it speaks to a problem within the community and lived experiences of these adolescents. The students had accessed information on their rights, and the Straight Talk newspaper provided a hotline that young

people could call if they had been victims of sexual abuse. Henry (1995) has posited that through Straight Talk, young people in Uganda are learning to escape gender stereotypes (see also Kickbusch et al, 2002). The findings of this study therefore corroborate these earlier findings because the students accessed the information on gender and adolescence mainly from the Straight Talk newspaper (see also Asera et al, 1997).

Analysis of both Andrew and Proscovia's story indicated that the storyteller or writer aimed at highlighting social issues that have impacted the HIV/AIDS preventive care strategies in Uganda. Research has shown that T.B. has become the most dangerous opportunistic disease attacking those with low immunity or HIV/AIDS (MoH, 2006). The resurgence of T.B. has been noted in sub-Saharan Africa and therefore awareness campaigns have to be done (UNAIDS, 2007). This perhaps explains why Andrew's story was used to let the larger populace know about T.B. and to be vigilant. In addition, the story was meant to let people know that they can access free T.B. treatment.

In a similar vein, Proscovia's story addresses the issue of stigma that is reported as impacting the spread of HIV/AIDS in Uganda. Studies have posited that many women fear to know their HIV/AIDS status because of the stigma associated with the disease (Baylis, 2000; Castle & Kiggundu, 2007; Kickbusch, 2001; Kickbusch et al, 2002). Therefore the media is using a female character (Proscovia) to address the problem of stigma and covertly speaking to men's behaviour towards infected women. This was deduced from the sentence, "Boys started calling her "sick girl." No girls are implicated in the story and yet the setting of the story is a co-educational school. I therefore interpreted this as an attempt to draw the boys' attention and other readers, to the stigma faced by women, and challenge the boys (and girls) to think differently about infected persons. Perhaps the author of the

story in this Straight Talk edition, wanted to let young people, especially the boys, to understand that the stigma towards women is a bad practice and needs to be stopped.

Also, the story challenges girls to know their HIV status and to live positively given that Proscovia is used as a role model to young people. Again I interpreted this as the author's attempt to introduce a public life issue (women's fear of knowing their status) to a young audience so that they begin to grapple with the ramifications. In addition, the story empowers girls by portraying Proscovia as a leader and peer educator on matters related to HIV/AIDS, stigma, and positive living. Proscovia is described in the story as a career-oriented woman and this speaks to issues of gender and equality.

The findings also revealed that the cultural and social practices of the people were taken into account when designing the information on health literacy, HIV/AIDS, and gender. This was evident in the section 4.2 that reported on modes of communication. The information providers drew upon the traditional knowledge systems like the use of stories, proverbs, and anecdotes to educate young people and the general public on issues related to health literacy, HIV/AIDS, and gender. These forms of communication maintained the indirect way communities talk about issues. As Kanu (2006) pointed out, stories, proverbs, and anecdotes are used in traditional societies to teach young people social and moral behaviour. Boateng (1983) suggested that the use of stories, proverbs and anecdotes ensured that the young and old people arrived at the same understanding of the issue under discussion (see also Rogoff, 2003). This aspect was ensured through having a medical doctor's comment and a Q and A section at the end of the stories (see, section 4.2. above especially the stories). In this regard therefore, the modern media is transforming the traditional mode to suit current methods for education. Traditionally, the young people

would have been told the story and allowed to arrive at their own conclusions on the moral purpose of the message (see Boateng, 1983; Dei, 2000; Rogoff, 2003).

The stories showed the blending of traditional and modern cultures although it also demonstrates the changing African culture. That is, in the T.B. story, the writer includes a person requesting for prayer and then medical treatment. Geest (1997) posited that in African communities, there is a belief in supernatural interventions for physical healing and many people consulted traditional spiritualists for treatment. Geest noted that with the advent of Christianity, prayer is seen as a direct substitute to this practice and therefore it is not uncommon to find as many pastors and priests as there are doctors in hospitals. In this story, therefore, there is the recognition of the belief in prayer but with salient instruction to seek medical attention as well. The story shows that many people are moving away from the practice of consulting traditional spiritualists by embracing Christianity or Islam and using modern medicine. Furthermore, Jackie is not portrayed as a stay at home mother (traditional role) but a working woman (a doctor) who at the moment is the breadwinner of the family as Andrew is incapacitated by T.B. This in a way highlights the importance of a partnership in marriage through educating women.

Further analysis of the data indicates that the African traditional knowledge systems (Kanu, 2006), detailed in Chapter 2 of this thesis, have been utilized in educating the larger populace and young people about health literacy, HIV/AIDS, and gender. Communalism and caring for the social well-being of others was achieved because the media like Straight Talk, New Vision, and The Monitor, have created a virtual community. The young people are encouraged by Straight Talk to share their experiences and ask questions, and through this sharing, many adolescents are able to learn about what is happening in the lives of their

counterparts in other regions of the country. Actually, Proscovia is not a fictional character; she told her story to a fellow student in an interview for the Straight Talk February 2006 edition. Proscovia's picture is included in the newspaper and so the students who accessed this issue know that her experience is real. A virtual community is being developed because the students were encouraged to write to Straight Talk to show their support for Proscovia and her work as a peer educator on HIV/AIDS and the fight against stigma. As Boateng (1983) suggested, the traditional knowledge systems included lived experiences so that young people learned the importance of community. This tradition (using real incidences) seems to have been drawn upon in relation to providing young people with a living example of someone within their community who needs their understanding and support.

However, some researchers have suggested that there should be an introduction of the community into schools, and schools into the community in order to re-establish the links between indigenous knowledge and young people by using indigenous communicative thought in schools (Dei, 2000; Kanu, 2006; Wright, 2000). This suggestion is in response to the observation that many parents are not involved in the learning process of their children and that young people have lost connection with their social context (Boateng, 1983; Nutbeam, 2000; Kanu, 2006). Although the students accessed information through stories, proverbs, and anecdotes, there was no evidence that these methods were being used in schools. Therefore I support Wright's (2000) suggestion that parents and young people should be involved in the gathering of stories to restore parental and community involvement in students' learning. From the data, it can be concluded that Uganda has to balance the methods of information dissemination in order to address the issue of community involvement in adolescent health matters.

4.4. Conclusion

This chapter presented the findings that responded to the first research question of this study. The question aimed at understanding what kinds of information students in Uganda access, and to establish whether or not the information met the knowledge needs of the youth. From the discussions above, it is evident that the information is designed to meet the knowledge needs of the youth. The youth were able to access taboo knowledge (sexual health information) through Straight Talk. The students also learned about their bodies, their rights and other pertinent information that enables them to maintain their health.

In relation to utilization of available resources (Silver, 2001), the findings revealed that the information providers have used stories, proverbs, and anecdotes to scaffold young people's knowledge construction on health, HIV/AIDS, and gender. The media used is locally managed and the information providers are practitioners within the country. In regard to taking into account the economic status of the communities (Kickbusch, 2001), Straight Talk is distributed freely to secondary schools. This is meant to boost the number of young people who have access to important information such as sexual health. The participants' comments on indigenous modes of communication indicate that the use of stories, proverbs, and anecdotes was important and catered to their interests. The use of these traditional communicative modes by modern media to educate the youth about better health practices provides an example of how these modes can be used to promote traditional approaches to teaching. This will serve as a preservative of indigenous cultural practices.

The next chapter (Chapter five) examines the factors that contribute to health challenges faced by young people in Uganda today.

CHAPTER V

5.0. FACTORS IMPACTING THE HEALTH PRACTICES OF ADOLESCENTS

This chapter provides the students' perspectives on the factors that contribute to health, HIV/AIDS, and gender-related challenges faced by young people in Uganda today. The findings presented respond to research question 2 of this study, which is: "In the students' view, what are the factors contributing to health and HIV/AIDS related challenges faced by young people in Uganda today?" The purpose of this question was to provide youth with an opportunity to articulate their views on what factors impact their health practices and life chances. The question responds to the observation made by Jaminez that: "Parents do not represent the views and aspirations of young adults like they do for younger children" (World Bank, 2007 p. 23). As detailed in my literature review (Chapter 2), research shows that there are numerous factors that contribute to the poor health of young people. These factors include knowledge gaps on sexual health matters that expose sexually active young people to the risk of HIV/STD infection, or pregnancy in the case of girls (Burns, 2002), gender inequalities (Kakuru, 2006; Mirembe & Davies, 2001), poverty, social and cultural practices (Kickbusch et al, 2002 UNAIDS, 2001; UNESCO, 2002). Therefore, the question was designed with the intent of establishing whether some of these known factors have been addressed.

Most of the findings presented in this chapter are from the life history interviews, focus group discussions and questionnaires (especially Q1 & Q2). The findings are discussed under four major themes: (i) peer pressure, (ii) rural-urban knowledge divide, (iii) socio-economic background, and (iv) social and gender norms.

5.1. Peer Pressure

During the life history interviews, the participants were asked to mention any challenges that impact adolescent health practices. All the students mentioned peer pressure as a major challenge. The responses were as follows:

Rose: Sometimes we get into bad groups and are forced to have boyfriends or girlfriends, in case of the boys.

Gina: Peer pressure, whereby, your friends tell you about their boyfriends or girlfriends and pressure you to also get one. This can lead someone to get HIV/AIDS.

Donald: There is the problem of peer pressure where you get into bad company, go to night clubs, drink, have sex and through this, you get HIV/AIDS because you don't remember to use a condom.

Petero: There are some boys who get into bad groups, and get girls. Some of them even can get HIV/AIDS.

Joshua: Peer pressure. There are some people who are in bad groups. So these people start getting into trouble like having sex and it can lead to HIV/AIDS.

James: The pressure to get girlfriends because everyone has one.

Timothy: Peer pressure where some boys have started misbehaving and taking bad drugs, and are even not studying hard in school.

Maureen: The boys face the challenge of peer pressure, like having a girl friend, and this can lead to HIV/AIDS.

Flavia: For the boys, the challenge is peer pressure. They get into bad company and even have sex and can get HIV/AIDS.

[Excerpts from life history interviews, Feb, 13 & 14, 2006]

From the students' explanations, peer pressure seemed to have greater impact on the boys than it did on the girls in this study. One of the interview exchanges held in February

2006 is used to illustrate why the boys felt peer pressure is a major factor in adolescents' health practices:

> **Timothy:** O.K. as boys grow up they face a number of challenges of which some of it is related to peer pressure. Some of the bad members encourage their peers to maybe go to night clubs, discos, and have sex. The boy himself might get HIV or be imprisoned for impregnating a girl below the age of 18 years.
>
> **INT:** So the peer pressure is the major challenge?
>
> **Timothy:** You can even get some boys they can encourage you, if you don't do what they want they can just organize maybe to beat you up. Even I had my friend called junior. We stayed with him but then there was a time he was tempted. Friends lured him into smoking and he has turned out to be an expert marijuana smoker. But of recent, I was told that he almost ran mad; he uses that very drug that his friends told him to use.
>
> **INT:** Is that cigarette or marijuana? What is the drug?
>
> **Timothy:** O.K. they mix cigarettes and marijuana
>
> **INT:** So these are big pressures
>
> **Timothy:** Big pressure from most of the friends some of them are not good.
>
> **INT:** Do you have peer pressure? Do you have people who ask you to do what you don't like?
>
> **Timothy:** Yeah
>
> **INT:** What kind of things do they ask you to do?
>
> **Timothy:** For example, if they have friends like girl friends, they encourage you to also have. But I stand on my principle to abstain.
>
> **INT:** Oh really? So you want to abstain? So why do you think it is important to abstain?
>
> **Timothy:** By abstaining some of these diseases, unwanted pregnancy, and imprisonment, can be avoided.
>
> [Life history interview, Feb, 13, 2006]

In Uganda, there is a defilement law that punishes any male who impregnates a girl under the age of 18 years. That is why Timothy talks about imprisonment of boys. To Timothy, peer pressure is very present in the school and the other students felt that it is one

of the reasons some people engage in early sex. It was common to read in the boys' responses to questionnaires and monthly reports, issues regarding peer pressure and bad behaviour. Even though the girls mentioned that peer pressure was a major factor in adolescent risk behaviour patterns, they argued it in terms of poverty. The girls' responses are therefore discussed under the theme on socio-economic background.

In general, peer pressure was experienced more by the boys and the pressure centered on having girl friends and engaging in sexual relationships. As Timothy stated, these practices expose one to diseases, and possibility of impregnating their girlfriends. This can lead to the unintended consequence of being imprisoned, or dropping out of school for both the girl and the boy.

5.2. Rural-urban knowledge divide

Four students' in their Q2 responses suggested that sometimes location and its impact on information access is a central factor that contributes to health, HIV/AIDS, and gender-related challenges faced by young people in Uganda. The students suggested that young people in urban areas have more knowledge on critical health issues compared to their rural counterparts. The Q2 responses by the participants are provided below:

Sarah: The information needs of adolescents will only vary with the community that the youth comes from. For example youth in the urban areas tend to get more information compared to rural teens.

James: Yes there is enough sexual health information but the one limitation is that communication. E.g. most youth are illiterate and most of this information is written e.g. *Straight Talk* magazine.

Petero: In our village, most of the adolescents don't know English and you find that most health talk shows on radios and TVs are presented in English. Some parents are also shy to educate their children about issues of sex.

Joshua: There are many sources of information such as radios, newspapers, televisions and magazines which have programmes and written ideas on

sexual health. Those in school and live in urban areas can access this information compared to those in the village.

[Excerpts from Q2, January, 25th 2007].

The above responses provide an understanding of how the mode and language used for information dissemination can become a limitation to promotion of better health practices.

As mentioned in the previous chapter (Ch. 4), some studies have suggested that there is a growing knowledge divide between the rural and urban populace in most developing countries (Morrison, 2003; World Bank, 2002). This is because most of the health information is communicated through print media and other modern technologies, which some communities cannot afford (Kendrick & Mutonyi, 2007; Madzingira, 2001). The above responses from Sarah, James, Joshua, and Petero corroborate these findings.

5.3. Socio-economic background

The data also revealed how a person's socio-economic background can impact the health practices of young people. The focus group and questionnaire responses showed that the socio-economic status of the family impacted the girls more than the boys. Some of the responses from the students will be used to provide an understanding of how the socio-economic background of the family impacts young girls' health and related practices.

During the FGDs with the students, Joshua stated that:

> Now if you come from a poor family, you have not had breakfast, how can you concentrate at school? Sometimes you just have to look for somewhere to get money and sugar daddies are the answer.
>
> [Excerpt from FGD, Feb, 15th, 2006].

In this excerpt, Joshua argues that girls from poor families are most likely to engage in sex in exchange for money because the girls want to meet a basic need, buying some food.

Five of the 12 students suggested that sometimes it is competition that drives the girls to engage in sex with sugar daddies in exchange for money. Rose provided some understanding on why girls from poor families are tempted to exchange sex for money.

> Because like we come from different families, there are some who come from rich families, some who come from poor families and some from moderate families. Now, in the hostel, there are many things you don't have, and your friends have come with all things you need in the hostel. For example you, brought sugar and something like g.nuts [peanuts). Now you find that you feel small. You feel you are not fit to live in such an environment. So you don't feel comfortable. Sometimes girls get tempted to get men so that they become equal with their friends.
>
> [Life history interview excerpt, Feb, 14, 2006).

Rose was talking about the hostels in which girls reside during the school term. As explained in the methodology chapter (Ch.3), Mulembe High school is a non-residential school, but the students who come from afar, reside in hostels. Rose is one of the students whose parents opted to pay hostel fees so that she could live near the school.

The issue of "sugar daddy" relationships was pursued in the life history interview with Sarah. The question was "do girls have sex in exchange for school fees? This was Sarah's response:

> Going out just because of school fees, a few of them give in to sex just because they want to get school fees. But you can get about 6 out of 10 giving in for sex just because they want to get expensive things, get money to buy powder, those make-ups. The reason I say that is, when you get school fees and pay, the parents will ask

you, where did you get the school fees? But when you buy these small things, they [parents] do not know.

[Life history interview, Feb 14, 2006).

In this statement, Sarah suggests that sometimes the girls engage in sexual relationships in exchange for money but ensure that their parents are not aware of this. Some studies have posited that girls exchange sex to get school fees and sometimes the parents consent to this practice (see Jones & Norton, 2007). However, in this study, the participants said that most young girls do not even want the parents to know that they are sexually active.

The students then suggested that youth in urban areas are most likely to engage in sexual relationships compared to their rural counterparts. This is what Tracy said:

Actually girls who are not at school sometimes are not at very high risk because they live their simple life. They go in for jobs like house girls (maids), they earn their living, and they get some little amount and buy what they want.

[Life history interview, Feb, 14, 2006).

For these students, girls in the rural areas do not have the competition that urban girls face. In addition rural girls have more parental guidance compared to the youth living on their own in the urban area. In the village, "there is less freedom and idleness as the youth are occupied with farm work or household chores respectively" (Flavia's Q2 response).

The students then talked about how the rich people commonly referred to as "sugar daddies" take advantage of young people and lure them into sexual relationships. These cross-generational sexual relationships or what the students called "something for something sex" are considered a major factor in the high spread of HIV/AIDS (UNAIDS, 2001). It is important to point out these kinds of relationships are not considered as prostitution because they are clandestine or in the students' words "these people don't stand

on the streets selling their bodies like the prostitutes." In general, the socio-economic background may influence a young person, especially girls living in hostels or in urban areas to engage in "something for something sex."

5.4. Social and gender norms

The students suggested that some young people, especially those who are out of school, face the pressure of early marriage compared to those who are at school. For the boys, parents may think they are of age and so encourage the boys to marry. For the girls, it is usually related to traditional understanding of the place of girls in the community, and early pregnancy that forces the parents to marry them off. Three participants eloquently explained the role of social gender roles and their responses are used below:

James: Some of these boys when they reach schools, the parents may fail to pay school fees. So the boys end up marrying at an early stage. And in that marriage the boys face problems like they cannot provide the basic needs for their family.

Sarah: In most cases parents treasure boys more than the girls. You find that in terms of any income generating activity they give that activity to the boys and the girls do housework. There is no income generating activity which they are allowed to do. When you come to schools like this, girls are few just because they are affected right from the background. Some of them are not considered. Most times they consider boys. At times they force these girls into marriage. They are forced to marry while they are still young so that they can pay dowry for the boys to go to school.

Phillip: You know some parents still believe in the olden days, they say such girls they can get spoiled so they should get married but actually those parents who know the need and the importance of education they have managed to take their girls to school and some of them are excelling.

[Excerpts from FGDs, Feb. 15 & 16, 2006].

Although Sarah argues that girls are often married off so that the school fees for boys are paid, James thinks that lack of school fees also affects boys and they end up marrying.

Phillip on the other hand brings the issue of early marriage into perspective by pointing out that girls' education is impacted by the parents' attitude towards education.

In order to provide some understanding of the issue on early marriage, an excerpt of an interview with James is provided below:

> **INT:** Why do people marry early?
>
> **James:** Actually consequences that come their way. You cannot explain to parents and they understand that this boy can continue studies, so this causes early marriage. For them [Parents] when the boys reach a certain age, they say marry instead of spending money on schooling.
>
> **INT:** What about the girls?
>
> **James:** Then also you find in these rural areas to the side of girls, they are forced to marry early. Some of these parents are interested in bride price, yeah they don't know about education. Some of them indeed have never gone to school now to educate them about education; it is very hard for them to understand.
>
> [Life history interview excerpt, Jan 13 2006].

In this interview, James explained how social and gender norms impact both boys and girls. To provide some context to James's response, James comes from a community that practices circumcision as a 'rite of passage' to adulthood. In most cases, after such ceremonies, the boys are declared men and are encouraged to marry (see Fuglesang, 1997).

The issue of dowry and women's social status has been one of the contentious issues especially in relation to the fight against the spread of HIV/AIDS. It is argued that many women are in bondage and abusive relationships because of the practice of dowry where a woman is not allowed to leave an abusive husband (HRW, 2002). As mentioned in chapter two, some families in Uganda have stopped asking for dowry (Byamukama, 2006). Some students are aware of this as exemplified in this conversation with Gina:

> **INT:** So tell me a little bit about dowry for girls. Do all parents get dowry or is it just in the rural areas?

Gina: They [Parents] get dowry and the man can like give you only two cows. And there are some parents who just give out [their daughter] saying that if the girl reaches there and you mistreat her, she will come back. He gives you [out] for free of charge so that if you are mistreated, she will come back.

INT: So if a husband pays dowry for the wife, then she has to put up with anything that happens. If a husband doesn't pay dowry for the wife, does that mean if mistreated, she can come home?

Gina: Yes.

INT: So the family says O.K. you don't pay dowry, but if you mistreat her, she will come back. But what happens if a man pays dowry, and the wife is not happy, she has to just stay there?

Gina: Yes.

INT: So does it happen that in each marriage you have dowry?

Gina: No. It is just that it is the parents of the girl to decide.

[Excerpt from life history interview with Gina, Feb 14th 2006].

From this interview, it is apparent that Gina knows the changing dowry practices. However, from the previous quotes from Phillip, James and Sarah, it is clear that some parents use dowry as a source of income. These are the families that practice early marriages and have not yet embraced the value of education for their daughters.

Generally, the students suggested that social and gender norms like early marriage and dowry are a problem for young people in Uganda today. The students thought these practices are common in the rural areas especially if the girls are not in school although sometimes those in school can be married off if their parents cannot afford to continue paying their school fees (see Jones & Norton, 2007). The students suggested that young people who marry at an early age usually are caught up in the vicious cycle of poverty (see James's response) and cannot cater for their families very well (see also Kakuru, 2006).

5.5. Discussion

Numerous studies have reported how peer pressure, knowledge gaps between rural and urban communities, poverty, and gender inequality; impact the life chances of adolescents (Amuyunzu-Nyamongo et al, 1999; Ankrah, 1991; Burns, 2002; Jones & Norton, 2007; Kakuru, 2006; Kinsman, Nyanzi, & Pool, 2000; Mirembe & Davies, 2001, Nyanzi et al, 2001; Twa-Twa, 1997). Most of these studies have detailed how the above factors impact the life chances of girls in Africa generally or Uganda in particular (Burns, 2002; Jones & Norton, 2007; Kakuru, 2006). However, few studies have documented how young boys are impacted by these factors (Gupta, 2000; Mirembe & Davies, 2001). The findings presented in this chapter therefore build on the existing literature on factors that impact young people's health practices and life chances, and makes a particular contribution to research that highlights the challenges faced by adolescent boys.

The students in this study suggested that peer pressure impacts boys more than their female counterparts. Mirembe and Davies (2001) found that boys experience peer pressure in the form of proving their masculinity by their sexual experiences. The male participants therefore corroborate this finding as Timothy, Phillip, and Petero all stated that they had been pressured by peers to have a girlfriend or have a sexual relationship. However, the male students said that they have chosen to abstain, just as the campaign against HIV/AIDS in Uganda suggests. The boys also suggested that social norms like early marriage impact a boy's life chances. James mentioned that the boys, who are encouraged into early marriage, especially after circumcision, are usually economically unable to sustain their families and therefore the young family gets trapped in the vicious cycle of poverty. The UNFPA (2007)

has found that most of these young boys are leaving the rural areas for urban centres with the hope of escaping the poverty trap and family expectations.

Although numerous studies have already detailed how the above factors impact the sexual behaviour and life chances of young girls' in Africa and Uganda in particular, I draw on Nutbeam's (2000) idea of "unintended consequences" to draw attention to the "something for something sex" commonly practiced by adolescent female students. Nutbeam (2000) commented on how most of the health policies and programs implemented in developing countries led to some unintended consequences (see Ch. 2, sub-section 2.5.3 of this thesis). In this study, the female students suggested that most adolescents, especially girls living in hostels, engage in sexual relationships because they want to appear equal to their peers who come from middle-class backgrounds. The unintended consequence of schooling is the low-self esteem young people from low-socio-economic background develop when they live together with their friends from the middle-class. The low-self esteem influences their choice to engage in the "something for something sex" so that these girls can purchase items that improve their peer-status.

I remember during my secondary school years in Tororo Girls' School (1990-1996), the school authorities decided that all students should wear uniforms throughout the school year as a measure to promote equality in the school. The school also banned expensive items like necklaces, earrings and other accessories (school bags) that girls brought to school. Some parents had complained that their daughters had developed low-self esteem because the parents could not afford the expensive items (clothes) that their friends brought to school. My experience however differs from that of the participants' experience because I was in a girls'-only residential school and not a co-ed non-residential school. Some

studies have suggested that girls attending co-ed schools experience the pressure to show their femininity and desirability as a girlfriend (Mirembe & Davies, 2001). In this regard, the pressure the female participants in this study face differs from what my schoolmates and I experienced in Tororo Girls' school. However, the need to appear "equal" is a common experience in both scenarios as explained by Rose: "sometimes girls get tempted to get men so that they become equal with their friends." In my school years, however, the parents bore the pressure of providing these extra items for their daughters.

The issue of parental involvement is one concern I want to highlight in this study. The participants suggested that most girls are engaging in sexual relationships to purchase some basic items without the knowledge of their parents. This assertion speaks to another unintended consequence of schooling. Parents in rural communities are sending their children to schools in urban areas to live in hostels so that they avoid walking long distances to school. The parents want to provide their children with an opportunity to study without much disruption with household chores (Kickbusch et al, 2002). The intentions of the parents to provide their children with an education are good but the parents are not aware of the low-self esteem that young girls who come from poor families develop. The students however understand that their parents have a large burden to meet their school-related needs like fees (both hostel & school) and materials (books, pens, & uniform).

Numerous studies have documented the impact of school-related and user fees[4] policies on the life chances of the poor, especially young girls (Boyle, Brock, Mace & Sibbons, 2002; Kattan & Burnett, 2004; Leach, 1998; Mogha, 2001; Okuonzi & Birungi, 2000; Tomasevski, 2005; UNICEF, 2005). There are a large number of different "fees" that private households sometimes have to pay for publicly provided education, including

[4] User fees are charges on healthcare services.

tuition fees, textbook fees or costs and/or rental payments, compulsory uniforms, PTA dues, and various special fees such as exam fees, contributions to district education boards, and the like. In many countries, private tutoring, although not strictly compulsory, often adds to the household costs of education (Kattan & Burnett, 2004).

Boyle et al (2002) have observed that not only does maintenance of fees impact the education chances of children from poor homes; it leads to increase in poverty levels in homesteads. Poorer households often incur indirect economic costs by sending to school children who would otherwise contribute to the household economy, by working for income, working in farming or through such tasks as collecting water and firewood or looking after younger children. These indirect costs are often more critical than direct fees in keeping children out of school and must be addressed in any policy work to increase enrollments (Tomasevski, 2005). Boyle et al (2002) found that in Uganda, the poor made sacrifices in order to send their children to school. School-related expenses cost about 33% of the household expenses, second to the cost of feeding. As a consequence, most of these families cannot afford healthcare and this impacts their life chances. This has implications for the achievement of other MDGs, for example, eradicating poverty, promoting gender equality, and improving life chances for all. All these studies call on policymakers to re-examine how these policies impact the education and life chances of the poor.

As Caldwell et al (1998) have observed, schooling has strained the economic resources of many communities, although many parents know that education is an investment. The economic hardship is experienced because in traditional Africa, by adolescence, the children contributed to the economic well-being of the families. But because of schooling, these young people are "unproductive" and are economically still

dependent on their parents or communities. Caldwell et al's explanation helps to highlight another unintended consequence of schooling—the straining of the economic resources of the families, and yet parents want the children to study. One should remember that most traditional families had many children and if all were to attend school, the economic strain on parents was worse. Sometimes the parents opt to marry off the girls so that they can educate the boys as a future investment. The participants raised this issue under the discussion on social and gender norms, and the practice of dowry payment. However, the students also mentioned that some parents have stopped asking for dowry.

The students also mentioned the rural-urban knowledge divide among adolescents, especially in relation to sexual health information, as a major factor that impacts the health practices and life chances of unschooled youth. I use this finding to underscore the importance of introducing a socio-cultural dimension into the health, HIV/AIDS, and gender discourse. As discussed in the theoretical framework of this thesis (Ch. 2), communities had traditional sex education institutions that equipped young people for adult responsibilities and marriage (Fuglesang, 1997; Muyinda et al, 2004). However, I reiterate some ideas from some research studies (Dei, 2000; Kanu, 2006; Turay, 2000) and suggest that the indigenous institutions can be re-tooled to address today's problems. In this regard, the problem is the rural-urban knowledge divide and how it relates to acquisition of pertinent health related information, especially sexual health and HIV/AIDS prevention.

The participants in this study discussed in-depth why girls engage in sexual relationships in exchange for money. The findings on adolescent girls' needs and how it impacts their education and health, reveals an unintended outcome of schooling (Nutbeam, 2000). Health promotion therefore needs to include programs that address the sense of

"inequality" that children from poor backgrounds encounter in schools, which influences them to engage in "sugar daddy" relationships, and puts the youth at risk. The students suggested that many parents are unaware of their children's sexual activities and this is supported by a recent report in the media (Mason, 2007), on cross-generational relationships. It is important these social issues be recognized as impacting the health practices of youth, especially the youth from low socio-economic backgrounds.

Lastly, although most studies have discussed the issue of poverty and HIV/AIDS as synonymous with rural communities (Jones & Norton, 2007; Kakuru, 2006; Nyanzi et al, 2001), the recent HIV/STD survey suggested a different analysis of the discourse. The recent HIV/STD survey statistics (see Ch. 1; MoH, 2006) have shown that HIV/STD prevalence rates are lower in the rural areas compared to the urban areas. The 2005 statistics (MoH, 2005) also show that the HIV/STD prevalence rates among urban females are higher (12.8 percent) compared to their rural counterparts (6.5 percent). Therefore, women living in urban areas are twice as likely to be infected with HIV compared to their rural counterparts. The urban men also have higher prevalence rates (6.7 percent) compared to their rural counterparts (4.8 percent). In general, the statistics show that females living in urban areas are twice as likely to be infected with HIV/STD, than men and their rural counterparts. In addition, the HIV/STD prevalence is seen to be higher among wealthier than poorer families (MoH, 2006). Kickbusch et al (2002) interpret this trend as a problem of gender inequality where gainfully employed and educated women, especially teachers, are found to be the most affected by HIV/AIDS. Mason (2007) suggested that wealthier men often get young women to show their sexual prowess or have multiple sexual partners and this explains why urban people are more vulnerable.

However, these statistics contextualize the participants' assertion that urban girls are most likely to engage in the "something for something sex" compared to their rural counterparts (see section 5.3). Many studies have detailed the dangers of these cross-generational (sugar daddy) relationships and how they create for young girls an environment of risk for possible HIV/STD infection or pregnancy with its associated problems like dropping out of school (see Amuyunzu-Nyamongo et al, 1999; Ankrah, 1991; Burns, 2002; Jones & Norton, 2007). In general I reiterate the call made by UNFPA (2007) for interventions that also focus on the urban problems that impact health practices.

5.6. Conclusion

This chapter has presented the challenges that, according to the participants, impact the health practices and life chances of young people in Uganda. If continued vigilance and tackling of social determinants of health is to be done, the issues like peer pressure, rural-urban knowledge divide, socio-economic background, and social and gender norms that impact adolescent health have to be taken into account. In general, these factors had more drastic consequences for girls than boys. Therefore if the gains made through providing sexual health information for young people (see Ch.4) are to maintained, it is important to ensure that the environment in which the information is to be applied is conducive. As some studies have shown, sometimes the girls who engage in cross-generational relationships for money do not have negotiating power for protected sex and therefore are at risk of HIV/STD infection or even pregnancy (Burns, 2000). Mason (2007) reported in the Monitor Newspaper that cross-generational relationships have become rampant among 20-25 year old female students because of the need to be "equal" to their wealthier

counterparts. Therefore, special attention should be paid to the factors that contribute to these cross-generational relationships.

The recent HIV/STD survey statistics for Uganda revealed that young people within the 10-19 year age bracket have the lowest prevalence rates in the country (MoH, 2006; UNAIDS, 2007). The students who took part in this study fall in this age bracket. However, just as the UNAIDS (2007) report has posited, the factors that contributed to the fast spread of HIV/AIDS need to be tackled to avoid the resurgence of the disease. The statistics also show that young girls aged (15-19 years) are nine times more vulnerable than boys to HIV/STD infection (see table 1, Ch. 1) and therefore there is need for continued vigilance (UAC, 2007). The current Ugandan President, Yoweri Museveni, who has spearheaded the HIV/AIDS education for youth, has suggested that although the prevalence levels among adolescents have lowered, people should not grow complacent (see Norton & Mutonyi, 2007). The president is committed to raising an "HIV free" generation and has asked for the development of a new HIV/AIDS curriculum that addresses the social challenges the youth face that impact their lives (MoES/PIASCY, 2005). In this study, the students mentioned four of these challenges: peer pressure, rural-urban knowledge divide, socio-economic background, social and gender norms. The impact of each factor on adolescent health practices has been detailed in the findings above.

The next chapter presents findings that discuss the impact of the debate on gender equality in the fight against health epidemics including HIV/AIDS.

CHAPTER VI

6.0. GENDER AND PUBLIC HEALTH PROMOTION IN UGANDA

This chapter presents the findings that related to research question three of this thesis which is: *According to these students, what is the impact of debates on gender equality in the fight against health epidemics including HIV/AIDS?* Gender equality is considered as one of the central areas to be improved in Africa if women's health is to be promoted, maintained and protected (Baylis, 2000; Burns, 2002; Chan, 2007; Kickbusch, 2001). The purpose of this question was to provide youth with an opportunity to engage in a discussion on gender and health. In addition, the question was designed to enable students to understand the concept of education for empowerment (W.H.O 2001) currently advocated in health and HIV/AIDS education programs in Uganda (MoES, 2006).

The findings presented in this chapter are predominantly from questionnaire three (Q3) and the critical inquiry discussions on selected published articles. The data will be presented in three major themes: 1) students' conceptualizations of gender equality. 2) Students' perspectives on critical issues related to gender. 3) Advantages of gender equality. The findings will be followed by a discussion and then the conclusion.

6.1. Students' conceptualizations of gender equality

In order to determine students' perspectives on gender equality and how it can impact public health and improve the life chances of people, it was important to draw out their understandings of gender equality. A specially designed questionnaire (Q3), which focused on issues of gender, health and equality, was completed by the students. Based on the students' responses, it was evident that many of them understood gender equality in

terms of rights and opportunities. The common definition of gender equality was "both women and men having the same rights and opportunities without discrimination." The students expounded on this by stating that "males and females are entitled to same rights concerning anything be it social, economic, or political." The students demonstrated a basic understanding of the term gender equality.

The students were asked in the questionnaire (Q3) to give examples of where gender equality, according to them, is practiced, drawing examples from their personal lives to public spheres. This sub-theme therefore provides an understanding of how the students have observed and interpreted gender equality practices in Uganda. Three sub-themes will be used to present students' responses: 1) gender equality in the private sphere, 2) gender equality in the public sphere, and 3) gender equality and community response.

6.1.1. Gender equality in the private sphere

In the private sphere (treatment of boys and girls at home) many students claimed there was gender equality and their families were progressive, but four female students argued otherwise. For those who argued that gender equality existed in their families, the common response was "both boys and girls are taken to school and do same household duties at home" (Donald's response). To this group of students, it was access to education and sharing of household duties that informed their perspectives on gender equality at home. The four female students who suggested no gender equality existed said:

> **Gina:** There is no gender equality in my family because both domestic and agricultural work is left for my mother.
>
> **Maureen:** No. Because parents sometimes do not listen to our views when it comes to our expressions and so we [children] are not free

to express our feelings. And on the other hand, the father does not consider the mother's "voice" in the home to very strong as his.

Sarah: No. Boys and girls are not equal in our home. You find that when you go back home, the girl goes to the kitchen to cook and the boys are just sitting. Girls do more housework than boys.

Tracy: No, the parents don't consider our opinions and we the children are not considered in decision making. As a girl, I don't have a voice at home.

[Excerpts from Q3 responses, Feb 16th 2007]

It was interesting to observe that Maureen and Tracy do not only concentrate on their parents' relationship, but also the relationship between parents and children as important in framing how one understands gender equality. To the four students, gender equality is more than providing education for both boys and girls but includes how they are treated at home. It also includes the way their mother is treated at home by their father or extended family.

6.1.2. Gender equality in the public sphere

When it came to the public sphere, all the students suggested that gender equality exists in Uganda and that the people are becoming more progressive in the way they thought about women's place in society. The students backed their claims by giving examples of how gender equality exists in the public sphere. In response to the question on whether or not girls and boys are treated equally in their school, this is what some said:

Karen: We have equal participation in health clubs; attend the same career guidance; and girls have extra points in university education.

Petero: Students take the same subjects and encouraged to offer whatever subjects they like without favour or segregation.

Joshua: There is a lot of interaction between boys and girls since all are exposed to the same facilities and services. This creates an impression that both have a responsibility to play in society.

Gina: Since both boys and girls are doing the same subjects at school, they are all equal. We also have health clubs whereby both boys and girls are involved, so we discuss about people's health.

Tracy: Both are given the same discipline and when they have wronged [broken a school rule], they are given the same punishment.

Sarah: There is gender equality because women are in high up positions. Even there are scholarships for girls to boost the education of women.

Flavia: Both girls and boys access the same health information in schools. They are active in the HIV/AIDS and Straight Talk clubs.

Timothy: These days, there is gender equality. You find that in national examinations, girls are out-performing boys.

[Excerpts from Q3 responses, Feb. 16th 2007]

The students' emphasis on equal opportunities in relation to the subjects offered is important because some studies suggest that girls lack support and are often regarded as academically weaker than boys (Kakuru, 2006; Mirembe & Davies, 2001). In this school, the students suggested that they are encouraged and supported by the teachers and Karen's response captures this when she makes reference to career guidance. So the students are not encouraged to offer subjects commensurate to their domestic roles as was found in a study conducted by Mirembe and Davies (2001) in one urban school in Uganda. In fact, Petero

was quick to point out that he is taking home economics, a subject originally believed to be for girls. Another example of girls stepping out of subordinate roles is related to health clubs where the students argued that leadership is shared.

In relation to the larger public (society) and gender equality, the students suggested that it could be observed that women are also taking up leadership positions which were originally reserved for men only. The first example was the fact that the school was headed by a female even though it is co-educational. The second was the fact that there are women in the parliament and that Uganda once had a female Vice President. This is how Tracy summed up gender equality in Uganda:

> Yes because people are educated, so they know the things they are supposed to do. Not like those days back when women were restricted to special jobs/work and men dominated throughout.
> [Tracy's Q3 response, Feb. 16th 2007].

One student (Karen) had a very interesting example of gender equality in Uganda. She wrote the following in her responses to Q3:

> In my community, the men and women have experienced a western change culturally. That is to say, the roles that traditionally were done by the women have been passed on to the men. The dress code has also changed, women wear trousers, which was not there before. [Karen's Q3 response, Feb. 16th 2007].

The factor of interest was Karen's association of gender equality with western culture. She cites the changing domestic roles (also mentioned by other students) but credits the change in the dress code to western influence. Leach (1998) observed that in developing countries, especially among the men, gender equality advocacy is not fully embraced because it was considered a western influence or practice. Therefore Karen's assertion bears some merit to

Leach's claim that gender equality is seen as a western notion. This became apparent when students wrote about gender equality in their local communities.

6.1.3. Gender equality and community response

In spite of the students' claims of gender equality in the public sphere, the responses were mixed when it came to talking about gender equality in their local communities. The question was: "does your community maintain a cultural and traditional understanding of the role of men and women, or is it more progressive? Explain." Seven students' responses highlighted the different roles men and women are to play in the community with some suggesting that it ensures unity and co-existence without violence. These are their views:

Flavia: Yes this is the way, women are to work for men e.g. preparation of food and men are also to make houses for women.

Donald: Yes my community maintains a cultural understanding of the roles of both men and women. This helps in enhancing peaceful co-existence between the two sexes and thus appreciating each others' role. Men do muscular chores like carpentry and women domestic chores like cooking.

Gina: The community maintains [a traditional view] because in every community a man has to take control of the family affairs, has to buy food in the home and pay fees for the children.

Petero: My community (Gishu) maintains a cultural and traditional understanding of the role of men. Man is a head of extended family and man is to be heir.

Joshua: The community still has the misconceived perception that a man has most of the responsibilities, regarding family issues and has a view that women must agree to the proposals made by the men.

Maureen: Yes traditionally my community still sets aside some roles which are played by males and not females. Like leadership is mostly meant for males, and females are considered a weak sex, compared to males.

Sarah: Women and men are equal in other terms. In economic terms and other things but family, the women should be submissive to their husband.

[Excerpts from Q3 responses, Feb. 16th 2007].

From the above responses, it could be concluded that although these students have examples of changing roles for both men and women in Uganda, within their micro-communities these changing roles are not quite evident. There exists a paradox in that the parents do send their children (both girls and boys) to school which can be interpreted as acknowledging gender equality, yet at the same time, the community expectations for the roles for men and women counter this type of interpretation. In the micro-community, the male remains superior to the female and gender equality advocacy is seen as external to the micro-functioning of the communities. Therefore these students have to negotiate their understandings of gender equality from contrasting environments, that is, in a school where they are equal and capable of doing anything, to living in a micro-community where women are considered inferior. It was remarkable to observe how the students held these two views side-by-side and how they tried to imagine how it should be in their future.

The other five participants (Phillip, Tracy, Timothy, James & Karen) suggested that their communities were more progressive although when questioned about the attitudes towards women's education, it became apparent that this assertion was not correct. The details are in section 6.3 of this chapter. As mentioned in the methodology chapter (Ch. 3), I used critical inquiry discussion based on Sirotnik's (1988) question template, to dialogue

with students over the impact of the debates on gender equality on health and life chances of women and girls. The next section reports what transpired in these discussions.

6.2. Students' perspectives on critical issues related to gender equality

The four articles (see methodology chapter) used in the discussions addressed different aspects of how gender inequality impacts people's health practices, especially in relation to women and girls. As mentioned in the methodology chapter, the boys were more vocal than the girls. Therefore, I first gave the students questionnaires on the topics under discussion so that I could compare the critical discussion responses with the questionnaires. Therefore responses from Q4 are interwoven into the critical inquiry discussions in order to provide an understanding of the students' views on gender equality and health promotion.

Also as mentioned in the methodology (Ch. 3), the articles were read in groups of threes and later discussed by the whole group in the critical inquiry discussions. Each group provided an overview of the article, and their comments, before the discussion was opened up for whole group discussion. All but Joshua made oral responses to the articles they read. Joshua wrote down his thoughts on the article he read, prior to the discussion. What transpired in each discussion is presented in four sub-themes: 1) Policy and gender equality, 2) vulnerability of female adolescents, 3) indigenous institutions and sexual health education, and 4) myths, HIV/AIDS and cross-generational sexual relationships

6.2.1. Policy and gender equality

The theme "policy and gender equality" emerged from the data on the students' discussion on the first article. The article by Gupta (2000) provided the bulk of the

discussion in this section. In order to provide the reader with the context of the discussion, the actual abstract of Gupta's article is provided below:

> The focus of Geeta Rao Gupta's plenary presentation of 12 July 2000 at the XIII International AIDS Conference is on the what, why, and how of gender, sexuality, and HIV/AIDS. Dr Rao Gupta discusses the factors associated with women's vulnerability to HIV; and the ways in which unequal power balance in gender relations increases not only women's, but also men's, vulnerability to HIV-despite, or rather because of, their greater power. She then addresses the question of how one is to overcome the seemingly insurmountable barriers of gender and sexual inequality. How can we change the cultural norms that create damaging, even fatal, gender disparities and roles? According to Dr Rao Gupta, an important first step is to recognize, understand, and publicly discuss the ways in which the power imbalance in gender and sexuality fuels the epidemic. She provides examples of sensitive, transformative, and empowering approaches to gender and sexuality and concludes that, in the final analysis, reducing the imbalance in power between women and men requires policies that are designed to empower women--policies that aim to decrease the gender gap in education, improve women's access to economic resources, increase women's political participation, and protect women from violence.
>
> (Electronic copy: plenary presentation, XIII international AIDS conference, Durban, South Africa).

This article was read by Phillip, Donald and James. Phillip opened up the critical inquiry discussion by providing an overview of the central points of the article as follows:

Phillip: Actually our article was about gender, sexuality and HIV/AIDS, the what, the why and the how. According to the researcher, gender and sexuality are very significant in the spread of HIV/AIDS. This was written in the African context. You see in Africa, there is always a difference in gender, the males are given more privilege than the females in all aspects of life whether sexual or even the roles in the family. You find that the male are often on the higher side. So we can see that this gender is a cultural construct which believes that the masculine gender is better than the feminine.

There are problems which have been brought about by this gender imbalance. For example women are not catered for in matters of HIV/AIDS. They are not looked after like accessing treatment and accessing care so that they can live on either positively or negatively. The information is not provided to them (females) in a manner which can help them. We see that the women in that matter are vulnerable. For example concerning culture, there is always silence among the women and they find it hard to express their problems. <u>Maybe they are oppressed in homes, violence or mistreated; they keep quiet because they know that the man is the controller of the whole family so he can do anything he wants.</u> Concerning young girls, there is this aspect of virginity which is highly valued and in one way or the other, this exposes them to

HIV/AIDS. The way they are exposed is to look for other ways of getting sexual satisfaction like lesbianism or something more dangerous like girls having anal sex with men.

> There is one aspect which is so disturbing and should be given more attention and that is power imbalance. You can see that men in Africa are regarded as more powerful than the women. This puts the women at a disadvantage because they are not listened to and even prohibit them from using some protective measures like family planning or protecting themselves from HIV/AIDS. On the side of men also, however much they are regarded to be more powerful and safer, they are also vulnerable in another way. For example a young man will think that since I am a man I need to exercise my manhood and as a result will have multiple partners and get HIV. The other part is how to control the situation because both are vulnerable. Have preventive measures that cater for women so that they can all be in control of their safety. For example if the man is not willing to protect himself, then the woman will look for a way of protecting herself because it is provided. Then the other way where there was emphasis was power balance between men and women [emphasis mine].

The highlighted portions point out the key issues of the article and the reason it was chosen for the discussions. From the article the students learned that gender is a cultural construct and also how gender imbalance impacts both sexes. Generally, Phillip demonstrated a clear understanding of the article and provided the others with enough background to foster an in-depth discussion. Donald and James shared their comments and this is what they said:

> **Donald:** According to the article, men have freedom of speech while the women are left to be ignorant about sex, which makes it difficult for women to know the repercussions of these sexual practices. Besides, the women would not be able to negotiate for safer sex. It is also wrong to assume that boys know everything because this stops them from getting guidance hence exposure to HIV infection.

> **James:** In societies men are considered to know more but when we go deeper like us, we don't know about things concerning sex experience and marriage. Like in a family, when you say you are getting married, they don't educate you about the challenges. Men also have multiple partners.

Both Donald and James zeroed in on the fact that men are also vulnerable and James underscores this in his response. The vulnerability of boys has been a recurring theme in the discussions and so James's comment provided a starting point for generating a

discussion on what others thought about issues of women and men's health. This is what transpired:

> **INT**: O.K. what do the others members of the group think?
>
> **Petero**: For me this thing that boys know too much, these days it is the opposite. Let me say, if they carry out a survey of people who are abstaining in this school, it is mostly boys.
>
> **INT**: So are the boys abstaining because they have lots of information and know about sexual health issues?
>
> **Tracy**: They know more.
>
> **Timothy**: But when you examine boys abstaining more than the girls, when the boys examine the penalties that are given after a girl maybe gets pregnant. Due to that fear, the boys try to abstain but for them [girls] at times they look at it as a way of getting some money.
>
> **INT**: So it is not because the boys have more sexual health information?
>
> **All**: [yes].
>
> **Petero**: The girls face a lot of temptations. For example, men will come and distract the girl but it is hard to find girls coming to distract the boy. So it is harder for the boy to be involved in sex than the girl.
>
> **INT**: O.K. But do you think that emphasis on virginity still exists in today's Uganda?
>
> **All**: It has died out.
>
> **Phillip**: The girls are now protected by the law and have more freedom.
>
> [Excerpt from critical inquiry discussion, March, 14th 2007].

What was interesting in this exchange is that Tracy thought the boys had more information while the boys took the opposite position. However, this argument came up again in the next discussion and so was pursued at length later. The issue of abstinence brought up heated discussions with the boys suggesting that the defilement laws end up protecting them because they worry about prison while the girls have the option of having sex with older men if the boys are being careful. The students reiterated that with virginity being an

option not a requirement, many girls engage in sexual relationships, which the girls, in fact, disputed. But again this was discussed at length in response to the fourth article.

The students decided to discuss the article in relation to boys and girls but did not pursue the discussion of power relations in marriage settings. However, I asked the students in questionnaire four (Q.4) to make suggestions on how best to protect the health of women especially when there is gender imbalance. This is what some of the students' suggested:

> **Gina:** This issue should be taken to parliament and debated about; it will in turn benefit all the people in the country because there are some people who do not know anything about gender equality.
>
> **Tracy:** This could fall on employment, because women are not favored though they are educated to whatever level.
>
> **Flavia:** Policy-makers should take the lead in gender equality campaigns so as to make the gender rights go on effectively. Why I say this is that on the side of the husband, if they are to make those gender equality, they could have their wives as slaves and sometimes they could be beating them often.
>
> **Phillip:** I would like to see a change in girl child education because it seems like when you are educated; it is easy to achieve something according to your wish.
>
> **Petero:** Change from polygamy to monogamy. Women should take part in policy making and also women should have key roles in the family.
>
> **Joshua:** A law which condemns the violation of the rights of one sex should be enforced by the government. Women must get the opportunity to express themselves through the establishment of women's groups and organizations with funding from the government.
>
> **Timothy:** The community must be sensitized about the merits of gender equality. People need to understand gender equality.
>
> **Karen:** Parents need to support gender equality and government should continue promoting it.
>
> **Donald:** The government should show people the importance of gender equality.
>
> [Excerpts from Q4 responses, Feb. 26th 2007].

The students' responses showed how much they thought government should take the initiative in ensuring the health of women. Another important point is the call for women to

take initiative and participate equally in the policies that impact their status in society. Tracy and Phillip's comments were significant in that they mention the issues of education and employment which to them is commensurate with women's empowerment.

Although most studies suggest that women who are educated have better health practices (Moulton, 1997), other studies suggest that this assumption is not necessarily true in relation to HIV/STIs (Kickbusch, 2001). The salient point therefore is to raise awareness and set up policies that ensure the rights of women are protected just as the students have suggested above. As mentioned earlier, the law against domestic violence has not been passed in Uganda and Flavia's response captures the importance of having this law passed by stating: "Why I say this is that on the side of the husband, if they are to make those gender equality, they could have their wives as slaves and sometimes they could be beating them often." In general, for women who are encountering domestic violence, the challenge for ensuring their safety and health remains of great priority.

6.2.2. Vulnerability of female adolescents

The article by Burns (2002) highlighted the challenges young girls face and how it makes them vulnerable to HIV/AIDS. The abstract of the article is provided below:

> Through a case study of a school in Eastern Uganda, it is clear that gender roles and expectations restrict the amount of information that girls get about sexuality at school, which increases their chances of contracting HIV, falling pregnant and losing educational opportunities. In addition, even if the girls had the information and the skills necessary to have healthy sexual relationships, power imbalances in gender relationships render them powerless in the face of masculine sexual freedom. Thus the two major points of this briefing follow. First, this school attempts to control feminine sexuality while masculine sexuality is unquestioned. Second, the briefing questions the assumption that once sexuality information is in the curriculum that teachers will be prepared, willing and/or permitted to teach it. This briefing first contrasts the concept of sexuality education with the usual way in which schools and HIV programmes go about education on sex and HIV. It then gives the general context of the case study, the methodology used and analysis of the results. It examines reasons for the failure of existing framework for education on HIV and sexuality

in the school, and argues for the possibilities of an outsider contributing to effective sexuality education. (Published in *Agenda*, 53, 81-88).

This article was read by three female participants, Tracy, Karen, and Maureen, and generated much discussion in the whole group. This is what transpired:

Tracy: O.K. I read about health education in a girls' school located in Eastern Uganda. This was on education and sexuality at school. It [the article] stated that teachers and the administration are aware of the challenges the girls are facing at school like pregnancy, risk of contracting HIV/AIDS and this can be stopped by using three strategies; isolation of the students maybe having single-sex boarding schools; abstinence and avoiding romantic love and sexuality by being active in sports like basketball. The girls are informed on this but 76% of the younger girls and 85% of the older girls assume they know everything about sex.

INT: Who else read the article?

Karen: The condoms are a disadvantage because they are expensive and people cannot afford to buy – one packet is 300 Shs. Adolescents are having sex without condoms and are transferring infection to the others. The other issue about the girls, they should not be idle because they [girls] will find themselves in other activities which are not building like sex, romantic relationships etc.

Maureen did not attend this discussion so we could not get her point of view. However, the two students provided an overview of the article and then the discussion began.

INT: So do you agree with the article? Do you think that is what happens, say in this school?

Tracy: Yes.

INT: Do girls in this school have avenues for sharing their problems?

Tracy: There are just clubs.

INT: Are there clubs for girls alone?

James: No. There is a person in charge of girls and boys in those clubs.

INT: So it means that when a girl has a private issue it is difficult for them to get help?

Timothy: No. There is a senior woman teacher.

INT: So are the girls given guidance?

Petero: They even have more guidance than the boys because they have people who come to talk to them.

James: Yes, and then counseling them.

Timothy: Madam you find that in that situation boys are sidelined. Since we joined here, there is nothing like counseling or talking to boys.

[Excerpts from critical inquiry discussion, March, 14th 2007].

What stood out during this discussion was that the female students first uncritically accepted what was said in the article until the boys challenged this. The male students brought out the issue of the Senior woman teacher who acts as a *Senga* in the school and also the visiting counselors. I should mention that during the initial visit to the research site in October 2004, Dr Norton and I attended one of these counseling sessions with a visiting nurse who was educating girls on menstruation. Actually, this is what the students were referring to as girls having extra educational programs. Apparently the boys do not have a similar program and rely on the *Straight Talk* and HIV/AIDS clubs and newspapers to get information. The female students commented on these "extra" programs as follows:

INT: So what happens in these girls' only meetings? Do the people select general topics to discuss, or are the counselors available for girls approach them whenever they have a problem?

Tracy: Those who come have a selected agenda and we don't have the chance of choosing the topic. Sometimes we are given chance to ask questions.

Karen: They come and give lectures and some students dodge these lectures.

[The other girls make agreeing sounds and nod in support of Karen's comment]

INT: That is understandable because it feels like it is another classroom lesson.

Petero: Sometimes they just come to do medical check-up

INT: What are they checking for, pregnancy?

James: Yes and then counseling them

Petero: Those who are pregnant don't even go there.

Karen: But the main purpose is to find those who are pregnant

[Excerpts from the critical inquiry discussion, March, 22nd 2007].

The female students do not find "extra" programs helpful. The male students however insisted that the counseling aspect is what they were referring to. In relation to the senior woman teacher or "senga", the girls do approach her for advice because she is in charge of the HIV/AIDS club. The students suggested that sexual health information is adequate for both boys and girls in schools, but it depends on what one chooses to do with it. In summary, the students suggested that adolescent boys and girls are equally vulnerable, but girls more so, if the vulnerability is related to sexual advances from older men.

6.2.3. Indigenous institutions and sexual health education

The article written by Muyinda et al (2004) was used to discuss the issue of sexual health knowledge gaps and the role indigenous institutions can play. The abstract of the article is included below to provide an understanding of what the paper was about.

> Although adolescent girls in Uganda are particularly vulnerable to HIV infection, providing relevant sexual health education to them is problematic. The *senga* (father's sister), is the traditional channel for socializing adolescent girls into sex and marriage among many ethnic groups in Uganda. This paper discusses the implementation and community acceptability of 'modern' *sengas* who were trained to provide HIV-related counselling to adolescent girls. Fourteen *sengas* were trained in two villages and, in the course of the 1-year study, 247 individuals made a total of 403 visits to them. By including both traditional services (such as advice on and assistance with labial elongation) and modern health and sex education, the *sengas* provided a 'middle road' between tradition and modernity. As a result, despite initial suspicion by the community, their activities were supported by the community generally and effective as intervention. [*AIDS Care journal, 16*(1), 69-79].

This particular article was read by Joshua, Timothy and Petero, but the whole group later discussed the article after the three had shared their views. Joshua opened up the discussion by briefly describing what the article was about and what his view was.

Joshua: O.K. For me I read the article and wrote down some points. Now about the *Senga* model of sexual health education. O.K. it has had some good impact on the population in the rural areas. Then the cultural beliefs embedded in the *Senga* institution makes the adults to view it as something which prepares adolescents for marriage. Some parents therefore are against sex education for young people unless it is in preparation for marriage.

INT: So do you agree that "modern" *Sengas* can be used today?

Joshua: I agree with some aspects, like it [*Senga* institution] has transferred knowledge to those who are illiterate or school dropouts because there is no one to guide them.

INT: O.K. Petero, what are your thoughts?

Petero: O.K. about the *Senga* institution for adolescent sexual health education, this is dying out in many societies. And when you get into details these people who are *Sengas* don't teach sex education. They just prepare someone for marriage. They will never tell you to abstain but when you get married, do this, this and this. Their work is to prepare people to go for a good marriage.

Timothy: About harnessing the Senga institution to help control the spread of HIV and AIDS. Actually the institution has tried to curb the rate of spread of the disease. But when someone hears the word sex education, they think it is some way of teaching the practices related to sex. So they [people] equate sex education with sex and don't pay attention to the meaning of sex education. The Senga institution has tried to do its work to some extent. It has tried to bring out the causes of some of the problems faced by adolescents and tried to address them. But you find that it caters for only the female adolescents and so it is better to bring in the uncles of the boys to help them to go through the challenges properly.

INT: But do you think the *Senga* institution can equip the girls very well on matters relating to sexual health?

Timothy: It does because it gives them the advice on their future life and the current problems they are passing through.

INT: What do the others think? Do you think the *Senga* institution is a good institution that should be revived in all communities?

Phillip: O.K. these *Sengas* are only concerned with the girls so as they said, perhaps they need to get the uncles to help the boys. They may educate the girl and they know what to do but if it is to be effective, they have to also think of ways of helping the boys.

Karen: I think the *Senga* institutions try to teach things in marriage like taking care of the home on the other side is that their emphasis is mostly on sex. So sometimes it encourages girls to have sex and when they get pregnant, they don't tell

them to abort so they drop out of school. But they don't prepare you when you are not getting married

Timothy: Madam but again they help. Now like those who go to school can have access to information on reproduction from elsewhere. But for those who have dropped out of school, you find that they are isolated and it is hard for them to come together and air their problems.

INT: So you think it is important to think about those who have dropped out of school, and those who are getting married?

All: Yes

[Excerpt from critical inquiry discussion, March 14th 2007].

Although in the end the students agreed that *Senga* institutions could be one way to get sexual health information to young people in rural areas, there was some ambiguity about its place in the society. Petero and Karen's responses in the discussion include the traditional role of the *Senga* institution, that is, prepare young people for marriage (see Caldwell et al, 1998; Fuglesang, 1997; Reid & Walker, 2005). What is interesting is that Petero wants these institutions to advocate for abstinence while Karen thinks the education should include abortion for those who get pregnant. Timothy demonstrated a more comprehensive understanding of how the *Senga* institution can be re-appropriated to provide sex education and HIV/AIDS-related information to youth in rural areas. In the end, Timothy's view produced a consensus in the group that these *Senga* institutions are necessary for out-of-school youth.

The underlined portions of the discussion are meant to emphasize the fact that the boys felt left out and wanted to ensure that sex education for boys in the rural areas is also carried out. Timothy and Phillip suggested that it is important for the *Kooja* (Paternal uncle) institution to be revived so that boys also have a place to share their problems. In traditional society, the adolescent girls and boys would be separated and educated about sexual matters and related issues by the *sengas* (for the girls) and *koojas* (for the boys).

However, with the HIV/AIDS discourse focusing on girls' vulnerability little has been written about the role of these *koojas'* in sexual health education for boys. This is the reason the male students suggested that the article did not focus on the sexual health knowledge needs of the boys. The argument for the inclusion of boys in sexual health education also came up again in this discussion, similar to the previous section.

6.2.4. Myths, HIV/AIDS and cross-generational sexual relationships

The fourth article was by Nyanzi et al (2005) and it pointed out the perceptions of bodaboda men on HIV/AIDS risk. The abstract of the article is below:

> This article reports findings from a study conducted among 212 private motorbike–taxi riders, locally called *bodabodamen*, from two study sites—a slum area and the urban centre of Masaka town. Qualitative and quantitative methods were triangulated; a questionnaire, focus group discussions, in-depth interviews, case studies, and interactive workshops were all used. There were high levels of awareness of HIV, much more than sexually transmitted diseases (STDs), because many participants had closely experienced HIV/AIDS. Knowledge about sexual health contained several misconceptions, misinformation, and myths rooted in both the historical and contemporary social cultural context. Due to high illiteracy levels, *bodabodamen* cannot access many standard health education materials issued by government and private health organizations through the print and electronic media, as well as those published in languages other than the local vernacular. These (and possibly other) disadvantaged groups remain at risk of HIV and STDs. Special efforts need to be made to provide appropriate health education. (*Sex roles*, 52, (1-2), 111-119).

The article provided the students with an opportunity to reflect on the myths associated with preventive strategies like condoms or pills and HIV/AIDS risk. The article was read by Sarah, Gina, and Flavia and the discussion began with an overview of the content.

Sarah: This article is about bodaboda men in Buganda. The bodaboda men don't believe in virginity because most of them associate virginity with illness, impotence, old age and most of the young men could not go for virgin girls because they don't know styles of sex. They claimed sex with virgins was painful and so discouraged virginity. But on the other hand, the Buganda culture was emphasizing virginity by giving prizes to the virgins when they get married.

INT: So virgin girls or virgin men?

Sarah: Virgin men oh sorry virgin women. They argued that virginity brought prestige to the family and the girl. Another thing, most of the bodaboda men did not believe in condom use because they are made by white men. They believe it is the way for white men to make African men not to enjoy sex, or making most of them to die in large numbers. They believed condoms are porous and could allow the virus to enter, and the oil inside the condom had the virus which could infect people. Most of them argued that they don't have enough information on condom use because the instruction is in Kiswahili. Family planning is the responsibility for the woman as she was the one to ensure she does not get unwanted pregnancy.

Gina: The article says that men do not want to use condoms because they do not understand the instructions.

Flavia: Men do not trust condoms because they are not safe.

[Excerpt from critical inquiry discussion, March 14th 2007]

The first highlighted portion points out the mixed views on the place of virginity. The men in the study felt boys need to show their sexual prowess, which in a way would support what Burns (2002) observed about the Ugandan culture. The second portion tackles the issues of condom use. In my Master's thesis study (Mutonyi, 2005), students had similar sentiments regarding condom use and so the current participants had an opportunity to learn how widespread the myths were. I must state that the students asked me to engage in a discussion on family planning and condoms, especially addressing the myths and fears associated with these methods. I did this in the capacity of a trained biology teacher who encountered topics on contraceptives in the biology curriculum. The discussion took up the first half of the time before the commentary on the article continued.

The discussion re-started with Petero making a comment on why girls have sexual relationships with bodaboda men. This is what transpired:

Petero: Madam these bodaboda men go out with these girls. The girls say that they have energy.

INT: Who has energy?

Petero: Bodaboda men.

Sarah: Now energy for what?

Petero: For sex, that is what I hear.

Sarah: We are informed girls so we don't do such things.

Petero: Especially those who have some money and the girls like that.

INT: So the bodaboda men have become the sugar daddies?

Petero: Yes.

Sarah: Most of them don't go out with every girl. They just marry them.

Petero: For me I am speaking out of experience. I have seen many girls with bodaboda men.

[Excerpt from critical inquiry discussion, March 14th 2007]

Petero's observation that girls have sex with bodaboda men because they are sexually strong could be similar to the findings of the article that suggest that sexually experienced women are preferred by these bodaboda men. The word "sugar daddy" has been used often by the students and because it came up again here, I thought it was important to discuss the term. So we held a focus group discussion to better understand what the term meant to each student. This is what the students said:

INT: When you talk of sugar daddy, what image comes up in your mind?

Timothy: Somebody who gives girls money or gifts for sexual favors.

INT: So if a fellow student gives a girl these things, could he also be a sugar daddy?

Sarah: Those will be called boyfriends.

Phillip: They [sugar daddies] are older than the girl.

INT: So a sugar daddy is someone who is older.

Petero: O.K. Let us put it like this, somebody who is supposed to be your father but instead has a sexual relationship with you.

Karen: The girls sometimes are not in love with these sugar daddies but just want the money.

ALL: [Yes. It is to get money to buy things they like].

INT: O.K., just to be clear. So do the sugar daddies necessarily have to be rich?

Timothy: They behave as if they are rich.

[Excerpt from critical inquiry discussion, March 14th 2007].

Through this discussion, it was clear that sugar daddies are those who are involved in cross-generational relationships and are not necessarily rich but are perceived by the girls to have money. The students did give their perspectives on why young people have sex, as was detailed in Chapter five, but this topic remains an issue of great concern.

However, to get the students to think about how men and women should be responsible for each other's sexual health, we held a discussion on whether or not partnership and joint health education programs should be held in communities. The following are some of the comments the students made:

Sarah: Yes, they should be given the same health information so that they can also understand what reproductive health entails and share the responsibilities. Both will get treatment if they have STDs.

Tracy: I think they should be given the same sexual health information because this helps both the woman and man to understand each other's needs. A man cannot help if he doesn't know your needs.

Karen: Yes. Men and women should be given the same sexual health information because they need to understand how to support women to get them treated against STDs.

Petero: The sexual health information should be the same because in Uganda, men think they are superior over women. But if given the

same information, it should be better. He needs to help in pregnancy.

Flavia: Yes, especially in this time of HIV/AIDS. It is important to know each others' status.

Maureen: Yes. The men need to understand women's problems so that they can raise a healthy family.

Timothy: Yes, so that the community learns that there is no difference between male and female health needs. All are equally impacted by bad health.

James: In this era of HIV/AIDS, it is important that both get the same information to maintain their health.

Joshua: Yes. Men should not think that they are superior. If they learn together, the gender issues will be solved.

Phillip: Yes, so that both genders can help each other out.

Donald: Yes, because men also have questions just like the women.

Gina: Yes, so that men can help women in caring for the family health.

[Excerpts from FGDs, April, 8th 2007).

These are examples of what the students thought should be the step forward if married women's health is to be protected. The students think that men need to be educated about the needs of women including issues of STD treatment and pregnancy. To these students, the women's health issues are not considered by men because the men do not understand the gravity of the situation. Mogha (2001) comments that because family planning programs and women's health issues have targeted women, it is observed that many men think it is the responsibility of women. This observation was made in the article the students read and mentioned by Sarah while she briefed the group on the main issues embedded in the article. Therefore the students' responses to joint discussions were influenced by the observation on how women-targeted programs impact men's attitude.

Given the students' perspectives on the role of gender equality in health promotion, the study sought to understand what they envision as the advantages of gender equality.

Therefore during the focus group discussions and in Q3, the students were provided with opportunities to share their perspectives on gender equality arguing for the benefits and perhaps what they envision as disadvantageous in equality promotion. The following section therefore highlights students' views on gender equality.

6.3. Advantages of girls' education

Although the discussion was meant to focus on gender equality in the spheres that the students mentioned, that is, social, economic and political, the students reduced the notion of gender equality to girls' education. However, given that many of the women advocacy groups like WID and GAD focus on women's education as key (Leach, 1998), it is not surprising that the students would associate equality to education. These movements (WID & GAD) have been the cornerstone for most advocacy programs in developing countries (Robinson-Pant, 2004). Typical sentiments for education of girls and gender equality included the following:

> If girls go to school in the future if she gets married, she will also have some part to play in the family like helping the children if he is not able and also things she learned in school, bringing up children, cooking healthy meals, such things. You find that you have a productive family (Excerpt from Joshua's Q3 response).

The students understood the value of gender equality or girls' education in instrumentalist terms often embedded in the social capital and human rights approaches to empowerment discourses like the WID and GAD frameworks (Robeyns, 2006). In the focus group discussion with the boys, this is what they thought are the advantages for girls' education:

> **James:** O.K. This girls education, in fact, for me I encourage it more even to that engineer level. Actually when you examine the population in Uganda, majority are the girls, so they are the ones to get more education <u>so that they can bring up these other boys.</u>

You find that if we leave these girls behind, you can have many health problems, some girls don't know about nutrition. You find that they are brought up in a way that they have never gone to school. Yeah I think and I support maybe we even go down and educate these girls though they are not in school. We set up workshops and educate them such that they can have better health.

Joshua: For me I think that girl child education should be continued by the government. Because if you don't educate a woman, then that generation which they will give birth to will have some adverse effects. Maybe the mother is illiterate or she does not have enough knowledge about nutritional issues, then she just feeds a child anyhow, and because of nutritional deficiency, the children will grow up, the brain will not be so sharp.

Donald: Education of girls is good because they can make good leaders. For example, in this school, the head teacher is a woman and she is managing the school well. This is the benefit of girls' education.

Timothy: Girls education is important because they are able to do all the things that men do. To have good health, the girls need to be educated and get the necessary knowledge.

Petero: For me I think girls' education is good because many of the jobs now can be done by women also. For families to have good health, the women need to get some education to also contribute to the family income. Also, they can get knowledge on family planning.

(Excerpts from FGDs, Feb. 15, 2006).

The analysis of students' views on girls' education reveals that most of the students have internalized the common rhetoric surrounding advocacy for gender equality. The highlighted portions all point out how women's role as caregivers in the family will be better done without a mention on the role men can play in improving women and their children's health. These sentiments were held by both the girls and the boys in this study in spite of their stating earlier that they would love to have gender equality, where men and women share family responsibilities. Some students thought in the future gender equality will be achieved and so in their generation, men and women will be doing similar jobs whether within the household or in the larger space. However, some male students thought that this will be a disadvantage because women will stop respecting the men and want to be the head of the household. Typical sentiments were:

When women are compared to men in relation to gender equality, they [women] too almost become the head of the families. And by that, there is misunderstanding due to the fact that some women give little respect to their husbands because both may be equal and working with almost the same salary.

[James's FGD response, March 26 2007]

The girls during the discussion thought men's fear of losing respect are unfounded but an excuse to hold on to the power they have. Maureen put it this way:

The men fear that when women are equal, they will take over the home. Most men want the women to remain submissive in the family. So men fear that educated women will not respect them but it is not true. It is just their fear.

[Maureen's FGD response, March, 26th 2007].

Therefore there is a need to tackle the assumption that if women are "equal", they will not "respect" the men. If this perception persists, the gender imbalance experienced in Uganda today will continue. The students then suggested that in most cases, the girls and boys are given gender appropriate jobs at home and they perceived this as gender complementarity. However, all the students said that their mothers do more household chores compared to the men, even though both could be in public service.

6.4. Discussion

This chapter examined the role gender equality can play in improving health and life chances of people in Uganda. Based on the students' responses, it is apparent that gender is equated to women, and equality to access or parity. The students used the growing number of girls attending school, the education of both boys and girls, the

scholarships girls receive, the number of female students taking science subjects and the number of women in leadership positions, as evidence of gender equality in Uganda's public spheres (see 6.1.2). The equating of gender equality with women, and access, is commensurate with the WID framework (Unterhalter, 2005). The students' conceptualizations of gender equality are therefore influenced by the advocacy arguments embedded in the WID framework. The students also explained gender equality in terms of how education of women would benefit the community. As discussed in the theoretical framework (Ch. 2), WID promotes social benefits of educating women and girls and how their education impacts development and family healthcare (see also Leach, 1998). The students' responses showed that they have internalized the message on the social benefits of educating women and girls.

Most of the male participants used the role women play in healthcare as a basis for advocating for the education of girls and women. The female participants however brought up the sexual division of labour inside and outside the household, to make an argument that gender equality is not practiced at the family level (see 6.1.1). The female participants' assertion speaks to the limitations of the WID framework as discussed in Chapter 2 of this thesis. According to Unterhalter (2003), the WID framework does not question the sexual division of labour because the approach is concerned with the external factors impacting gender equality. Robeyns (2006) adds that WID's focus on instrumentalist gains of women's education pushes people into pre-set social roles or "functionings" like family care provision. The male students in this study talked about the advantages of women and girl's education in relation to how family health could be impacted. Therefore the findings presented in this chapter corroborate the observation made by Unterhalther (2005) and

Robeyns (2006) that the focus on external gains of women education does not take into account the individual, but how women's education benefits others. Baylis (2000) suggests that implicitly, the WID framework can lead to a discourse of blame given that family health is understood as the responsibility of women. Therefore poor health in the family becomes a woman's problem.

As Robeyns (2006) observed, most studies that focused on why maternal education was important to development highlight women's role in family health practices as the greatest motivation for gender equality (Browne & Barrett, 1991; Hobcraft, 1993; Katohoire, Scheutz, Sabroe & Whyte, 2004; King, & Hill, 1993). Some studies have questioned if the focus on the instrumental gains are not merely educating women to be better mothers (Fiedrich, 2004; Leach, 1998, Longwe, 1998). The male participants' responses seemed to promote this notion. Robinson-Pant (2004) takes up this issue of educating women to become better mothers in the edited book titled "Women, literacy and development: Alternative perspectives."

The issue of gender equality as disrupting family cohesion because women might not "respect" the men was also raised by students. This assertion also speaks to another disadvantage of the WID framework. As Robeyns (2006) observed, WID framework cannot challenge the underlying inequalities and hence does not probe the social norms that perpetuate gender imbalance. These unchallenged gender inequalities embedded in the social norms are therefore passed on from generation to generation. The idea that educated women might not "respect" their husbands is an example of how a given understanding of the term "respect" could become a hindrance to gender equality. The participants equated "respect" with women's subordination to the authority of men within the home (see 6.2.1 &

6.3). A woman who is perceived as not submissive to her husband is said to be "disrespectful." People who hold the view that educated women do not "respect" men, might not support the education of their daughters and the perception will passed on to their male children. As discussed in the literature review, the issue of "respect" and submission has greatly contributed to the high HIV/AIDS prevalence rates among women in Uganda. The observation is that any show of "disrespect" leads to wife battering, which has contributed to women's inability to ask their husbands to use condoms (HRW, 2002).

Some of the students' responses on gender equality included aspects of the GAD framework. The students used the example of boys taking subjects like home economics to argue that gender equality is practiced in schools. Also the students mentioned that women are now head teachers of co-ed schools (e.g. the research site), and this is evidence that women are accessing power in spheres where men would have been the preferred choice. The participants also mentioned that girls are taking up leadership roles in student-led groups within the school (e.g. HIV/AIDS clubs and student headships). These examples are commensurate with the GAD framework that investigates the distribution of power within existing structures. GAD views equality as a process of redistribution of power or equity and therefore the students' responses relate to this aspect of the framework. Also the female participants' inclusion of distribution of work within a household as a measure for determining gender equality draws from GAD framework for gender advocacy. Some students also suggested that there is women empowerment, a concept used in the GAD framework (see Tracy's response, section 6.1.2). Therefore GAD and WID are the major frameworks within which to understand the students' conceptualizations of gender equality.

However, some students understand gender equality as a western cultural practice. For example, some students connected their conceptions of gender equality as an adoption of a "western cultural practice" like women wearing trousers. Karen said, "In my community, the men and women have experienced a western change culturally... women wear trousers, which was not there before." Leach (1998) found that many communities in developing countries regard gender advocacy movements as an imposition of western culture on their community practices. One of the critiques of the WID and GAD approaches for gender advocacy is their use of western notions to interpret gender relations across cultures (Fiedrich, 2004; Unterhalter, 2003). In general, Unterhalter (2003) has pointed out that the demerits of WID and GAD are that these frameworks are embedded in Western and Eurocentric understandings of gender relations. Some studies have questioned the effect these gender relation frameworks have on non-western communities (Fiedrich, 2004; Robinson-Pant, 2004). In regard to health, the groups that resist these "western cultural impositions" are suspicious of programs highly promoted by the west. The discussion in 6.2.4 regarding bodaboda men's sexual practices raised the issue of condoms being made by "white men." Because of this understanding, the men rejected the use of condoms (Mutonyi, 2005; Nyanzi et al, 2005). The repercussions for not using condoms include the risk of HIV/STD infection because currently, condoms are the only protective method against these diseases. In return, the non-use of condoms greatly impacts women and girls' health and life chances (Blum, 2004; Chan, 2007; Mohga, 2001, UAC, 2007).

There was evidence of gendered perspectives throughout the discussions. The female students wanted gender equality to include family relations while the boys focused on the issue of complementarity. The female students indicated that they, like their

mothers, do not have a "voice" within the family. The male students on the other hand focused on the external aspects of gender equality, for example, attending school and doing household chores. In this regard therefore, the female students' views could be seen to relate to the GAD framework and perhaps underscore the need for a capabilities approach to gender equality promotion. The male students' perspectives however are embedded in the WID framework with some aspects of maintaining the existing socio-gender roles within communities. The male students might see the benefits of educating the girls, but will not necessarily join the advocacy for changing certain social practices, especially matters relating to roles of men and women within the family.

In this regard, I argue for the integration (or inclusion) of other frameworks like post-structuralist and the capability approach within the WID and GAD already operating in Uganda. I build my case on the fact that although there are external gains of gender equality within the public spheres, the gender imbalance within micro-spheres like families, remains unchallenged. The WID and GAD frameworks have been instrumental in educating women and girls about their rights, and influenced policies, which are extrinsic gains of gender equality. The capabilities approach however concerns itself with intrinsic value of gender equality and resource control (Robeyns 2006). The emphasis of this approach is the ethical or moral value of promoting education or gender equality (Unterhalter, 2003). I extend the moral aspect of capabilities approach to argue for its introduction in the gender equality discussions in Uganda. The female students raised questions about gender equality within the households while the male students suggested that men should be involved in health issues that affect women. Furthermore the students mentioned that although people within their communities send their daughters to school,

few of them value the education of girls. These issues are related to what capabilities approach concerns itself with – ensuring that people learn to value girls' education whether or not there are external gains (Sen, 1999). In the capabilities approach, people learn to value the individual and not the external contributions the person might make, as emphasised in WID and GAD approaches.

The capabilities approach can therefore be effective in dealing with gender-power imbalance and women's sexual health. The studies used in the critical inquiry discussion highlighted how gender-power imbalance creates an environment of vulnerability for women, particularly in relation to HIV/STD infection (Burns, 2002; Gupta, 2000). The women are vulnerable because of their low status in society, and consequently, the community does not value them as individuals or humans. If the capabilities approach is therefore introduced into the gender equality discussions, perhaps there will be a change in how people respond to gender equality campaigns. Women also need to learn to place value on themselves and their daughters because some studies have noted the differential treatment mothers accord to their sons and daughters (Singhal & Svenkerud, 1994; UNESCO, 2001). Sen (1997) has suggested that "to be sustainable the empowerment process must alter both people's self-perception and their control over their lives and their material environments" (p. 2). I use this quote to argue that in Uganda today, women and girls' self-perception needs to alter, but most important, the community's perceptions of the female gender, needs to be altered. The capabilities approach concerns itself with altering people's self-perceptions, and therefore should be included in the gender equality discussions in Uganda.

The introduction of a capabilities approach in the gender equality discussions could be instrumental in bringing parents and male students on board on issues of young girls' health and life chances. The participants advocated for the inclusion of men in family health matters. This observation has some merit especially in relation to current studies advocating for men's involvement in reproductive health matters (Hawkes & Hart, 2000; Wegner et al, 1998). These studies argue that if the traditional attitudes of men towards women's health issues are to be addressed, the men need to be educated about their role in maintaining the reproductive health of their spouses. Traditionally, women's health issues are to be addressed by the women. But in relation to HIV/STI, this attitude needs to be changed (Hawkes & Hart, 2000). Baylis (2000) argues that women in relation to HIV/STI are often portrayed as vectors (disease transmitters) during these health promotion campaigns. Mohga (2001) comments that because family planning programs and women's health issues have targeted women, it is observed that many men think it is the responsibility of the women. This, according to Mohga, has added the burden of family health issues as the responsibility of the women. Mohga too advocates for health programs that include men's roles in the reproductive health of their families and spouses. The students' views on partnerships in marriage are therefore relevant to these kinds of studies.

These suggestions could provide the entry point for discussing and altering the gendered roles society has accorded men and women in Uganda. At present, the female students stated that women who are employed outside the home are working a "double day" because they are left to shoulder all the responsibilities for the unpaid work in the household. Robeyns (2006) has posited that because men have been socialized to perform particular responsibilities, many who have developed intrinsic pleasure in caring for family

in relation to staying home with children have experienced community rejection. Therefore gender equality campaigns should not only pay attention to women's problems but should include the roles men can play. As stated in sub-section 6.2.2, the male participants said that most men do not know how to get involved in family health issues because the gender equality programs have excluded men. Some studies have also called for the inclusion of men in health discussions if gendered social norms are to be challenged (Wegner et al, 1998; White, 2004). In this regard, Robeyns (2006) argues that the capabilities approach provides a lens for the analysis of the effects of these gendered roles and enables communities to articulate what each gender has reason to value.

The capabilities approach can also be used to bring ethics into the enacting of laws and policies that protect women's health (Unterhalter, 2005). The GAD approach has been instrumental in the setting up of laws (e.g. the defilement law in Uganda) that protect the rights of women and create awareness among the communities about their rights. However, the findings of this study suggest that the law (especially the law on molestation) has not effectively protected girls from sexual abuse and exploitation. According to Robeyns (2006), the capabilities approach challenges policy makers to think ethically about the policies being put forward. For example, it is not enough to pronounce women's rights to good health and education and yet not put up measures that address, enforce, and enable the utilization of these rights. In the case of the study, it is not enough for the government to educate young people about their rights to information and enact laws against molestation, but not address the issues of sexual abuse and exploitation in communities and in schools. Perhaps if governments began using the capabilities approach alongside WID and GAD, the cross-generational relationships and issues of molestation could be addressed.

However, communities need to partner with governments in this process of gender equality promotion, given that in most cases, the government-led policies have caused parents to abdicate their responsibilities (Nutbeam, 2000; Robeyns, 2006; Sen, 1997). The theory of communalism could be used alongside the capabilities approaches to equality. As Dei (2000) pointed out, communalism is concerned with the social welfare of the marginalized groups. In this study, the marginalized groups are identified as women and youth. Given that Airhihenbuwa et al (2000) observed that many African communities do not view self as an individual but a group, it is important to integrate this notion in the gender frameworks. The failure of the equality movement especially in changing the gender norms within families has been attributed to the role emotions, culture, and environment play in people's decision making process (Airhihenbuwa et al, 2000; Kickbusch et al, 2002). Therefore the capabilities approach can provide the language (Robeyns, 2006) through which the communities can articulate their values in relation to the current problems (Kanu, 2006), and the communalism philosophy can be used to strengthen the implementation of suggested solutions. As some studies have suggested, understanding the role of African traditional social practices in community functioning and decision making is important, if effective solutions to current problems in Africa are to be designed (Airhihenbuwa et al, 2000; Dei, 2000; Fiedrich, 2004; Wright, 2000).

Caldwell et al (1998) have suggested that most parents do not support the sex education of their children if the education is not in the context of preparation for marriage (see also Nakazinga, 2004). Other studies have suggested that the lack of parental involvement in the sex education of their children is because these indigenous institutions have collapsed and schools are seen as a replacement (Fuglesang, 1997; Muyinda et al,

2004). Given the differing opinions, some parents may oppose the revitalization of the institution while others might support the idea, just as Muyinda et al (2004) found in their study. The students in this study suggested that these community institutions, such as *senga* and *kooja*, could be appropriated to provide health education to the youth who are not in school. The appropriation needs to include issues of gender equality and community health.

I specifically use Kanu's (2006) idea of *Sankofa* (looking into the past to move forward) to suggest that the role of various community education systems or institutions like *Senga*, need to be studied and used to adapt the present. Communalism could perhaps explain why women empowerment programs understood to be a western ideology not a universal right, have not changed communities' gender-social norms (Airhihenbuwa et al, 2000; Leach, 1998; Mohga, 2001). In addition, communalism could also explain why some women, knowing their rights through participating in literacy programs, do not use their knowledge for individual gain, but interpret empowerment as a means for making them better mothers and members of society (Fiedrich, 2004; Robinson-Pant, 2004). The communalism philosophy, coupled with the popularity of WID gender framework, perhaps make it difficult to address the gender roles within the families.

In general, the different frameworks need to be used in promoting gender equality if the health and life opportunities of communities in Uganda are to be improved. Both the external factors and the intrinsic gains are important aspects for engaging in gender equality discourse. Sen (1997) stated that "a change in access to external resources without a change in consciousness can leave people without the resilience, motivation and awareness to retain and/or build on that control, leaving space for others to wrest control" (p.2). In a similar vein, Sen suggested that "programmes which start by raising people's

consciousness but are unable to deliver greater control over material resources, can lead to frustration and high dropout rates." These statements help to situate and underscore the importance of incorporating all the frameworks in discussing issues of gender and equality. This combination of frameworks is needed in the discussions related to health literacy, HIV/AIDS, and gender. At present, the women have been accepted in the public spheres of life in Uganda but in the private spheres, their vulnerability remains a problem. As Kickbusch (2001) observed, HIV/AIDS has claimed the lives of many educated and gainfully employed women in Africa because they remain powerless in their homes.

6.5. Conclusion

The students in this study demonstrated a general understanding of gender equality. However, the issues are only discussed in relation to external factors or instrumentalist gains of what gender equality can do, for example lead to development and equal participation in political or administrative duties. But within the family units and micro-communities, the idea of gender equality is replaced with complementarity or what the students called co-existence where men are to do "masculine" chores and women "domestic" chores. In the discussions, the male students suggested that this should be the idea promoted in families so that women do not usurp the power of men, especially when looking at the issue of "respect" to husbands. This is an example of why it will be difficult to change gender norms within family settings by policy and education programs that are perceived as external (see Fiedrich, 2004).

Published articles and Sirotnik's (1988) critical inquiry process was a productive way of scaffolding students' understandings of the relationship between gender equality and HIV/AIDS. The students developed the language with which to engage in the

discussion, pointing out merits and demerits of cultural practices. This approach also opened up the space to talk about the vulnerability of women and adolescents, with the boys and girls admitting that there may be differences in vulnerability among young people. What made the difference however, was the fact that girls experience sexual pressures that boys are able to avoid. In addition, not many people obey the defilement law and this put girls at a disadvantage. It was interesting that the boys thought the defilement law, although meant to protect the girls, indirectly protected the boys' sexual practices. The boys suggested that because of fear, many of them opt for abstinence, but they think the girls on the other hand are not taking advantage of the law, opting for sexual relationships with older men known as "sugar daddies."

However, it is not just simply a case of opting for sexual relationships with older men, but extenuating circumstances like poverty and cultural attitudes that play a role in these decisions. In examining the students' responses, it is apparent that matters of sexual relationships in relation to HIV/STI or reproductive health are complex. It is not enough to provide facts and details on health challenges, or offer free healthcare services, when what makes people not access, or utilize this information, remains a challenge (Jones & Norton, 2007). One has to grapple with issues of love, trust, attitude towards given programs, and all the other factors that impact people's decision making. Just like Kickbusch et al (2002) observed, it is not just empowerment but also emotive, cultural, social and environmental factors that impact people's decision making. Also one should take note that doing research on sexual relationships within marriage settings is highly dependent on self reported accounts, which cannot be easily verified (Huygens, Kajura, Seeley & Barton, 1996). These factors should be taken into consideration when addressing HIV/AIDS issues.

In engaging the students in a discussion on gender equality, it became apparent that one cannot exhaustively grapple with this concept. Everything has to be held in tension, looking at merits and demerits of each gender initiative, just as some studies have pointed out (Fiedrich, 2004; Robeyns, 2006). It was more acceptable to talk about gender equality in the public spheres like education, schools and public offices, but when it came to family relations, the argument was for individual negotiations. In spite of using articles that pointed out the plight of women within marriage settings, it was not easy to address gender equality under such circumstances. The students demonstrated a desire to see changes happen by calling for policies that protect women's rights, but they were not sure what individual roles for men and women in the promotion of rights could be.

The desire for parental and community involvement was also raised by students in this study. During the discussion of the Burns (2002) article, the male students deplored the absence of sex education programs for young boys inside and outside school. The students also mentioned that most of their sex education is through *Straight Talk* because teachers and parents do not talk to them about such matters. It is important to reiterate that some of the indigenous institutions and cultural educational practices that brought parents and children together should be introduced into schools (see Kanu, 2006). Nonetheless, the revival of these practices might not necessarily increase parental involvement in their children's education because parents are busy trying to make a living in order to meet the needs of the family. Many of the participants were living with one parent because the other was working in another town or even country and sending money for their school fees and other needs. This separation in families and the subsequent impact on adolescent behaviour is one example of the unintended consequences of some initiatives (Nutbeam, 2000).

The articles I selected focused on the vulnerability of women because as I stated in chapter two, it is important to make women's health issues topical because more females than males are impacted by major epidemics (Baylis, 2002). However, it became apparent in the discussions that one cannot talk about women's health without including the role of men as well. All the participants acknowledged that female students are at risk mostly because of the cross-generational relationships that boys do not experience. This observation was important because it was the reason I used these kinds of articles. In general, both the male and female participants felt that they need more guidance if they are to embrace gender equality initiatives. In relation to knowledge gaps, the students thought that the youth living in rural areas needed more avenues to get sexual health education (see 6.2.3). Within schools, the female students felt that there is need for better programs, even though they have a senior woman teacher and programs with visiting counselors. The male students thought they too need to have counselors to talk to them.

The next chapter presents the findings that responded to research question four, highlighting the students' perspectives on what should be done to improve the health and life chances of women, youth and all people in Uganda.

CHAPTER VII

7.0. STUDENTS' PERSPECTIVES ON PUBLIC LIFE ISSUES

This chapter reports the findings that addressed research question four of this thesis, which is: *What do the students consider to be the way forward for Uganda to achieve better health and improve life chances for all?* As mentioned earlier, health literacy promotion aims at making health a political issue so that governments take more responsibility for their citizens (Orbinksi, 2007; St. Leger, 2001; W.H.O 2002). However, it was not only this issue that motivated the soliciting of students' perspectives on the way forward for Uganda, but the observation by Jaminez (World Bank, 2007) that young people's lack of voice makes them a weak constituency for reform. So this study provided students with opportunities to imagine areas that demand action (Sirotnik, 1988; St. Leger, 2001) and to share their views on what kind of political reform in Uganda would promote better health and improve people's life chances.

The students' perspectives were solicited through questionnaires (Q5) and during the focus group and critical inquiry discussions. The participants discussed issues related to adolescent health, like contraceptives, and general public life issues. I will first present the findings that related to adolescent-related issues (7.1) and then the discussions that centered on general public life issues (7.2).

7.1. We should treat the cause not the symptoms

During the discussions on factors that impact adolescent health, the students revealed that most girls, who find themselves pregnant, choose to terminate their pregnancy. The students also talked about how young people abort without the knowledge of their parents, and Rose explained it as follows:

> Now like I have said, you get pregnant, your parents trust you so much, they don't or can't think of that and like you are the only girl at school. You have gone far like in senior four; their whole hope is in you, now you get pregnant. Your parents don't expect you to get pregnant. In the village your grandmas have hope in you. Now you will have disgraced the whole family if you have the baby and you will be the laughter of the place, there where you stay. So you decide to have an abortion because you want to continue with your education. You don't want your parents to distrust you. You want to have a bright future. You also want to help your parents, your relatives so you decide to abort.
>
> (Excerpt from life history interview with Rose, Feb. 14, 2006).

I should mention that Rose did get pregnant but she did not have an abortion. Because the rest of the students now had an example of a peer who might drop out of school because of pregnancy, we held a discussion on the possible solutions to adolescent health-related challenges in Uganda. In questionnaire five (Q5), the students were asked three basic questions:

1. Should abortion be legalized in Uganda?
2. Do you think contraceptives like condoms and pills should be readily available for adolescents in Uganda?
3. What challenges would Uganda face in providing contraceptives for youth?

The first question was asked because in May 2007, one of the legislatures in Uganda presented a proposal in parliament, arguing for the legalization of abortion. I used this as an

opportunity to get students' views on an issue that was publicly being debated. Currently, abortion is illegal except if the mother's health is perceived by doctors to be in danger.

In each of these questions, the students were given opportunities to argue for, against, or engage both sides. Apart from one student who declined to respond on religious grounds, the others had very interesting opinions on the issues under investigation. The students argued on both sides and stated what their final stance was. In relation to abortion, the students thought the following are the advantages of legalization:

Maureen: The youth who get pregnant when they are still in school will have a choice to go back to school, since a few people will know that she was pregnant.

Timothy: It will reduce on the number of street children in Uganda.

Joshua: It will reduce the ever growing Ugandan population.

James: The girls who got pregnant through rape are saved from raising bastards.

Sarah: It will minimize early marriages when one gets rid of the unwanted baby, which would have forced one to get married in order to bring up the baby.

Petero: It will reduce on school dropouts and conflicts between boys, girls and their parents.

Donald: Abortion can reduce violence in homes arising because of cheating on your partner.

Karen: Those with pregnancy complications can be relieved of the pregnancy.

Tracy: It will reduce on the number of people giving birth. The number of jobs will increase and unemployment will stop.

Flavia: Population growth will be stopped. Jobs will be enough.

Phillip: It will help those who get defiled not to miss their education.

[Excerpts from students' Q5 responses, May 28th 2007].

In the students' responses, it was evident that most of their opinions were guided by the desire for uninterrupted education. The reference to early marriages, defilement or rape indicates that these are paramount issues in the lives of these students. Two students however included the fact that with abortion, the number of people giving birth will drop, leading to skilled labour gaps. This would ensure that there will be more jobs in the future.

Having pointed out that abortion might help in dealing with unwanted pregnancy, the students stressed that it does not help in relation to fighting HIV/AIDS, and spousal responsibilities to each other's sexual health. In the end, the students suggested that abortion should not be legalized in Uganda but done at the discretion of the doctors especially if the mother's health is in danger, or one has been raped. The reasons for arguing against legalizing abortion included the following:

Petero: There will be an increase in sexual immorality and people will stop taking responsibility of their lives.

Phillip: Already Uganda has very few doctors (1:5000 patients) so before legalizing abortion, there should be more training for doctors who can do a good job.

Joshua: The number of defilement cases will go up and this is what Uganda is trying to fight. So abortion should not be legalized.

Karen: Prostitution will increase because people will not care, if they can abort. This will increase on the number of people with HIV/AIDS.

Sarah: Abortion is against the law of God, so it should not be legalized

Gina: It will lead to misuse of sex especially in adolescence.

Timothy: Abortion does not prevent HIV/AIDS and STDs.

James: It is against the African culture to murder.

Maureen: It can lead to death if not done properly.

Flavia: Abortion is not acceptable. It is against my faith.

[Participants' Q5 responses, May 28th 2007].

The students demonstrated an acute awareness of the problems abortion could solve, but were quick to remind us that the major health challenges like HIV/AIDS could escalate. The students support laws and policies that provide a safe environment for girls instead of policies that might exacerbate the health problems that Uganda faces today. I am not certain if the doctor-patient ratio Phillip uses above is accurate, but it helps underscore the enormous challenge of providing safe abortions for young people.

In relation to contraceptives like condoms and pills, the students reiterated that these are already readily available in Marie Stopes healthcare clinics in Uganda. However, pills are only prescribed to married people. The students then wrote about the advantages of providing pills for youth, which included all the points discussed under abortion but incorporated the fact that condoms can prevent HIV/STD infection compared to pills and abortion. For example Timothy wrote:

> For those who are sexually active, lack sex education, ignorant about what abstinence means to their lives, can't control their emotions, yes contraceptives should be made readily available. This will reduce their risks of acquiring STDs and HIV, pregnancies that are unplanned for and unmanageable number of children.
>
> [Timothy's Q5 response, May 28th 2007].

This group of students was knowledgeable about the difference between using pills and condoms as a contraceptive. However, the students did point out that what is preventing people from using these contraceptives will still remain a challenge.

In response to question three of Q5, the students thought the following would be the challenges Uganda would face in promoting contraceptive use in Uganda:

> **Timothy:** People rejecting the contraceptives because of the myths surrounding condoms and family planning pills including the fact that they make people barren or impotent.
>
> **Joshua:** There will be an increase in HIV/AIDS since people don't like using condoms. Most youth will take pills to prevent pregnancy (which affects their education) but have unprotected sex, which exposes them to HIV/AIDS.
>
> **Phillip:** Lack of enough healthcare personnel and services to cater for the large population.
>
> **Flavia:** There will be an increase in expenditure for contraceptives yet people are facing more pressing needs.
>
> **Petero:** The advocacy for abstinence will be eliminated and young people will become immoral.
>
> **Sarah:** People do not believe in family planning.
>
> **Karen:** Most people fear to use contraceptives because they think they are not safe.
>
> **Tracy:** People think that contraceptives make them barren and so they will not use them.
>
> [Q5 responses from the participants, May 28th 2007].

The students therefore concluded that in reality, the disadvantages of abortion and provision of contraceptives outweigh the advantages. The students emphasized that it is important to educate the youth about the importance of abstinence, given the enormous

challenges they could face should they engage in pre-marital sex. Then the students suggested that education to change people's attitudes towards contraceptives is needed if government is to spend money on purchasing contraceptives. But for the moment, it is important to remember "Uganda is poor and cannot afford to promote activities that can bring more challenges" (Gina's response).

So the students engaged in a discussion on the practical solutions to adolescent health-related solutions. Below are some of the students' suggestions:

a) Community education

The students suggested that it is important for adults, government and advocacy groups to come together and educate communities about the importance of education especially for girls. This will ensure that people understand and support education and perhaps this will reduce incidences of early marriage. Karen said "if girls come to school, they will access sexual health information that will help them to stay safe" (quote from FGD, April, 8th 2007). The other students supported this but added that the most important issue is that people will understand the value of education. Also people will know that their children can go back to school after giving birth so this can help reduce the number of girls who do dangerous abortions.

b) Parents should take interest in the lives of their children

The students mentioned that parents should check on their children to know what they are doing. This is because many of the girls in the "something for something sex" do it without the knowledge of their parents, so it is important that such children be monitored. The students felt that because many parents work in different districts or are in the village while their children are living in the hostels, there is limited guidance on sexual matters.

Given that most of the participants are either staying with one parent or in the hostel, I inquired if they feel that there is limited parental guidance, to which they said yes. The students also mentioned that they don't really talk to their parents. An excerpt of this discussion is used below:

> **INT:** Do you talk to your parents about your health needs?
>
> **Karen:** There are some parents who are free [can talk to their children].
>
> **Joshua:** Yes. The only thing is some of them are busy and so they have little time to address your issues.
>
> **INT:** Petero is that so?
>
> **Petero:** For me I fear even my parents. There are some things you cannot talk to your parents about, now how can you start?
>
> **Flavia:** When I was young I used to say but now I don't. Even my dad is not here and my mom is in the village.
>
> **INT:** So whom do you talk to?
>
> **Flavia:** Only God.
>
> **Timothy:** I talk to them but not so much like when I was young.
>
> (Excerpts from FGD, Jan. 31st 2007).

Because the students in this study don't have conversations with their parents, they thought this practice should be changed if adolescents are to be helped.

c) Employment for youth

The students suggested that because young people are engaging in sex for money, there should be employment for youth. Their argument was that those in the village are occupied with agriculture but those in school, who cannot dig, should be trained in other income-generating activities. The young people should learn to work and earn money to buy what they need, instead of relying on "sugar daddies." This will help them avoid the use of sex as a means of employment.

e) Have youth friendly services

The students suggested that healthcare services should have either counselors or experts in adolescent health so that young people can get good medical attention. At first I thought this suggestion was related to access to contraceptives but on further probing, it became apparent that it was not the case. Below is an example of why some students want adolescent friendly services:

> For me I think they should be different because if you go where there is an adult, then you fear to talk out your problem. It becomes difficult to explain your problem because of the age difference (Karen FGD, Jan. 31st 2007).

In their questionnaire responses, the students suggested that these healthcare services would be useful in educating young people about the importance of abstinence and the dangers of engaging in unprotected sex. The students stated that because these people would be experts, the young people can listen. Currently adolescents do not seek help because the counseling services are designed for adults, especially married people.

In general, the students suggested that four things need to be done to reduce the numbers of adolescents having abortions. These were: community education, parental involvement, employment opportunities for youth, and adolescent-friendly counseling services. The next section presents the students' suggestions on how public health and life chances for all people in Uganda can be improved.

7.2. Students' views on public life issues

I used the MDGs to initiate the FGD, but the students had their own suggestions. Analysis of the findings shows that the students thought seven (7) areas need improvement

if health is to be promoted. These are: (i) education (ii) advocacy (iii) corruption (good governance) (iv) agriculture (v) environmental conservation (vi) protection of the "common person" and (vii) provision of good healthcare services, each of which is discussed respectively below:

7.2.1. Investing in education

The students thought education should be the first priority for action and investment. The main argument was that if people are to understand their rights and make governments accountable, they need to have an education. Also education is important if people are to have improved health practices. The common response, as illustrated in the vignette below, was:

> O.K. To me they say that behind a successful man a woman must be there. So if the woman is not also successful, I don't think the man will also be successful. And for this lady to be successful, she must have some knowledge on how to be successful. And that knowledge can be acquired through education. So I don't see the reason why these guys [women] should just sit back there and do a lot of nothing. So we shall not have any success in the community because they have to bring about the success when they are also knowledgeable about the success. Because you cannot be ignorant and you think that you will succeed.
>
> [Phillip, FGD, Jan. 25th 2007).

The vignette illustrates why the students thought education is key. This statement also reveals how the WID framework has influenced the students' understanding of the role of women's education, it is for others (Unterhalter, 2003). However, five of the 12 students had other views on why investment in education is crucial. This is explained as follows:

Phillip: So you find that in most times this primary education, especially in government schools, there is no seriousness among the teachers, and the pupils don't attend classes. So you find that the goal is not achieved but there could be more effort, then actually it could be good. And the other person who says that you fund tertiary, you cannot jump from nowhere and go to tertiary, you have to go through somewhere, but that place has to have a good foundation so you have to put in effort to achieve the goal.

Timothy: Now at least they balance. You see primary you put in 53% and then people end up dropping out. Sometimes they invest in one area and forget others. For example in education, they are depending a lot on primary, so they put there like 63%, then secondary like 11%, then tertiary takes the least and yet tertiary is the one which is more important. Though it depends on primary, but they invest too much in primary, and not the others.

Phillip: That is what I am talking about, putting in more effort.

Timothy: This UPE program has benefited those in urban areas who are paying that extra charge to the school. It helps motivate the teachers, but in villages, nothing is given.

Karen: Me I think that what makes teachers not bother about primary education is that, the pay [salary] is less than what they are doing. You cannot give in much when you are not getting.

Joshua: Then another thing is that they have forgotten that a teacher is the most important person. You cannot become a lawyer, teacher or engineer without the teachers. So they have forgotten that. These teachers teach but they are paid little money. But a person like an MP is eating [earning] millions of shillings, yet he is the one who has passed primary through the teacher's hands, but you find that the teacher is earning 20,000, which is very embarrassing.

Karen: They are giving teachers less and sometimes it is not on time.

Timothy: The salary is little and then after sometime they come and retrench you that you qualified long time ago.

Sarah: Teachers have no alternative sources of money given that PTA[5] was abolished in schools with the introduction of UPE.

Timothy: Most times the teachers don't even want to go to school. In most cases, they go to school around lunch time because lunch is being provided. Even community members go and make the school their hotel. There is no learning taking place.

[Excerpt from FGD, Jan. 25th 2007].

In this discussion, the students highlighted three major areas for action. These are: 1) equal investments in primary, secondary and tertiary institutions, 2) ensure that teachers, especially primary school teachers get a salary that motivates them to teach and 3) ensure that people get quality education by paying teachers on time and providing necessary materials like those found in urban schools; and curbing school drop out rates.

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[5] Teachers used to get money from the PTA fund, in an addition to their monthly salaries. However, in a bid to make schooling affordable, and to encourage parents to send their children to school, the government abolished this fund in all government-aided schools, when UPE was introduced (MoES, 2006).

The students argued that without proper education, literacy levels will still be low and people will remain ignorant about their rights to better health services, or people will not change their health practices. For example one student said:

> There is a tendency for people to say that because I am used to eating matooke [local food from the plantain family], even if I have money, let me continue to eat matooke because I am used to. So at the end of the day, you eat a food type in excess, so you leave the other one without even taking, so at the end of the day, your health will not be O.K. As you grow older, the body becomes weak, and once you have a deficiency in nutrition, then we are not likely to improve on health. [Joshua, FGD, Jan. 25th 2007].

The students wanted to underscore the link between education and health. So to these students, the best place to start is education and making sure all levels of schooling are fully funded and supported. As Phillip said, *"you cannot jump from nowhere and go to tertiary, you have to go through somewhere, but that place has to have a good foundation so you have to put in effort to achieve the goal."* In this statement, the student was making a critique for investing in only some areas of education as later explained by Timothy above. It was clear in the discussion above that the students thought teachers are being underpaid and are thus not motivated. Generally, the students perceived education as key in promoting health in Uganda.

7.2.2. Raising community awareness

Closely related to education was the call for advocacy to promote peoples' rights. The students felt that there should be both top-down and grassroots advocacy for the rights of people, but it all begins with educating the communities. This was captured below:

> **James:** It is important to educate those who are outside school. Of course those who are educated understand what is happening but those who are not, they don't know their rights.

> **Timothy:** Actually for me I will just take it to the government side. They should just create some adult literacy education to

bring up some of the parents who don't know the values of education, the ones who were denied education.

Karen: People need to understand what is going on in the country. Those who are not informed do not ask for their rights.

Tracy: Many people in the villages have no access to information. There should be workshops for these people.

Maureen: The churches should also be involved in educating people.

Petero: Even the mosques and other religions.

[Excerpts from FGD, Jan. 25th 2007].

These students thought that in order to get the larger populace to understand what is happening in Uganda, literacy for all through adult education should be promoted. The students suggested in the discussions that even the local council leaders (LC1) should be used to tell people about their rights, although the students were quick to point out that some of these local leaders were illiterate themselves. This is what one student said:

> The problem is that there is too much bribing during elections and it puts there hindrance. You vote somebody who is not capable of doing something but because of money, he goes to parliament and yet he is not economically educated. Maybe he doesn't know much about economics and when it comes to draw up proposals, the person tends to ignore the big areas where people can rise up important views
>
> (Sarah, FGD, Jan. 25th 2007).

Sarah's assertion caused laughter and turned the discussion to the topic of corruption. Because the issue of corruption was discussed again, I have included the students' views under the sub-theme of good governance.

Sarah's observation made the students suggest that "election literacy" should be promoted where people get to understand how voting for the "wrong person" affects the country and the community. The students thought that communities can be educated that they have the power to vote out non-performing legislatures. But first, the people have to understand this process. In general, the students thought that massive advocacy through

raising awareness, including voter education, is an important recommendation. The salient point was the need for people to be aware of their rights and to understand that they can change their circumstances through voting wisely or even demanding education for their daughters, as the students suggested.

7.2.3. Fighting corruption and promoting good governance

Following the statement of bribing during elections, was a call for fighting corruption through good leadership. The data collection coincided with the period when members of the Ugandan parliament were demanding vehicles worth 60 million Ugandan shillings ($ 34,000 USD). The students' were reacting to this demand by MPs and said:

> Now you hear that the Members of Parliament want 60 million each to buy vehicles, and they are 332 MPs. When you multiply that money it goes beyond 300 million. Now that encourages people to leave other sectors of the economy and say let us join politics because this is where money is centered. So those centres [other jobs] collapse and people say if I become a businessman, I will not get the money, let me try politics. For you are here busy suffering, you have nothing to do. [Phillip, FGD, Jan. 25th 2007].

Another example is as follows:

> Maybe there will be more development but because of corruption, things are not O.K. The government may release some money, but the people use it for their own things. So you find that there is nothing happening. The government is releasing money but you find that in health centres, there are no drugs, etc. At times the government may release money for the support of orphans but people just steal the money (Karen, FGD, Jan. 25th 2007).

The students felt that such demands by legislatures stem from lack of good governance and knowing what the priorities are. The discussion on good governance was related to fighting poverty. The students contended that if Uganda has money to buy vehicles worth 60 million for 332 legislatures, then that money should be used to fight poverty. However, as the second statement used above posits, corruption is a major problem where most people in leadership positions are stealing the money meant for fighting poverty.

The students therefore suggested that good leadership should be the starting point if Uganda has to promote health and development. This was summed up as follows:

> The first thing is what, is having good leadership. When you have leaders who are interested in people who come from the same ethnic group, you find that one part of the country is developed and another is not. Another one [region] may be medium growth so that is the first problem of having bad leadership. To improve on that, we need to have good leaders in power. We need to educate the masses about development projects or creating jobs, such that you reduce on the population of job seekers and increase job creators.
>
> [Timothy, FGD, Jan. 25th 2007].

The main issue raised by the above statement is that of selective development where some areas are doing economically better than others. According to the Uganda Bureau of Statistics report (UBOS, 2005), Eastern and North Eastern regions of Uganda are the least developed and have high poverty rates. This observation helps to put the students' response in its proper perspective. The students state "*so you find that one part of the country is developed and another is not and another one may be medium growth so that is the first problem, having bad leadership.*" The students contend that tribalism is one of the types of corruption practiced in Uganda today.

The issue of corruption is forefront in World Bank dealings with developing countries (World Bank, 2007). Uganda has just lost major funding for its HIV/AIDS, T.B. and Malaria program because of corruption (UNAIDS, 2006). Just like the students' call for good governance, the World Bank has earmarked 2007 as the year for promoting good governance. According to the students, the best place to exercise good governance is proper investment in all economic sectors. Below is an example of what students suggested:

> **Petero:** The government needs to put in lots of funds and effort. Not concentrating on one thing and forgetting the others or putting funds in one sector and forgetting other sectors. I think the government should put in more funds in the health sector in order to improve on health.

James: Putting money in the health sector alone is not enough because the health sector is also dependent on other sectors like electricity, so it should balance at least all sectors.

[Excerpts from FGD, Jan. 25th 2007).

It is important to mention that in the above statements, the students demonstrate an understanding of the interconnectedness of health issues with other sectors. This suggestion is similar to the call for a multi-sectoral approach in health promotion (Schirnding, 2005). However, to these students, a multisectoral approach is not just about each sector talking about health but each sector receiving adequate funding to ensure smooth running of programs. But all is dependent on good governance through fighting of corruption.

7.2.4. Promoting agriculture

The students observed that Uganda's economy is agro-based, but recent emphasis on industrialization has left agriculture sidelined. Furthermore, 85% of the Ugandan population are dependent on farming but are not earning enough from the crops. According to the students, this is one of the reasons many young people are leaving rural areas for urban centres where it is believed there are better paying jobs. Because of this argument, the students suggested that agriculture should be promoted through protecting the farmers. The students posit that one way of protecting farmers is through reviving of cooperatives that can enable farmers to get a good price for their produce. Some students said:

Timothy: The government should restore the old groups like cooperatives that bring together farmers so that they sale to one common importer. Yeah those days, people were benefiting from agricultural cooperatives like BCU [Bugisu Cooperative Union] because they were contributing to the school fees, but now it is only the parent.

Sarah: During Obote's regime, there were these cooperative societies whereby someone could sell their properties at a good price. But right now, the farmers work for long time, and don't sale. Finding market nowadays is very difficult and people are selling things at low prices because they have to put transport costs. During those days, government vehicles would go into the

villages, and buy the goods from the people and take them to the companies so that the farmers benefit. But as for now, the farmers are not benefiting.

Gina: It would help the people in the village who depend on agriculture.

All: Yes. Agriculture needs to be promoted.

Flavia: Nowadays agriculture is not benefiting and many people depend on it. That is why many people are living in towns.

Maureen: Yes. You find many people who are educated and not employed just loitering in towns. They [unemployed people] know that they will not get money if they do farming.

[Excerpts from FGD, Jan. 25th 2007].

Obote was the predecessor to the current Museveni government and that is what the students are referring to as "those days". The students argued that if poverty is to be eradicated, there should be proper investment in agriculture as many people in rural Uganda are dependent on farming. For example Phillip said: "you find that most of us survive on agric and yet less money is allocated to agric so how can we eradicate poverty." The students quickly tied this statement to the MPS demand for vehicles worth 60 million instead of improving the infrastructure that would enable farmers to transport their produce to market centres in the urban areas. This is explicated in the statement below:

Let me give an example: These MPs are saying that they need vehicles that cost 60 million so that they can pass on the roads. But on the other hand, I think you are supposed to repair the roads first, before you can move on it. So they forget the root cause of the problem. So if we knew the causes of poverty, I think this one would be one of them, because instead of saying let us repair the roads; they are saying that let us buy vehicles that can pass on these bad roads. Now the common man is supposed to benefit from the good road; let me say all of us are supposed to benefit. So the MPs want to benefit alone by buying these cars.

(Joshua, FGD, Jan. 25th 2007).

The students were underscoring their point on how shortsighted some of the programs or ideas in Uganda are. To these students, it would be better to have repaired

roads that serve the whole population than buy vehicles that will increase the economic divide between the rich and the poor. The students then said that because politics seems to be a lucrative business in Uganda, many people will vie for political office to make quick money. This means that the poor who cannot bribe their way into political office will remain marginalized. So in order to protect the rights of the poor, it is important that agriculture, which is their main source of income, be supported by the government. Generally, cooperative societies were seen as one way of ensuring farmers get proper pay for their produce, coupled with investments in the agriculture sector.

7.2.5. Conserving the environment

Closely related to issues of agriculture was the call for environmental conservation if people are to have a good harvest. One student during the FGDs said:

> The problem with farming nowadays is the unreliable weather. The seasons have changed. Sometimes you plant and the crops dry up because of too much sunshine, and then you plant again, and it rains heavily. Because of global warming, pollution from industries, the weather is now changing. So once you grow the crops, you cannot have high yields.
>
> (Tracy, FGD, Jan. 25th 2007).

With this observation, the students suggested that environmental conservation should be the ideal course of action. Some suggested that land consolidation should be done, while others thought planting trees was the remedy. This is what four students said:

> **Flavia:** Encourage maintenance of environment through planting trees.
>
> **Joshua:** Consolidate land to have a greater output of crops. Today people grow only small crops.
>
> **Donald:** Provide farming goods like fertilizers and pest killers because some people cannot afford it.
>
> **Karen:** There is too much pollution of the environment, especially from these industrialized countries. We are feeling the heat here in Uganda. It is important to plant trees.

[Excerpts from FGDs, Jan. 25th 2007].

Issues of environmental sustainability are of local and global concern. Schirnding (2005) makes a case for environmental conservation and closely links it to poverty and health. The most recent appeal is made in Al Gore's documentary *An Inconvenient Truth.* In the same way, the students in this study suggested that if the environment is not conserved, the major economic activity for most Ugandans will suffer, leading to increase in poverty and therefore poor health. Perhaps the "inconvenient truth" for these students is that some may not have their school fees paid, because their parents depend on agriculture to fund their education. The students are therefore aware of the importance of environmental conservation and why action needs to be taken.

7.2.6. Protecting the common person

During the focus group discussions, the students kept referring to the common man or person who is forgotten during decision making processes. The students were taking on issues of privatization and its impact on the lives of the poor or "common person". The common person was defined as one who is not in the corridors of power. This is how the discussion on privatization transpired:

Joshua: The problem with privatization is that, once these foreign investors come, build up a business, and get those profits, most of them go with them to their countries. You find a foreign investor from the UK coming here and after earning a profit, goes back to UK which is already well developed.

Sarah: And most of the people employed there are foreigners. If they would sale the things to people within the country, it would be better but they sale to the foreigners, like Indians.

Joshua: The one who is already developed continues to be developed, and the one who is developing, you go backwards. So that is the problem. They go with profits to their home countries.

INT: So you think the West has worked in such a way that they receive from these African countries…[got interrupted by participant]

Joshua: The West plays what they call double standards. They take away something from you, and on the other hand, they say they are setting up a business. On the other hand, they are taking it away. That is why Africa is still going backward because they exploit us.

Petero: The president says that Africans are the greatest donors.

INT: We are donors?

Petero: They say we are donors to those people in Europe and the West. Because they come here, they exploit us and after, they take and develop their own countries.

Sarah: For example now that they have found oil, you find that many people will be displaced in order to get that oil. But you'll find that those who are benefiting are those who are coming from out (the West). They will perhaps ask the common man to do the digging, but they will take the profits. Maybe the only thing we will benefit is the fuel lowering its price, which will not benefit everybody. It will benefit the rich ones. Many people will be displaced from their land.

Joshua: Another thing is that Africa is full of resources but no capital. Government does not invest in extracting these resources so that they can benefit the common man. So at the end of the day, they leave these investors to extract these minerals. Once they [minerals] get exhausted, the investors just take off without looking back.

Sarah: If the government itself could extract the oil, it would benefit the common man.

Petero: But they don't have the money. Generally, we don't have the machinery.

[Excerpts from FGD, Jan. 25th 2007].

At this point the discussion focused on the problem of depending on donor funds for the national budget. It is important to point out that this exchange provides an example of how the three groups, "the performers", "the debaters" and "the lone ranger" were complementing one another's' opinions. The quieter members, "the scribes" would either nod in support of another person's opinion, but they joined in the later part of the discussion. In the discussion excerpts above, it is apparent that the students think that

privatization does not benefit the country. The reasons are quite clear but what I would like to highlight is Joshua's conjecture that the donors play a "double standard" when it comes to dealing with Africa. Lewis (2005) in his book *"The race against time"* talks about the UN policies and programs that have been detrimental to the African economy. Other studies have pointed out how privatization, for example of health services, caused health inequalities in communities in developing countries (Mohga, 2001; Okuonzi & Birungi, 2000). The students decried the exploitation associated with the process of privatization.

However, closely linked with the students' strong perceptions of privatization was the voluntary brain drain that goes on as people move from developing to developed countries. The students thought that people who would have led the country towards development have all left for greener pastures. The sentiments of the students were:

> These people who are leaving their countries and immigrating to Europe, they are affecting the home countries. Because if your country is poor, and you are running away from it, how can it develop if you are not there? You are the one to develop the country, as it cannot develop itself. [Sarah, FGD, Jan. 25th 2007].

The students thought that this immigration happens for these reasons:

> **James:** Where life is hard, you look for where to survive. But sometimes it helps, especially if the person remembers the home people. Maybe my mom is poor in the village, and you send her some money for her to make a business, it can help.

> **Joshua:** Another problem is Africans examine themselves as minors. So you don't think of doing anything for their countries while these European countries, they feel so much for their countries. We just say we are already poor, we don't know anything. So they [Africans] just settle, accepting the circumstances.

> **Tracy:** It is just that the jobs are not enough, so people go out [Europe and the West] to do odd jobs and make money.

> **Karen:** Sometimes it is better to go out and send money home to help those who are not financially O.K.

> **Maureen:** The problem I think is too much corruption. People who are qualified might not get a job unless they bribe. So they look for elsewhere.

Group: Yeah. That is a problem.

Phillip: I understand there is a lot of money out there. Uganda is losing many doctors and yet we need them here.

Donald: There should be job creation in Uganda so that people stop going out. Otherwise we will not develop.

[Excerpt from FGD, Jan. 25th 2007].

I must state that as a person studying in a developed country who perhaps has "opportunities" for a better life, this conversation was used to open up dialogue over what my plans were when I have completed my studies. The participants were of mixed views on what is appropriate: making a life in the West and catering for your family back home or going back home to develop your own country. It was interesting to have students grapple over what their own choices would be if given the opportunity to choose where to live. The students suggested that it was better to stay in Uganda where they can be of use, as most of the participants were aspiring to pursue medicine in the future. It was not clear whether this choice was made because of feeling nationalistic or because of the discussion that had pointed out why the brain drain is not good for the country and development.

However, the most salient point in this discussion was the issue of curbing the brain drain and so the students suggested that employment should be provided within the country. One student said "we have seen many people who have graduated who are lingering in town" (Gina's response). The participants thought that unemployed graduates will definitely seek a way out and most end up leaving the country. The issue of brain drain was also raised by Orbinksi (2007), who questioned how developing countries are expected to meet their own health-related needs when most qualified medical personnel are employed in Europe and other Western countries. The BBC News (January, 2008) carried a story titled "Africa being drained of doctors." The story points out that European and

Western countries are major employers of doctors from Africa. For example, in the UK, 17, 620 African doctors and nurses, were recruited in 2007 alone. These are doctors born and trained in their home countries. Therefore Phillip's observation was accurate, as he mentions the growing number of doctors seeking jobs elsewhere. In summary, the students thought privatization and brain drain affect the common person and recommended that governments should come up with means of protecting the underprivileged.

7.2.7. Providing good health care services

The students identified development of good healthcare services as another area for action. The students decried the overcrowded healthcare services currently in Uganda and suggested that perhaps more and better equipped health centres should be set up. The issues raised about the current healthcare centres were lack of qualified personnel especially in rural health clinics, and insufficient drugs alongside overcrowding. Three students commented on why people don't visit health care centres and this is what they said:

Petero: It is because the health centres are overcrowded. You can go in the morning and come back in the evening, so it is better you go to this other clinic and go back home quickly.

Joshua: Even with these unqualified doctors, you can go and bargain. If you don't have enough money, you can bargain and you agree to pay a given amount and then later bring the balance. But there in these hospitals, there is no bargaining, if you don't have money, they will not release the patient. So these unqualified doctors have a good bargaining aspect.

James: It is like those hospitals in the villages don't help much. O.K., the only drugs you find there are panadol and chloroquine, so if somebody has a disease, maybe a complicated disease, somebody has to come to the main hospital like in Mbale or in Mulago.

[Excerpts from FGD, Jan. 31st 2007].

With these comments, the other participants suggested that perhaps there should be a fresh examination of the health clinics, especially in the rural areas, so that better care is

provided. The students argued that people use traditional medicine because the practitioners are easily accessible. The students then said because the good hospitals are expensive, people get pharmaceutical medications from unqualified and off the counter transactions, a practice that has been identified as dangerous to health (Jong-Wook, 2003).

The issue of what place traditional medicine has in the modern world, has become one of the major discussions in the World Health Organization (Omaswa, 2006). Studies that have examined the role of traditional healers have pointed out that in the rural communities, traditional medical practices still go on, and this has led to re-evaluating how they can be incorporated in mainstream medical practice (Diallo & Paulsen, 2000; Tabuti, Dhillon & Lye, 2003; Teh, 1998; Tsey, 1997; W.H.O 2000, 2002). The students recalled incidences where they have used traditional medicine; however, some thought it should be banned while others thought it should be encouraged. This is what transpired:

INT: O.K. Now let us focus on some traditional things; do you think that people of your generation believe in traditional medicine?

James: A quarter of the generation

INT: A quarter of the generation. What do you think is wrong with traditional medicine?

James: O.K. madam, mostly this involves witchdoctors or sacrifice. Also it is dying away. So now people are turning to these artificial ones.

Petero: People believe in it. There is a plant called Aloe Vera, it is a traditional plant, and nowadays even rich people are planting it. So traditional medicine is not dying out. Doctors are now proving that there are some good medicinal plants.

James: There are some plants which can treat malaria. It is confirmed by even these doctors. But there is this side where these people involve witchcraft. They think everything involves bewitching.

Joshua: Some people use traditional medicine. But on the other hand people say that traditional medicine does not have prescriptions. You just take even if you have large amounts or small amounts.

Timothy: But there are some which are recommended by these doctors.

Petero: Like this Aloe Vera I am talking about, it can cure malaria. It is even better than these other medicines, and you can just take very little. Even it does not have these side effects. But these other drugs, if you take like chloroquine, you get these side effects of itching.

Timothy: For some it [chloroquine] does not itch them.

Petero: But for me it does.

James: What I have heard about these local medicines is that if you have been using them since your childhood, you can stay normal. But if you turn to use this other one you die faster. In fact there is an old man in the village who doesn't go to these hospitals, he uses these local herbs.

Joshua: Many modern medicines have side effects.

INT: What do you think Flavia?

Flavia: People are taking traditional medicine. People are using it to visit witchdoctors so I don't believe in it.

[Excerpt from FGD, Jan. 31st 2007].

In the end the students thought that there should be a blending of these practices if people who believe in traditional medicine are to be catered for in the promotion of health for all. This was stated as follows:

> At least the people should be allowed to go for modern laboratory check up to diagnose the illness, so that they know what they are suffering from. Then the people are given the choice whether or not to use a traditional method to deal with the problem. The problem today is people take this traditional medicine without knowing exactly what they are treating. [Timothy, FGD, Jan. 31st 2007].

The students thought that in their generation, there will be fewer people using traditional medicine but felt that in the rural areas, it is important to recognize the role of traditional medicine in light of poor healthcare services offered in the present.

7.3. Discussion

The role of the social context in decision making became apparent when students discussed the issue of contraceptives for youth in Uganda. The students provided some

arguments for legalizing abortion and the advantages for allowing youth to access contraceptives as detailed in section 7.1 above, although in the end they argued against it. However, the students also suggested that if such policies are implemented, it is important to recognize the role of religion, and personal attitudes towards abortion and contraceptives. These suggestions speak to how the social context influences people's decision making process. For example, those who profess the Christian faith will not support legislation that advocates for abortion and contraceptives. The participant who did not respond to the questionnaire discussing contraceptive use is Catholic. Some studies have found that religion has influenced how some people in Africa relate to HIV/AIDS information and the use of condoms (Geest, 1997; Smith, 2004). Caldwell et al (1998) also found that people do not practice modern family planning because of their religious beliefs.

Besides the role of religion, people's personal beliefs and attitudes towards abortion and contraceptives influence how they relate to family planning messages. For example, Kiapi-Iwa and Hart (2004) found that some teachers, parents, and health providers in Uganda do not support abortion, or young people's access to contraceptives. The people in Kiapi-Iwa and Hart's study argued that young girls who got pregnant should take responsibility for their decisions. Similar sentiments were held by teachers who took part in a study evaluating a comprehensive HIV/AIDS curriculum for secondary school developed by UNAIDS (Kinsman et al, 2001). Mirembe (2002), however, argues that the personal beliefs of people could be influenced by government's stance on providing contraceptives for youth. Mirembe observed that in Uganda, the curriculum is meant to instill morals in young people as a means of preventing AIDS. These studies underscore the importance of understanding the social context in which the policy is to be implemented. The students in

this study suggested that it would be important for policy-makers to educate the communities before investing in the purchase of contraceptives or legalizing abortion.

In chapter 2 of this thesis, I presented studies that invited debate on how some policies are incompatible with the communities in which they are to be implemented (see Airhihenbuwa et al, 2000; Caldwell et al, 1998; Kickbusch et al, 2002). In this study, the students are extending the same challenge of inviting people to debate how a policy like legalizing abortion will impact the communities in Uganda. The students thought that although there are merits to legalizing abortion, there are also demerits in that people who molest young girls might never be punished for their crime because they will force the girls to abort. In this regard, the students argue, the defilement law will become irrelevant and the sexual abuse of young people might increase. In general, the students understood that the social context contributes greatly to how people will respond to given policies.

The need to recognize the economic differences between the developed and developing world was another important point made by the students in this study. This point was made apparent during the discussion on legalizing abortion. The students mentioned the need to recognize that Uganda does not have enough medical personnel and infrastructure to effectively implement such a policy, should it become law. Caldwell et al (1998) have argued that most researchers from developed countries advocate for legalizing abortion and providing contraceptives for youth in developing countries in Africa, without taking into account the economic and infrastructural differences in these countries. Caldwell et al observed that while most governments in developed countries have a healthcare system that ensures that hospitals have all the necessary drugs and equipment, the same cannot be said about African countries. In this regard, therefore, it is not

appropriate to advocate for a policy which contributes to the economic strains existent in developing countries.

In Chapter 2 of this thesis, I have presented findings from some studies that have highlighted the consequences of implementing policies without taking into account the economic inequalities of participating communities. For example, Okuonzi and Birungi (2000) found that the British healthcare model introduced in Uganda was incompatible with the economic status of the country. As a result, Uganda has failed to maintain these healthcare centres. Mohga (2001) found that the medical user-fees policies that had worked in developed countries were not practical for African countries. Mohga observed that people from poor communities, and mostly women, were denied access to medical care because of such a policy. Okuonzi and Birungi (2000) observed that in Uganda, the user-fee policy and now privatization of Medicare has led to health inequalities between urban and rural communities, men and women, and developed and developing countries.

Therefore although these policies were designed to address a particular need, they have had the unintended consequence of increasing the health gap between developed and developing countries (Ahmed et al, 2000; Kickbusch 2001; Mohga, 2001). Under sub-theme 7.2.7, the students discussed how user-fees have impacted the health practices of poor people. The students suggested that many poor people opt to use traditional medicine or consult untrained pharmacists because they cannot afford the user-fees charged in main hospitals or by private healthcare providers. In general, the participants in this study underscored the need to take into account economic differences when promoting certain policies or health practices. In this regard, the students' views contribute to the studies that have invited a critical debate on the impact of some policies or programs that were

designed from a western perspective and implemented in African countries because of the pressure of international donor bodies (McQueen, 2001; Mohga, 2001; Orbinksi, 2007).

Some of the issues raised by the students require local solutions. Issues including: lack of parental involvement in their children's sex education, providing youth-friendly counseling services, and fighting corruption to benefit the common person, need to be locally addressed in Uganda. The lack of parental involvement and provision of youth-friendly counseling services could be addressed through the re-appropriation of indigenous sex education institutions as suggested by Muyinda et al (2004). These could help complement the work being done through the *Straight Talk* monthly newspaper for secondary school students. The challenge would be how to revitalize these institutions in urban centres and within schools. Kanu (2006) has suggested that perhaps African countries should design curricula as a cultural practice, whereby traditional ways of passing on pertinent information are promoted. Given that some studies have suggested that the taboo nature of sex discussions hinder teachers and parents from broaching topics on sexuality (Burns, 2002; Kinsman et al, 2001), it is important to investigate how these topics can best be included in the national curriculum, taught and discussed within the classroom, without compromising the cultural practices.

In Uganda, UNESCO has attempted to find a cultural approach to HIV/AIDS prevention and care (see Sengendo & Sekatawa (1999). Bass (2005) has also reported that Uganda is using community-based approaches that understand the cultural context in which ARV treatment is provided. Uganda has generally been applauded for its "social vaccine" to HIV/AIDS that led to the reduction of infection rates from 32 percent in the early 1980s to the current 7 percent (USAID, 2002; UNAIDS, 2002; W.H.O 2007). The current

challenge is developing culturally appropriate ways for teachers and parents to explicitly provide and support sex education for adolescents. At present, the students are asking for safe places for discussing sexuality-related issues in the absence of parental and community involvement. The students want youth-friendly counseling centres.

The issue of corruption could be addressed through the concept of communalism (Dei, 2000; Kanu, 2006). The students suggested that most of the parliamentarians and leaders are corrupt because they have forgotten their moral duty to their communities. The spirit of communalism was designed for instilling moral responsibility in young people towards their communities (Dei, 2000). Perhaps if the concept of communalism is re-introduced, the moral conscience of the people would be re-awakened. However, communalism should be promoted along with laws that deal with corruption. As explained by the students, corruption has become one of the worst problems in Uganda today. In fact, the World Bank and UN suspended funding to Uganda because of corruption (UNAIDS, 2006). Therefore, even though it is important to instill moral responsibility in young people, there should be a crackdown on corruption if the funding allotted for improving the health and life chances of the underprivileged is to reach its target. As the students stated, the common person is the one who suffers when leaders are corrupt.

The students' views on education, community awareness, privatization, environmental conservation and investment in agriculture speak to the need for social action if people's health and life chances are to be improved. The call for social action is embedded in the theory of critical conscientization (Freire, 1970) whereby the oppressed people's consciousness of the causes of their situation is strengthened, and the possibilities of transformation made apparent. I suggest that social action needs to be done because of

the numerous unintended consequences resulting from some policies and investments. For example, in relation to investing in education, the students mentioned that because the teachers are not earning enough, the quality of education at elementary levels has dropped.

The students posited that only the children in urban private schools are receiving quality education for their children because of the extra money teachers receive. As a consequence, the majority of the children, who are from a poor economic background, are marginalized through receiving low-quality education. In this regard therefore, it is important that communities take action and demand better investments that ensure their children receive quality education. Therefore, it is not enough that the Ugandan government (with the help of World Bank) invest in building schools rather than the salaries of teachers, who have a direct impact on what kind of education the students receive. As the students stated above, most of the teachers are using the schools as "hotels" because of the feeding programs in the schools, but actual teaching is minimal. The World Bank (2007) is now calling for investment in quality education in all countries promoting universal primary education. The call by World Bank indicates that there is some merit in the students' assertion that there is need for quality education in Ugandan primary schools.

Social action should also be taken in relation to issues of corruption and protection of the "common person." The students made strong arguments for the need for change given that the Ugandan MPs were asking for expensive vehicles at the expense of improving the livelihood of the people in Uganda. As the students suggested, there should be "election literacy" whereby the people are empowered to take action against plans that do not benefit the country but only lead to exploitation of the poor. The fact that Uganda has lost crucial funding to the health sector because of poor governance and corruption is

an indicator that it is time for social activism against such practices. As the students explained above, it is the common person who suffers. Carlisle (2001) has suggested that grassroots activism is important in keeping governments and leaders accountable to the people. Carlisle also suggests that people should be made aware of their rights and empowered to exercise these rights through social activism. The students in this study made a suggestion similar to Carlisle's in the discussion on raising community awareness.

In regard to protection of the common person, the government of Uganda should take the lead in acting on behalf of the people. The students discussed the shortcomings of privatization and liberal market policies on the Ugandan economy. Lewis (2005) has documented how aid not trade policies employed in European and Western policies for Africa negatively impact health and life chances of communities, especially women and children. Given that major economic bodies like World Bank only work with governments, it is important that the Ugandan government form partnerships with international organizations interested in promoting fair trade for developing countries. At present, NEPAD is the negotiating body for African economic interests and Uganda is a member. However, as Orbinksi (2007) has suggested, it is important that people living in developed countries apply pressure on their governments to change the unfair policies that strangle the economies of Africa, which have already been hard hit by the HIV/AIDS epidemic.

In regard to social action for the improvement of health and life chances of communities, St. Leger (2001) has suggested that health literacy be promoted. St. Leger argues that health literacy encompasses all the issues that impact the well-being and life chances of a person, that is, the social and physical determinants of health. In general, health is impacted by education, gender inequality, environment, agriculture, and poverty.

This has resulted into a call for a multisectoral approach to health in developing countries (Schirnding, 2005; W.H.O 2002). Health literacy is also concerned with making health a political issue (Nutbeam, 2000; Orbinksi, 2007; St. Leger, 2001). This political aspect of health literacy could be instrumental in empowering people to take action against corruption and policies that exploit people, as students have discussed above.

7.4. Conclusion

The seven points for action would be the students' "MDGs" for Uganda. The students chose not to use the 8 familiar goals but examined general issues they thought were central in promoting health in Uganda. I used the MDGs to set up the discussions and these sparked off the students' views as detailed above. Therefore, as an extension of Sirotnik's (1988) framework, the students know that action can be taken and have ideas for what should be done and how it should be done. However, there was a pervasive fear that these goals cannot be met in Uganda today because of the high levels of corruption. The students did not think corruption can be rooted out because it is done both at the top level and lower level of governance. They even made reference to the fact that within schools, there are some students who plagiarize or cheat in examinations and that such students will in the future become corrupt leaders. At this point in the discussion, the students suggested that the need to see change is there, but how to implement change is still elusive. One student (Flavia) then reminded the group that after identifying the central areas for action, it was fitting that we remember to pray for change to happen because prayer brings hope.

In general, the seven points raised by the students are critical to health promotion and improved quality of life in Uganda. Each point has dire consequences if not adequately addressed, as explicated by the students. At the root of all these points is the need to

eradicate poverty, which is the number one MDG. Issues of education, advocacy, agriculture, environmental conservation and protection of the common person were closely linked with problems associated with poverty, and how it in turn impacts health literacy, HIV/AIDS and gender. In summary, if the youth in Uganda are given a voice, they can become a constituency of reform (World Bank, 2007). The students in this study were passionate about the public life issues that impact them as individuals and the society at large. This passion became apparent when the students engaged in discussion of the seven points presented in this chapter. Currently, the youth in Uganda do not have a voice and therefore I reiterate the call by St Leger (2001) and World Bank (2007) that young people should be given the opportunity to engage in discussing issues that impact them and their society. Sirotnik (1988) suggested that students should understand that change is possible (see also Giroux, 1995). The students in Uganda should be provided with opportunities to engage in discussions on public life issues, think critically, and make a difference through participating in social action (St. Leger, 2001).

The next chapter of this thesis presents a summary of findings; implications for policy, theory, and practice; limitations of the current study; and recommendations for further research.

CHAPTER VIII

8.0. SUMMARY OF FINDINGS, IMPLICATIONS, LIMITATIONS, AND RECOMMENDATIONS

In this chapter, I present and summarize the key findings of the study (8.1) and develop implications for policy, theory, and practice (8.2). I then discuss the limitations of the study (8.3), and provide recommendations for further research (8.4).

8.1. Summary of the research findings

This study investigated youth perspectives on the complex relationship between health literacy, HIV/AIDS, and gender within the Ugandan context. The four research questions that guided this study were as follows: (i) What kinds of information on health literacy, HIV/AIDS, and gender do secondary students access? (ii) In these students' view, what are the factors that contribute to the health and HIV/AIDS related challenges faced by young people in Uganda today? (iii) According to these students, what is the impact of debates on gender equality in the fight against health epidemics including HIV/AIDS? (iv) What do these students consider to be the way forward for Uganda to achieve better health and improve life chances for all? These questions were developed based on three propositions made by leading international agencies like World Bank, W.H.O and UNAIDS, which are concerned with tackling the social determinants of health in order to improve the health and life chances of people in the developing world. The findings of each

of the questions have been discussed above and therefore in this section I present a summary of these findings.

The findings of this study revealed that the adolescent students who participated in this study were interested in information that answered their questions on adolescence and sexuality. The students accessed information relating to reproductive or sexual health, HIV/AIDS and how boys and girls are impacted. The information was made available to the students through the media but especially through the adolescent-friendly newspaper *Straight Talk*. The information in *Straight Talk* was designed to dispel myths and misconceptions relating to adolescence and related matters including menstruation, wet dreams, and HIV/AIDS. The information was provided in a language and manner that was accessible to school-going youth in that it included stories, proverbs, and anecdotes with which students could easily identify. In general, the information educated youth about their rights, and also transcended cultural taboos by providing young people with pertinent sexual health information.

However, even though the students accessed pertinent information on sexual health, HIV/AIDS, and adolescence, the findings on research question 4 showed that the students want parental and community involvement as well. The students' responses indicated that having peer-to-peer exchanges through *Straight Talk* served a purpose, but suggested that sometimes, it is important to have an adult to answer some private questions. The students then suggested that perhaps adolescent-friendly counseling services that protected their privacy would be necessary. The students wanted a listening ear and not more instruction, as is usually the case when they talk with their parents, especially on matters relating to sexual health. I therefore propose that alongside the *Straight Talk* newspaper, perhaps there

should be avenues for adolescents to seek face-to-face advice with counselors. These counselors should not be employees of the school, as the students would doubt if their right to privacy was being honored. Perhaps more parental and community involvement would also be appropriate, but not necessarily the solution as the students indicated that they would not want their parents to know about their sexual behaviour. The students mentioned this during the discussion on why young girls have sex in exchange for money.

The findings also revealed that adolescent girls face more challenges in regard to maintaining their health and well-being compared to the boys. The female students have to battle issues of community attitude towards their education, and sexual advances from richer and older men that boys do not face. Furthermore, the girls seemed to be more affected by their socio-economic background, as discussed by the students in this study. Most of the girls living in the hostels felt "unequal" to their peers from middle or higher socio-economic status, and so had developed low self-esteem. The male students living in the hostels did not report a similar problem. However, the boys also struggled with peer pressure, especially in relation to proving their sexual prowess and masculinity. Unfortunately, low self-esteem and the peer pressure often lead young people to engage in sexual relationships. For the girls, sex is usually with an older man who can afford to buy the items that she might require in the hostel, while for the boys, the sexual relationship is often with an age-mate. The sexually active youth, especially the girls, are at risk of getting pregnant and dropping out of school (Burns, 2002). However, from the findings in this study, it is apparent that the Ugandan Ministry of Education is ensuring that young girls know that they can return to school after giving birth (see 4.1.2). The girls have to negotiate with their parents about baby sitting and welfare, as government does not provide childcare

centres. The challenge, however, is how to protect the girls from HIV/STD infection given that in these "sugar daddy" relationships, the power imbalance prevents the girls from negotiating for condom use (Jones & Norton, 2007; Nyanzi et al, 2001). These cross-generational sexual relationships appear to be the major challenge in the fight against HIV/STI in Uganda today (Mason, Oct. 2005). Therefore it is important to address the issues that lead to "sugar daddy" relationships.

The study findings also revealed that men or boys need to be included in the gender equality campaigns. During the discussions on gender equality, the male participants constantly pointed out how most of the programs excluded the role and responsibilities of men. The students suggested that because of this oversight, many men do not know how to get involved in the health issues impacting women. The students' suggestions corroborated the studies that have critiqued some of the women-targeted programs, which have had unintended consequences of depicting women as victims and without agency (Baylis, 2000; Castle & Kiggundu, 2007). Some other scholars have argued that men's role in ensuring gender equality has not been recognized (Desai & Alva, 1998; Wegner et al, 1998; White et al, 2004). Therefore, as the students in this study stated, if women's health and life chances are to be improved, it will require the education and involvement of men. The students thought that as people advocate for the re-appropriation of the *Senga* indigenous institution (see Muyinda et al, 2004), a parallel program for boys should also be designed, so that both boys and girls grow up knowing their responsibilities to one another. This suggestion has some potency given that the question of how to improve the sexual health of married people in relation to HIV/STDs is a major concern for local and global communities (UAC, 2007; UNAIDS, 2007). The statistics from Uganda show that new infections occur within

marriage, especially among the discordant co-habiting or married couples (MoH, 2006). Most of these discordant couples are not aware of their sero-status and therefore do not use condoms to prevent infection (UAC, 2006). If young people are taught early about their sexual responsibilities, in the future they will protect the health of their spouses.

In this study, it was apparent that although the students had a basic understanding about gender equality and its importance in terms of promoting or improving health practices, it was not clear how the concept applies in the private sphere and micro-community. The students know that gender equality includes women having a voice and being part of the decision-making process. In this regard, the students had understood gender equality as conceptualized in the WID and GAD frameworks for analyzing gender relations. The students accessed information on how gender inequality puts women at risk, but the students had no examples of how equality is practiced within families. Many of the students understood gender equality within family as an issue of co-existence and complementarity in order not to disturb the peace of the home or society. However, the discussion of gender equality and the notion of "respect" require a re-examination of the students' suggestion of co-existence that does not disturb the peace of society. A possibility exists that the girls who have "external empowerment" might not necessarily have control over their health within the micro community or family. Research has shown that many educated and gainfully employed women, often perceived as empowered, have not necessarily escaped the brunt of domestic violence and HIV/AIDS. This is because of their low status in the family (Chan, 2007; Kickbusch, 2001). The idea of co-existence or complementarity, if not well examined, could translate into the perpetuation of some of the social norms that promote gender imbalance. As Sen (1997) suggested, giving marginalized

people control over external factors and resources without changing their self-perception or consciousness can leave space open for others to wrest control. The society's perception of women also needs to be altered if equality is to be attained.

I therefore propose that the capabilities framework that analyzes gender relations within the private sphere be used to educate communities on their responsibilities to each other (see 2.3). According to Robeyns (2006), the capabilities approach not only challenges the larger status quo, it also strengthens the consciousness of people about the causes of their situation and teaches them to build on this to transform their control over external resources (see also Sen, 1999). Therefore, given that the WID and GAD frameworks have been used to give marginalized people, especially women, control over external resources, I suggest that the capabilities approach should be introduced to complement these two frameworks to build on what has so far been achieved. The unique contribution of the capabilities approach would be the focus on strengthening the people's consciousness about the causes of their situation and how they can transform the situation (Unterhalter, 2003). Not only will the capabilities approach focus on women, it will also include men and enable both genders to examine how their earlier socialization causes the power imbalance and health challenges experienced today. The students in this study suggested that there are distinct roles for men and women (see Ch. 6), providing an example of how early socialization along gender roles influences the way young people engage in the discourse on gender equality. The capabilities approach would provide young people with the language and lens (Robeyns, 2006) for analyzing gender relations and provide youth with an opportunity to articulate how these roles can be transformed to promote a more equitable society. This was one of the reasons for engaging in gender equality discussions.

A close analysis of the capabilities approach reveals that the framework has some ideological links with critical pedagogy and critical theory (Freire, 1970) in which the critical health literacy concept is embedded (Kickbusch, 2001; Nutbeam, 2000; St. Leger, 2001). Similar to the capabilities approach, the critical health literacy concept or critical pedagogy is concerned with raising awareness among communities about the causes of their oppression, and the purpose is to encourage people to take action or to liberate themselves (Freire, 1970). Given that critical health literacy is concerned with tackling the social determinants of health (e.g. gender imbalance, poverty, poor healthcare services, social and cultural norms), I therefore propose that this concept be adapted in the discussions on health, HIV/AIDS, and gender within schools and communities in Uganda. As I mentioned in the theoretical framework (see Ch. 2), I suggest that health education be replaced with health literacy because people in Uganda, especially young people, have health, HIV/AIDS, and gender-related information but are not able to apply it in real-life situations. This is because the social context in which the knowledge is to be applied is not supportive of change (see Kakuru, 2006; Mirembe & Davis, 2001). The inability to apply the knowledge has been attributed to the gender imbalance (Gupta, 2000; Mohga, 2001), breakdown in the social fabric (MoH, 2006) and poverty (Baylis, 2000; World Bank, 2002). All these factors were discussed at length by the participants in this study.

I advocate for the adoption of the health literacy concept because it allows for the inclusion of a socio-cultural dimension in the tackling of problems faced by communities in developing countries (Kickbusch et al, 2002). The findings in this study revealed that young people, especially those not attending formal education institutions, and people living in rural areas, are more vulnerable to poor health and this impacts their life chances.

The students proposed that government and the community should provide avenues for educating these people about their rights to better health through access to information. The participants suggested that youth attending school have the advantage of accessing health information through various media like radios and *Straight Talk*, while their rural and uneducated counterparts could not access the same privilege. Therefore, the use of traditional media was recommended alongside the re-appropriation of indigenous sex education institutions. As mentioned in the theoretical framework, the use of traditional communicative tools have already been utilized to provide health, HIV/AIDS, and gender-related information to young people, and people living in rural communities (Kendrick & Mutonyi, 2007; Majalia, 2004; Morrison, 2003; Norton & Mutonyi, 2007; Singhal, 2004).

The socio-cultural features that could also be appropriated for education for social change and improved health and life chances include integration of theory and practice, and communalism (Dei, 2000; Kanu, 2006). As I suggested earlier, these two features (integration of theory and practice and communalism) would help respond to the critique that the health information and programs currently promoted in developing countries are decontextualized (Airhihenbuwa et al, 2000; Dei, 2000; Kanu, 2006; Kickbusch et al 2002). As Airhihenbuwa et al (2000) suggested, for health promotion to be effective, the theoretical and methodological issues must speak to the social, cultural, economic, political and spiritual aspects of the people's lives, as well as to their specific needs and aspirations (see Dei, 2000; Geest, 1997; Mushengyezi, 2003; Nutbeam, 2000; Kickbusch et al, 2002).

Some studies have recommended a cross-fertilization of indigenous knowledge with new knowledge (scientific knowledge) in order to dispel myths and misconceptions (Kickbusch, 2001; Nutbeam, 2000; World Bank, 2002). Dei (2000) suggests that it is

important that the articulation does not reproduce the existing dependency on external knowledge and resources at the expense of the people in local communities. The local knowledge systems need to be respected. The suggestion by Dei speaks to what Nutbeam (2000) observed as the unintended consequences that well-intentioned health programs and structural strategies had on communities in developing countries. The interventions were done on *behalf, on* and *to* people instead of *by* and *with* people (see also Kanu, 2006; Wright, 2000). The findings of this study provide examples of some of the unintended consequences of some of the theoretical and methodological approaches to gender equality in health promotion, and therefore help to underscore the need for the inclusion of the socio-cultural dimension, especially if girls' health is to be improved.

Through the discussion with the students on the way forward for Uganda if the people's health and life chances are to be improved, I reiterate the call by World Bank (2007) and others (Mitchell et al, 2006; St. Leger, 2001) that young people should be given a voice to become a constituency for reform. The students demonstrated an awareness of what was happening in their communities and made some suggestions as to what areas could be improved to promote better health practices (see Ch. 7). The inclusion of youth in social activism (St. Leger, 2001) could enable young people to encourage parents and governments to adhere to certain laws like the one against early marriage and defilement. The students posited that, currently, these laws are not adequately adhered to and that is the reason young girls face numerous health challenges, including pregnancy, early marriage and HIV/STD infection. The article by Norton and Mutonyi (2007) reports how young people in Uganda, through the HIV/AIDS clubs, used the information on girls' rights to

education to demand that one of the teachers return their peer to school. The story demonstrates that young people can be organized to effect change.

I conclude this thesis by reiterating that all the local achievements can be strengthened by global partnerships. As the findings revealed, there are some international policies and programs like privatization and structural adjustments that have had direct impact on the health and life chances of people in developing countries like those in Africa. Therefore it is imperative that all stakeholders interested in health issues of the developing world, partner with local communities to promote better health and improve the life-chances of all people. In the theoretical framework and in chapter seven, I have provided some examples of organizations spearheading the campaigns for global action (see also Cohen, 2002; Lewis, 2005; Orbinksi, 2007). However, I cannot conclude this discussion without mentioning that in spite of the numerous health-related challenges faced by people in Uganda, the government and communities are working together to address these issues.

8.2. Implications for policy, theory, and practice

In this section, I discuss the major issues which have arisen from the study starting with policy, then theory and lastly practice.

8.2.1. Implications for policy

In this thesis, I drew on major propositions from international aid agencies to develop the research study. In this section, I discuss how the findings speak back to the leading policymakers and educational policy in general. These are: (a) Listen and respond to the voices of the youth, (b) ensure that policies include specific details, (c) create possibilities for youth to develop a united voice, (iv) develop policies that allow for

flexibility with respect to local needs, (d) match policies with services and (e) encourage the development of local, national, and global partnerships. These recommendations are elaborated upon respectively below.

a) Listen and respond to the voices of the youth

The World Bank (2007), UNAIDS (2005) and W.H.O (2002) reports have argued that youth should become a constituency for reform. This means that policy makers should demonstrate their commitment to this call by listening and responding to the voices of the youth. One of the issues that policymakers need to listen and respond to is the impact of school-related and health related fees on the life chances of youth, especially the girls. Tomasevski (1998, 2005) has observed that although the World Bank recognizes education as a human right, it views education as a traded service. Similar sentiments are extended to healthcare services where user-fees are charged (Okuonzi & Birungi, 2002). As a consequence of viewing education and healthcare as a traded service, many children especially girls from poor families, are impacted. In chapter five, the students mentioned how parents will marry off their daughters so that they can get dowry and pay fees for their sons. The male students also stated that if the parents cannot afford to pay the school fees, young men are encouraged into early marriage. This has led young people, especially girls who do not have alternative sources of income, to engage in cross-generational relationships that create an environment of risk to HIV/STD infection or pregnancy.

However, given that the World Bank is not ready to remove fees at secondary school level in spite of knowing the impact all kinds of fees have on the education [and life chances] of the youth and the poor (Kattan & Burnett, 2004), it is important to consider how the youth can best cope with this challenge. The World Bank's argument is that where

fees make a contribution to the quality of schooling [or healthcare provision], simple abolition of fees could have undesired consequences (World Bank, 2005). When one examines the MDGs, there is not a word about guaranteeing free education for all, and also NEPAD insists on school fees (Tomasevski, 1998, 2005). The World Bank is thinking of introducing scholarships, loans, and bursaries but oftentimes these are merit based and the poor who do not have access to quality schools will not access these services (Kattan & Burnett, 2004). Therefore there is need for the leading international policymakers to listen to the voice of the poor especially since these organizations market themselves as caring for the well-being of the poor.

As discussed in chapter five, most poor families spend up to 33% of their income on education and many have opted not to take their children, especially girls to school, arguing that the benefits from secondary education do not warrant such an investment. In Uganda, 31% of the population is below the poverty line and does not have a steady source of income, and yet they have to pay for education and healthcare (Mohga, 2001; UNFPA, 2007). Boyle et al (2002) found that most children from poor families are also the most vulnerable to illnesses and often have poor health (see also Kakuru, 2006). Therefore, if indeed the three organizations World Bank, UNAIDS, and W.H.O are interested in promoting health for all, it is important to understand the health problem from the perspective of the poor and not the economically powerful nations. Lewis (2005) has made a case for revisiting policies and focusing on the voices of the poor who cannot access the corridors of power where most decisions are made.

In chapter two (see 2.6), I cited studies that have invited debate on how policies and programs based on the success of economically powerful countries impacts the livelihood

of people in developing countries (see Kickbusch et al, 2002; McQueen, 2001; Okuonzi & Birungi, 2000). The MDG are also embedded in the philosophies of powerful economies and that is why many African countries will not be able to achieve most of these goals by 2015 (UNDP, 2005). However, these are the policies that get implemented and the poor continue to be marginalized. The health and economic gap continues to widen between developed and developing world, the urban and the rural, the men and the women, and boys and girls. The common person is left to eke out a living in order to access the benefits of services like healthcare and education.

However, as the participants suggested, we must deal with the reality of their world (see 7.1). The reality is that they have to pay fees in order to access quality education. Consequently, the students asked for employment opportunities for youth so that young girls do not use sex as a source of income. The challenge the young people address to the policymakers is coming up with equitable alternative sources of income that cater for the poor youth and girls in particular. As Sarah stated in chapter five, the girls often lack access to income generating activities when compared to the boys. Therefore, the response from policymakers should include a gender dimension. In addition, the alternative sources of income should not come at the expense of schooling as the students know that education is central to better life and health (see Ch. 7). Perhaps before the long term MDGs can be achieved, the World Bank and other leading policymaking bodies (e.g. NEPAD) need to come up with short and medium term goals that provide the backbone for achieving the larger purposes.

Opportunity: Given that it is these leading international policymakers advocating for involvement of youth in major public life decision-making process, there exists an

opportunity for youth perspectives to be heard and responded to. As stated earlier, recommendations by international policymakers are often implemented by participating developing countries (Gillies, 1998).

Challenge: Some studies have pointed out that when international bodies recommend participation from local communities this translates into implementing already pre-set goals not necessarily listening to the voices of the affected people (Brehony, 2000). Furthermore, the poor often have no access to facilities that would provide them with opportunities to share their perspectives on policies that impact their well-being.

b) Ensure that policies include specific details

The findings in chapter four indicated that the students had accessed information that was meant to build their self-esteem and make them aware of their rights to education and sexual or reproductive health. However, the students mentioned that the defilement laws and policies have not been effective in protecting the rights of young girls. In addition, the students talked about early marriage and how it affects the life chances of the girls, especially those in the rural areas. These observations need to be addressed by policymakers and policies developed that ensure these young people exercise their rights. The defilement law needs to be refined and all those who break it should be prosecuted so that the young people know that it is effective. The fact that early marriages, cross-generational relationships, and molestation were mentioned as major hindrances to young people's health practices (see Ch. 5) is testament that currently, parents and the law enforcers are not taking this policy seriously. It is important that better laws and policies are developed that spell out punishment not only for the offenders but for parents who are

complicit in encouraging sexual relationships that break the law, for example, marrying off their young daughters.

However, the laws and policies should take into account the factors that contribute to their being ineffective. For example, the law against defilement or early marriage becomes ineffective if the parents have to make a choice between education costs and household income because of the fees involved. Studies have already shown that under such circumstances, the parents will opt for not educating their children and consequently the practice of early marriage will continue (UNICEF, 2005). Therefore as long as poverty is an issue, the education of the girls is in jeopardy. The girls will continue to feel unvalued as their only "value" is in marriage and bride price. By extension, most of the set MDGs will not be achieved as many young people enter into marriage without adequate information and get trapped in the vicious cycle of poverty, high child and maternal mortality, and gender inequality, which are the target areas in MDGs (see Kakuru, 2006).

The role of culture in people's decision-making process needs to be investigated as well. In most cases, once the youth of school-going age are not in school, the common option is to encourage them to marry. This happens mostly after the rite of passage ceremonies in some communities, including the community from which most of the participants were from. This is the reason James talked about culture and early marriage (see Ch. 5). In chapter two, I discussed studies that explained the attitudes of parents towards education and the role "rites of passage" plays in parents' decision making process (e.g. Caldwell et al, 1998; Fuglesang, 1997). If the child is not in school, the logical option for most parents would be preparing them for marriage. Such parents will not recognize that they are breaking the defilement law because customarily, they are acting within their

rights (HRW, 2003). Therefore, policymakers and politicians need to examine the repercussions of some policies and develop more effective laws that take into account the social context in which decisions are made.

Opportunity: Both international and local policymakers are beginning to examine the impact of some policies like school fees on health and life chances of poor communities (Kattan & Burnett, 2004; Kirungi, 2000; MGLSD, 2006; UNICEF, 2007). There exists an opportunity for these policymakers to come up with better policies that promote the human rights of all people, especially the marginalized.

Challenge: Chan (2007) has posited that in most cases, change happens but at a very slow rate. In addition, the required changes might fail because of lack of support. For example, issues of gender inequality do not have enough support in local governments and yet these policymakers understand the impact it has on health.

c). Create possibilities for youth to develop a united voice

If the youth are to become a constituency for reform, schools should be seen as a space where these responsibilities begin to be exercised. The youth need a forum for publicly engaging in discussions that address issues. For example, the inter-relationship between gender inequality, cross-generational relationships, and life chances of women or marginalized people. Throughout chapters 4 to 7, it was evident that the participants were passionate about the plight of the poor people, especially those in the rural areas. In chapter seven the students had views on what should be done to improve the life chances for all people. I therefore propose that within the schools, there should be a space where young people begin to talk about these issues and collaboratively plan how change can be effected. However, these forums should be distinct from discussions that have pre-

determined goals because the desire for change has to come from the youth themselves. In chapter six, the male participants brought up the issue of visiting counselors for the girls. The female students stated that they do not turn up for these sessions because they are lectured at and not listened to. I therefore suggest that any space for discussion should be youth-centered and not program-centered.

St. Leger (2001) and Orbinksi (2007) have advocated that health issues should become political and schools can begin the process for young people (see also World Bank, 2007). The female participants said they lack a voice in their communities and this has impacted how they relate in schools. I suggest the issues that lead to young people's lack of "voice" be the starting point for youth empowerment. As Sirotnik (1988) suggested, it is important that all pertinent information related to a major issue be provided so that young people are aware of the inter-connectedness of certain practices on people's lives. Perhaps the male participants will learn that their female counterparts do not engage in sexual relationships as an alternative choice as they insinuated in chapter five and six of this thesis. Furthermore the young people would perhaps define what "respect" means in relation to women's empowerment and life chances. Presently, the students seemed to have no language to adequately reflect on how the notion of respect impacts the lives of young girls, even though they advocated for girls' education and claimed to support gender equality. St. Leger (2001) argues that schools can be the best way forward to changing dominant cultures (see Giroux, 1995).

Opportunity: Most schools in Uganda have HIV/AIDS and *Straight Talk* clubs that could become spaces for youth to have a united voice. In addition, the former commonwealth secretary, Don McKinnon, launched a plan of action for youth in Uganda,

where youth are encouraged to actively participate in decision-making processes (Mulondo, Oct. 2007). Therefore the schools could be linked with this national youth centre and together develop a united voice to effect required change (St. Leger, 2001).

Challenge: Most young people, especially girls, are socialized to be followers not leaders as suggested by participants in this study. There will be need for guiding youth, especially girls, through this process (St. Leger, 2001). The students have some examples of women leaders but more needs to be done. In addition, schools have so many topics to cover in the school curriculum that teachers might be unable to support the process.

d) Develop policies that allow for flexibility with respect to local needs

In chapter four, I discussed how indigenous communicative modes have been used to convey important health, HIV/AIDS, and gender related information. These modes have been adapted for modern knowledge needs and medical personnel have become the storytellers. However, the challenge is how to develop policies that allow for indigenous knowledge use within schools, besides the local communicative modes. Kanu (2006) and Dei (2000) have questioned the imperialistic knowledge systems that are used to address problems in Africa without the recognition of local knowledge. Dei (2000) argues that traditional notions of development, welfare, and health embedded in the communities' culture and ideological understandings should be used to address the problems faced in Africa today. However, most policies are based on European or Western-based economies and ideologies; it is therefore difficult to find the place for indigenous knowledge systems.

In this study, the tension between modern and traditional systems became apparent when the participants talked about traditional versus modern medicine. Most of the students were ambivalent about the role of traditional medical practices even though Petero was

supportive of the practices. Also, the students were not sure about the place of indigenous institutions like *senga* or *kooja* as these have been replaced by schools and modern ways of accessing sex education. The participants were caught between viewing traditional practices and their community experiences as primitive (see Boateng, 1983). The question therefore is "how do we deal with the unintended consequences of given policies?" Or "How can educational policies lead to the re-introduction of traditional knowledge systems in schools without compromising set standards?" Kanu (2006) has argued for a change of curriculum but the World Bank, which pays for most of the education expenses in many African countries, wants no compromises on quality. Of course quality here means the practice meets the pre-set standards, and is in accordance with dominant epistemological intellectual paradigms of the developed world on which most of the policies are based (Kerka, 2003). Canagarajah (2002) has observed that indigenous knowledge is still treated as received wisdom and unexamined beliefs that are parochial, irrational and backward.

Opportunity: As major international policymaking bodies recognize NEPAD as the negotiating body for many African communities, perhaps there will be room for flexible systems that take into account local needs and practices. In addition, UNESCO exists to promote and support good cultural practices so there is opportunity for advocacy for inclusion of indigenous knowledge systems in schools and healthcare. Boyle et al (2002) have suggested that educational policy should focus on children's "talk" within the classrooms, particularly for rural children and underprivileged backgrounds. Oftentimes, the worlds these children inhabit and their realities are under-represented in official curricula. Schools are playing an important role in mediating the official world of modern knowledge systems embedded in the text books, and the 'real worlds' of the learners.

Challenge: The critique of the behaviour change communication model (see Ch. 2) was based on the fact that it was meant to replace traditional practices with modern practices. Examples of this would be family planning and contraceptive use (Airhihenbuwa et al, 2000). In addition, the teaching process proceeds with the implicit objective of erasing the knowledge learners bring to the classroom and imposing the authoritative knowledge on their learning process (Boyle et al, 2002). I therefore adapt McQueen's (2001) suggestion that alternative means for evaluating programs be developed by participating developing countries. Health literacy, HIV/AIDS, and gender-related issues in Africa may be of global concern but each country can come up with how best their intervention strategies can be evaluated by international funding bodies. However, international policymakers need to recognize the need for flexible systems in respect to the local needs of the people (see Brehony, 2000).

e) Match policies with services

If the leading international organizations are indeed interested in promoting better health practices in Africa, it is important that these policymakers provide better health services. The students mentioned the issue of overcrowded hospitals, no pharmaceutical drugs, no medical personnel and poor quality schools in rural areas as impacting people's health practices. Therefore as the World Bank and W.H.O focus on the interconnectedness between gender, education, and health through developing the MDGs, it is important that each goal or policy is matched with appropriate services. Perhaps more schools and hospitals should be constructed alongside increased teacher salaries and well equipped hospitals. In addition, the reasons that lead people to practice voluntary brain drain need to be examined. The BBC (2008) report has shown that although many African countries need

healthcare providers, most of their qualified doctors seek employment in developed countries, citing lack of equipment as the main reason they cannot practice in Africa. Therefore policymakers should match policies with services for them to be effective.

The students also brought up the issue of trade versus aid and how it impacts the livelihood of the common person. Their argument is that if poverty is to be eradicated, the trade policies need to be changed so that 80 percent of the people who depend on agriculture can have a decent income from their produce. Lewis (2005) has already discussed this issue and has also argued that what African countries need is fair trade and not the aid or loans currently being promoted by World Bank. In this regard therefore, the leading policymaking bodies and politicians need to recognize that having eradication of poverty as the number one goal and yet having policies that stifle the source of income for most people is a mismatch.

Opportunity: Many non-governmental organizations have begun highlighting the policies that lead to poor health practices (Lewis, 2005; Tomasveski, 1998; 2005). Perhaps this will draw the attention of most leading funding bodies as both Lewis and Tomasveski have spoken of these issues directly with UN officials and have set up non-governmental organizations to support poor communities. World Bank is revisiting its policies on given issues like school fees and girl education (World Bank, 2007).

Challenge: Most leading funding bodies pay attention to research sanctioned and funded by them. Therefore it will take a long time for them to listen to "outside" voices or perspectives (Robinson-Pant, 2004). This is the reason most governments implement policies that might not be beneficial for their communities, for example, user fees in healthcare centres (Mohga, 2001). Uganda is currently struggling with maintenance of

quality education and growing number of students since the introduction of EFA because the policy was implemented before enough schools were constructed (Kirungi, 2000).

f). Encourage the development of local, national and global partnerships

Health, HIV/AIDS, and gender issues in developing countries are substantive and require support and resources for them to be effectively addressed (Ahmed et al, 2000; Cohen, 2002; Lewis, 2005; St. Leger, 2001). Schools can provide an initial space for addressing these issues, but for large scale change to happen there needs to be community, national, and global support through partnerships. Kar et al (2001) evaluated empowerment programs and suggested that success could be achieved through: assistance from funders; media use; support and advocacy; public education and participation; organization of associations; unions and cooperatives; work/job training and income generation; empowerment education and leadership training; and rights protection and legal reform. Orbinksi (2007) suggests that all these can be achieved through partnerships forged at all levels, that is, local, national, political and international. These partnerships can be led by the powerless themselves but not without the support and advocacy of the powerful like those in the developed countries (Brehony, 2000). I therefore reiterate this call for partnerships in this study if the health, HIV/AIDS, and gender related issues that were raised by the adolescent students are to be effectively addressed.

Opportunity: Special interest groups already exist in Uganda including women's and children's rights advocates, and these can provide a starting point for engaging in local and national partnerships. In addition, organizations like *Doctors Without Borders* are raising awareness, and spearheading international partnerships with less developed

countries through provision of free training and treatment (Orbinksi, 2007). Many others, including the Stephen Lewis foundation, are examples of the power of partnership.

Challenge: Not many people know their rights and most often, policies that ensure the protection of rights for vulnerable persons are not effective. It is therefore crucial that policies that protect and inform people of their rights to better health be enacted to foster grassroots partnerships. Women's groups do exist but are not politically empowered (Leach, 1998). This could be a similar fate for student led activism being advocated for by St. Leger (2001) and the World Bank (2007). Given that MDG for gender equality is based on parity, not empowerment, the social inequalities that impact women are not being addressed (Leach, 1998; HRW, 2003; Robeyns, 2006). It is important that policymakers develop better policies and come up with ways to liaise with organizations that are interested in empowerment.

In general, my rationale for using propositions from international bodies like World Bank, W.H.O, and UNAIDS was based on the understanding that in most cases, these bodies determine what kind of policies and programs get implemented in developing countries including Uganda. As Bown (2004) suggested, it is important for qualitative researchers to strenuously engage policy makers, because these policies oftentimes drive the discourse on major issues in developing countries. Therefore, the six points discussed above are the major implications for policy that were drawn from the findings. Generally, policies should include a gender dimension, pay attention to economic inequalities, cultural and social ideologies, and power differences between young people and older people, if health promotion is to be effective in developing countries, for example, Uganda. The next section focuses on the implications for theory or how the findings speak back to theory.

8.2.2. Implications for theory

I used three theoretical frameworks (youth lens; indigenous knowledge and gender frameworks) to interpret the findings of this study. In this section I interrogate these frameworks with implications for theory.

First, I address the question of the position of youth perspectives in dominant discourses. In this study, I used youth lens as a conceptual framework for investigating young people's views on the relationship between health literacy, HIV/AIDS and gender. However, given that there is no existing conceptual framework that addresses youth perspectives, most of the students responses were discussed based on the already existing theories on health literacy, HIV/AIDS and gender. The assumption of this study was that the youth would have a view point that is different from existing discourses, which needs to have legitimacy as a philosophical stance in research. The question I pose is "how can youth lens as a conceptual framework contribute to existing discourses on various public life issues including health literacy, HIV/AIDS and gender?" As the World Bank (2007) and other scholars (Giroux, 1995; Mitchell, 2006; St. Leger, 2001) call for youth perspectives as legitimate voices for reform, the challenge is how scholars or researchers can contribute towards development of a conceptual framework through which their ideas can be interpreted or understood by policymakers and educators.

Research involving young people is not new. There are numerous studies that have investigated young people's views on health literacy and HIV/AIDS (Jones, 2008; Kinsman et al, 2001; Mitchell, 2006; Mutonyi, Nielsen & Nashon, 2007). These studies could be used as a starting point for conceptualizing a framework that includes youth views not as an additional voice, but a legitimate body of knowledge. This has been the argument

in feminist standpoint philosophy (Harding, 2004). However, conceptualization of youth perspectives might require training youth to become researchers or authors of knowledge. This will be a challenge because, currently, it is assumed that adults speak on behalf of youth, which helps young people develop apathy towards most public life issues (Giroux, 1995; World Bank, 2007). This perhaps explains why even after decades of advocacy for youth involvement, especially among critical theorists (Britzman, 1991; Giroux, 1995; Nutbeam, 2000; Sirotnik, 1988; St. Leger, 2001), youth involvement remains a challenge. Perhaps with the renewed call from World Bank (2007) for change in policies so that youth perspectives are included, researchers and educators will develop frameworks to accommodate youth perspectives as well.

Second how can we, in research, introduce indigenous perspectives into the dominant discourses on major issues like health literacy, HIV/AIDS and gender? In this study, I attempted to integrate indigenous perspectives and dominant epistemological frameworks in my interpretation of students' responses. In chapter two, I presented both discourses by drawing on studies that help provide an alternative interpretation on health related discussions on Africa. I have used this approach throughout the data presentation and discussion as a means of finding ways to include indigenous perspectives in major discourses, for example, access to sexual health information, and understanding gender relations through a capabilities approach and communalism philosophy (see Ch. 6).

However, my analysis depended on hegemonic discourse regarding the issues investigated in this study. For example, the gender equality discussion had a focus on women's issues. The selected articles all focused on women and girls with a critique of traditional practices. The male participants challenged this by suggesting that gender

equality discourses include men as well, not just women alone. This led to the discussion on whether gender equality is more about complementarity and fairness not necessarily about challenging power-relations between men and women. I have argued that this view is problematic because women will remain subordinate given that Uganda is a patriarchal community (HRW, 2003). However, I am also mindful of the studies that have pointed out the negative portrayal of African men as brutal, and the blaming of women as passive, victims and vectors of diseases, resulting from the discourses on gender equality (Baylis 2000; Mohga, 2001; Wegner et al, 1998; White et al, 2004). My question is: "How can the communalism or Ubuntu philosophy (Dei, 2000; Wright, 2000) inform discourse on gender equality in African communities?"

Communalism philosophy puts others above self (Dei, 2000; Kanu, 2006), the opposite of major gender discourses that focus on individual rights. Airhihenbuwa et al (2000) have argued that because of the place of self in African communities, many people are not sure about gender equality advocacy. The students had accessed the major gender discourses but they also wondered how equality can be balanced with community responsibility. Therefore, the challenge is how to introduce indigenous perspectives as a legitimate epistemology and not just an alternative knowledge system (Canagarajah, 2002) in major discourse, so as to provide a more holistic debate on issues. If indeed the society's indigenous knowledge systems impact how people take up discourses like gender equality (Airhihenbuwa et al, 2000; Dei et al, 2000; Dei, 2000; Kanu, 2006) the challenge is finding ways of illustrating how critically interconnected components of indigenous knowledge are, in the context of dominant discourses. In this study, I have integrated capabilities

approaches with communalism philosophy, although further counter-discursive negotiation needs to be done.

Scholars, especially postcolonial theorists, are beginning to question and invite debate over dominant discourses in relation to indigenous knowledge (Aikenhead, 2006; Canagarajah, 2002; Dei, 2000; Kanu, 2006). In health, some scholars are focusing on traditional health practices and documenting the social practices of African communities as discussed in chapter two of this thesis (see Caldwell et al, 1998; Geest, 1997; Kendrick & Mutonyi, 2007; Muyinda et al, 2004). This process could provide opportunities for legitimizing non-western knowledge systems. However, Canagarajah (2002) has argued that publications on indigenous knowledge celebrated in academic and popular discourses are picked according to the interests of the dominant communities in a way that does not disturb their hegemony. Given that most non-western communities do not have resources for publishing, their knowledge systems will remain marginalized in academic discourses.

The third question addresses how gender equality discussions can transcend the focus on women. How can equal importance be put on the health related challenges faced by men and women? The students in this study advocated for joint health promotion strategies that do not focus on women and lead to discourse of blame for either gender. The current gender frameworks as it relates to health promotion focus on making women's challenges topical. This is important given that more women than men are dying of major epidemics. However, this means that men in marginalized positions are ignored and have no forum for inclusion. This seemed to be the reason the participants wanted an inclusive discussion of gender challenges. I drew on this suggestion to point out that other studies (e.g. White et al, 2004) have asked for inclusive discourses. However, I did not have a

conceptual framework within which to exhaustively interrogate these views, as the gender frameworks and major studies focused on women. In the end too, the participants discussed gender equality as the advantages for women's education (see Ch. 6). The counter question is what impact will an inclusive framework have on making women's issues topical? There is enough evidence that when it comes to health including HIV/STD infections, it is important to focus on women and girls (Chan, 2007; HRW, 2003). However, how then can men become a part of this discourse and how can we limit the negative portrayal of both genders, especially women given that this exacerbates their problems (Mohga, 2001).

Perhaps the post-structuralist framework that discusses equality in terms of identity instead of gender (Unterhalter, 2005) could provide a place for discussing issues of marginalized men. Given that post-structuralism has found legitimacy in academic circles, it could be instrumental in engaging in inclusive discourses on issues relating to health literacy, HIV/AIDS, and gender in developing countries. However, as mentioned in the theoretical framework chapter, post-structuralism, in regard to health issues, has focused on marginalized sexualities. In addition, the framework has not gained prominence in many African countries because most of them do not access these scholarly discourses. Therefore research on power imbalances will remain dependent on existing hegemonic gender frameworks like WID and GAD. What is required is designing studies in post-structuralism that can influence major policies.

In general, there is need to find a balance between youth lens, indigenous epistemologies and hegemonic discourses in understanding the health literacy, HIV/AIDS and gender related challenges in developing countries, especially in Africa. The place of communalism in the health related discourses needs to be investigated further. The other

epistemologies like African communicative modes have already found legitimacy through the growing support of edutainment approaches to health promotion (Singhal, 2004). The next section discusses implications for practice with a focus on Uganda.

8.2.3. Implications for practice

As mentioned in the introductory chapter, Uganda is designing a new health and HIV/AIDS curriculum for secondary school students. In this section, I draw from the findings of this study to make recommendations and implications for practice in Uganda. I have suggested seven (7) implications for practice if health literacy promotion is to be achieved in Uganda. These are: (i) health and HIV education should move beyond content into social action, (ii) education should be relevant to the community, (iii) teacher education programs should incorporate critical pedagogy (iv) professional development should be part of a teacher's continuing education, (v) current teaching strategies should be student-centered, (vi) available resources and traditional methods should be used to scaffold students' learning, (vii) schools and authorities should be committed to critical health literacy promotion. Under each suggestion, I have discussed the opportunities and challenges that would impact the implementation of the suggested change.

a). Health and HIV education should move beyond content into social action

For students to become active members in their communities and put their knowledge into practice, it is important for activism to be incorporated into curriculum. St. Leger (2001) posits that political activism needs to be a part of the schooling experience for young people because they learn that they are functioning members of the society. This suggestion is important especially in relation to dealing with topical issues like molestation,

defilement and exploitation of girls by parents, teachers and members of the larger communities. Other issues include the rural - urban health disparities and oppressive practices that hinder young people's education and foster gender inequalities. The school curriculum should therefore be designed in a way that allows these topical issues to be discussed so that students acquire the necessary skills to collaboratively and creatively contribute to social change. The current national curriculum is prescriptive, filled with too much content and with minimal opportunities for students to engage in activism.

Opportunity: Uganda is undergoing the process of revamping the health and HIV/AIDS curriculum for secondary schools. Curriculum developers need to make the curriculum flexible with general suggestions instead of focusing on too much content. Given the amount of content covered in the media on health issues in Uganda, it will not be difficult for teachers to access necessary material for classroom instruction. Furthermore, topical issues relating to health, HIV/AIDS, and gender are part of the lived experiences of the students. All the students need is an opportunity to learn how best to contribute and foster meaningful change. This can be modeled for them through incorporating guidelines that lead to advocacy within their school curriculum. In addition, most schools have health and HIV/AIDS clubs that are student-centered. These clubs could be used as centres for planning advocacy around a major issue faced by the students within the school or within their communities. The students have already learned to organize themselves around information dissemination (Norton & Mutonyi, 2007) and therefore it will not be difficult to have advocacy incorporated into some of their club activities.

Challenge: Uganda has a fragile democracy and so any form of political activism if not well planned could lead to clashes between groups with opposing opinions. Even

within the schools, the teachers and support staff hold differing political views and so the possibility of using students for political gain exists. There will be need for careful framing of the purposes for health advocacy and activism. The students need to be taught how to have a critical voice without necessarily disregarding authority or government health programs. Furthermore, not many teachers are trained in health related issues and are also learning from the media messages, just as the students themselves are doing at the moment. For students to have a critical voice will require the teachers to have critical voices as well.

b). Education should be relevant to the community

In addition to a curriculum that allows for topical issues to be discussed by students, the content should be relevant to the lives of the students. Nutbeam (2000) argues that the major criticism of health education curriculum is that it is full of facts that are often not of immediate importance to the students' lives. As a result, people do not change their health practices because the content is understood as external to and irrelevant to their lived experiences. Robeyns (2006) posits that education is often understood in terms of its instrumentalist gains without considering the relevance of what is taught. This explains why parents will send children to school but not pay attention to the quality of education they are receiving or governments invest in universal education without tackling the inequalities that prevent some children from attending school. I therefore adapt Robeyns' suggestion that it is important for education to be an intrinsically relevant. This might enhance people's desire to act responsibly whether or not there are extrinsic rewards.

Extending this to health and HIV/AIDS education would mean that students are given opportunities to understand the value of gender equality and responsibilities to one another. Young people need to cultivate the intrinsic value in maintaining their health be it

in relation to malaria prevention or to seeking the improvement of other people's lives. The challenges faced in promoting better health practices in the adult population in Uganda should be used as examples of how education can be relevant event though some extrinsic gains exist. This requires a curriculum that fosters critical and reflective practices that enables the students to understand that learning is a life long process (St. Leger, 2001).

Opportunity: The sero-behavioural HIV survey results have led to re-evaluation of the ABC strategy for HIV communication used in Uganda (Ouma, New Vision July, 2007; UAC, 2006). Furthermore World Bank has invested in Ugandan secondary education with the assumption that increase in literacy will lead to better health practices (MoES, 2006). There exists an opportunity for advocating for an education that is meaningful both to the students and the communities at large. The curriculum on health and HIV/AIDS education should be embedded in the lived experiences of students and communities.

Challenge: Change within schools is a slow process and the education structure lends itself to promoting extrinsic values of education. The curriculum is designed in business philosophy, that is, it is driven by market demand, and skills development depends on the economic demands of the society (Cochran-Smith, 2004). Therefore students are trained to look towards instrumentalist purposes of education without consideration of the intrinsic value of what they are learning at school (Unterhalter, 2003, 2005). Unfortunately, through the WID framework, the economics philosophy has also been used in promotion of gender equality and HIV/AIDS education (Longwe, 1998; Sen, 1999; Robeyns, 2006). It will therefore need a revamping of the approaches to advocacy if education is to be relevant and life long learning is to be achieved in Ugandan schooling process.

c). Teacher education programs should incorporate critical pedagogy

For teachers to promote critical health literacy and spearhead activism in schools, the teacher education preparation programs should incorporate critical pedagogy (Freire, 1970) in the curriculum. The teachers need to learn the difference between a critical voice and criticism that devalues what is important (Kanu, 2006). Therefore just as the curriculum for secondary schools should be designed to foster critical pedagogy, the teacher education programs should take a lead in implementing such a curriculum. Teachers need to learn to critically question current educational practices or societal structures and creatively plan innovative teaching strategies that enable students to utilize their acquired skills and knowledge in changing their lives and their societies for the better. Teachers need to experience critical education that enables them to surpass current practices by teaching as if the curriculum content or societal practices could be different.

Opportunity*:* As mentioned earlier, there is discontent with what is happening in Ugandan schools today. As the Minister of Education advocates for teachers to use critical pedagogy in teaching, one can argue that the starting point should be in teacher preparation programs. Furthermore, education has been one of the sectors that have been affected by the HIV/AIDS epidemic and teachers have experienced the oppressive practices through social stigma said to be prevalent in schools (MoES, 2006). Teachers need to be nurtured to address these issues within educational institutions if they are to adequately engage the topical issues in adolescent students' lives and lead students in activism for change.

Challenge: Teacher preparation programs in Uganda foster teaching strategies that take curriculum content as prescriptive and unassailable. The programs are embedded in British teacher education programs that have gone unquestioned and unchanged since

Uganda's colonial times to the present. Therefore it will take changing teacher education programs, and retraining of teacher trainers in critical pedagogical skills in order for them to nurture these pre-service teachers to teach critical health literacy (Nutbeam, 2000; St. Leger, 2001). Furthermore, education is still understood in economic principles and so instrumentalist, technical, and authoritarian approaches are fostered in the current teacher education programs and passed on to students.

d). Professional development should be part of a teacher's continuing education

Besides teacher preparation programs nurturing pre-service teachers' critical pedagogy (Freire, 1970; Giroux, 1995; Sirotnik, 1988), professional development should be embedded in the school system in Uganda for in-service teachers. For practicing teachers to become pivotal in educational change or health literacy promotion, they need to be trained in critical pedagogy and teaching strategies that are commensurate with this theory. Criticizing what is going on in schools without developing the skills of teachers, will not lead to critical health literacy education. Teachers need time to learn new health frameworks, and this needs a long term investment in teacher education programs that promote professional development in health and related issues in Uganda (St. Leger, 2001).

Opportunity: Professional development has become one of the central packages for the education sector budget for the 2007/2008 financial year. In addition, USAID has invested in and is funding professional development for secondary school teachers (MoES, 2006; New Vision, June, 2007). Previously, professional development was an initiative undertaken by individual teachers without the support of the government.

Challenge: There are many in-service teachers and so it will take time for meaningful professional development to be done in schools. Currently, the programs are

focusing on science educators as Uganda is interested in developing its science and technology economic sectors. Furthermore, many of the in-service teachers perhaps were trained culturally never to question authority and so it is a practice that they pass on to the students. Time is required for schools to encourage the questioning of authority or confront the taken-for-granted ideas and practices within societies.

e). Current teaching strategies should be student-centered

In order for students to be able to become active participants in their own learning process and society, the current teacher-centered teaching strategies need to be changed. The teacher-centered instruction method needs to be replaced with student-centered approaches if schools are to become critical health literacy promoting (St. Leger, 2001). This will require a change in the organizational and internal features of the schools and the distribution of power between the school and its pupils (Sirotnik, 1988). Teachers need to develop innovative ways of getting students to participate in their learning besides the traditional question and answer approaches used in classroom instruction. There is need for rethinking the role of teacher in the classroom and how the purpose of education is viewed. The changes have to happen simultaneously if student-centered learning is to be effective.

Opportunity: A study like this one provides an example of how students can be active in information gathering and how their perspectives on given issues can be solicited. Furthermore, having student-led health and HIV/AIDS clubs shows that students can be active learners. The *Straight Talk* newspaper provides an example of innovative ways teaching can be changed from being teacher/adult centered to student-centered because the content is often determined by the adolescents themselves (Kickbusch et al, 2002).

Therefore, teachers can become facilitators of the learning process through confronting some of the taken-for-granted practices that students engage in, in their everyday lives.

Challenge: Teachers have been for decades trained to be the information and knowledge providers. Hence they are seen as experts and students as an empty slate ready to uncritically absorb what is taught (Britzman, 1991). Furthermore, teachers have strong values and beliefs about what education and schooling should look like, which lend themselves to teacher-centered or text book instruction strategies (Evans, 1996; Fullan, 2005; Hangreaves, 1991). This is complicated by the fact that government has regulations for schools and standard examinations that lead to teacher-controlled learning at the expense of student-centered learning (St. Leger, 2001; Winter, 2000).

f). Educators should use available resources and traditional methods to scaffold students' learning process

The common question whenever change is suggested is that of availability of resources (Werner, 2002). However, Silver (2001) understands resources as the locally available materials including the human resources that can be used in information dissemination. The biggest challenge faced by many schools is that of enough textbooks for the students (MoES, 2006). However, little is mentioned about the newspapers that contain information on public health issues impacting communities in Uganda. The students in this study accessed information on health literacy, HIV/AIDS and gender from leading national newspapers like *The Monitor* and *The New Vision* alongside *Straight Talk*. In addition, the content was detailed and current, purposively addressing the problems faced by adolescents in Uganda. These newspapers are a resource that can help make health a topical political issue and could be pivotal in advocating for change that promotes better health for all.

Teachers need to find creative ways of incorporating these resource materials within the classroom instead of relegating them to after-school activities.

Furthermore, the newspaper content is also utilizing indigenous forms of teaching like stories, proverbs and anecdotes, which students are familiar with. Incorporating these methods in the teaching styles in classrooms will help scaffold students' learning process not only in relation to content but from a home culture to a school culture. This is what Aikenhead (1996) calls the process of border-crossing where students have to transition from home into a school culture (see also Nielsen & Nashon, 2007). If these indigenous methods are used, the transition is not as abrupt as is often the case. This process can enable students to make connections between their school and home knowledge and think of practical ways of utilizing the information—achieving the main goal for education.

Opportunity: Teachers are often seeking ways of teaching for understanding and oftentimes they look for necessary teaching tools like indigenous ways of learning. Most of these practices are not acknowledged or recommended by the authorities/experts although they are prevalent in classroom instruction (Canagarajah, 2002). The media therefore is leading the way in acknowledging the potency of these indigenous teaching methods. All that is needed is to bring the students into the dialogue through providing space for them to be active learners as is often the case in traditional learning systems (Boateng, 1983; Kanu, 2006; Rogoff, 2003; Wright, 2000). Singhal (2004) writes about education-entertainment used in various parts of Africa, and Uganda can learn from the various examples. Already, the leading newspapers are using education-entertainment through using stories, proverbs and anecdotes in their articles on health. Schools use education-entertainment in the health and HIV/AIDS clubs (Norton & Mutonyi, 2007).

Challenge: The large classroom numbers make it impossible to have enough resources for everyone and to meaningfully pay attention to each student. This is complicated by the fact that the content in the curriculum is extensive, and needs to be covered on time, if students are to pass the national exams. This makes learning a teachers' performance and less about the students' information or learning needs. It will be difficult to incorporate health literacy, HIV/AIDS, and gender topics in a crowded curriculum.

g). Schools and authorities should be committed to critical health literacy promotion

In order for teachers to engage in critical health education, unilateral support for these activities needs to be provided by authorities in government and schools. This is because critical health literacy that leads to social and political activism goes beyond classroom instruction. The support will involve provision of resources, protection of the rights of the participants, endorsement of health activism programs, and finances for planning and implementing suggested plans. The commitment will also require investment in teacher training programs and professional development through teacher-initiated research projects on health, HIV/AIDS, and gender issues within their communities. The working conditions of the teachers should offer a supportive environment not an atmosphere hostile to critical health literacy or activism for social change.

Opportunity: Uganda is looking for ways of promoting health practices and the development of a new health and HIV/AIDS curriculum provides an example of that commitment. What is needed is for the authorities and schools to recognize that for change to happen, it requires critical health literacy education that empowers their students to take action when required. If Uganda is not to be complacent (MoES, 2005; Norton & Mutonyi, 2007), it is time to take the next step in health promotion and education.

Challenge: Schools and education systems are under constant pressure from competing societal demands. The schools become overburdened in the process with many urgent programs. Therefore, there must be increased and widespread support for schools in their efforts to educate and promote critical health literacy practices among its students.

Generally, the above are the implications for policy, theory and practice from the findings of this study. The challenges are substantial but are not insurmountable if all stakeholders work together through meaningful partnerships and legal reforms. I conclude by joining the other voices in calling for, youth involvement in social change, partnerships, and making governments accountable for health and improved life-chances for its citizens.

8.3. Limitations of the study

Engaging in research that focuses on health literacy, HIV/AIDS, and gender with implications for education is very complex. Therefore, conducting a 2½ year study afforded the opportunity to gather as much information as possible on the issues under investigation. But as Merriam (1998) notes, every research process and technique for data collection is not without its limitations. Therefore, this study bears the limitations of the methods used for data collection, although margins of error were minimized through using various forms of data collection techniques that helped the process of triangulation.

Furthermore, given that I was doing research in my own backyard (Glesne, 2006), there exists a possibility that I might have not pursued some issues at length. Having critical friends was helpful. On the other hand, I am an outsider as I am studying in Canada and older than the participants in the study. So choosing to focus on adolescent students' perspectives minimized my personal views and biases from impacting the type of data collected. However I do recognize that my status as a female student undertaking PhD

studies in Canada created a power imbalance between me and the participants. Sometimes the students were more interested in learning about my life in Canada than in the issues under investigation, and during the FGDs, the female students felt that I could join them in countering the views of their male counterparts. However, being aware of this gender and power imbalance enabled me to be reflective of and vigilant about the situations where power relations would come up during the group interactions and discussions.

Another limitation could have been my conducting a study where a family member was the head teacher. However the design of the study made the head teacher's role and influence minimal. The bulk of the data collection was done by the students through journaling and reflective reports, and the on-site data collection was done during the holidays. The topic of study too limited relevance to the head teacher. The meetings times were determined by the students and neither the head teacher nor any other teacher was present. In addition, the students knew that the study did not have any implications for their academic pursuits and so approached it as extra work. In most cases, the students even turned up late for the meetings, which made me know that they were not intimidated into taking part in this study. In fact, the participants were motivated to participate in the study not because of my relationship with the head teacher, but the need to engage in further discussion on some topics. As explained in chapter six, the students were interested in discussing biology topics like contraceptives, body changes and reproductive health when the critical inquiry discussion was held. To these students, I became an outside source of information. Finally, because I did not take on any teaching role while doing my data collection, the students understood that I was a researcher and not a teacher. In this regard,

even though I was doing research in my own backyard, the students had no reason to respond to the questions in order to please me; further, the topic was open ended.

For researchers with quantitative research orientations, it is important to note that the purpose of this study was not to come up with universal principles, but to provide an understanding of the health and HIV/AIDS related challenges faced by adolescent boys and girls in relation to larger public health issues, and what measures can be taken to ensure that their health and well-being are maintained. This thesis therefore provides one example of how students in an urban school engage with the issues of health literacy, HIV/AIDS, and gender, with some implications for policy, theory and practice.

Finally, I highlight the issue of language used for data collection. In the methodology, I detailed the criteria used for selecting participants and it included that they were comfortable speaking and expressing themselves in English. Perhaps more information and insights would have been gained from allowing the students to use their local dialects. I must however state that not all participants were from the same language group and so English became the unifying medium of communication in this study.

8.4. Recommendations for further research

This study responded to the call to engage youth in discourses relating to public issues in their societies (Giroux, 1995; St. Leger, 2001; World Bank, 2007). Through providing the students with an opportunity to document information of their choice, and later, by engaging them in discussions over health, HIV/AIDS, and gender issues, the students were able to articulate their thoughts on some of the larger challenges facing Uganda today. In writing this thesis, the students' perspectives form a part of the national and international dialogue over what is happening and what more needs to be done to

achieve the goal of health for all. However, more needs to be done in terms of providing young people with an audience so that they can in person present their views and have their voices validated by government and other stakeholders in Uganda.

In relation to building literature a base on the relationship between health literacy, HIV/AIDS, and gender, this study provides a Ugandan youth lens. However, more research needs to be done especially among students at University and college level as the participants in this study made reference to the vulnerability of this category of students to HIV/AIDS infection. There is a dearth of information on the health, HIV/AIDS, and gender challenges faced by the students at University and College level in Uganda. This would be an important study to complement research that has been extensively done at primary and secondary school levels in Uganda.

Given that the study focused on the implications for education and policy, it would be worthwhile to do research with teachers on health literacy promotion. This study does not provide perspectives of teachers on the issues that were under investigation, but in order for the teachers to implement a critical health literacy curriculum, their views, values and lived experiences need to be researched. Research shows that the teachers' beliefs on given issues impact how they engage in teaching (Evans, 1996). So for schools to promote health literacy, teachers' views need to be investigated.

Finally, it would be of interest to engage in research with un-married and married young people, who are not in school. The students in this study made comments on the challenges faced by this category of people. It would be of interest to pursue a study that examines how these young people engage in issues on health literacy, HIV/AIDS, and gender in their context. Given that the students in this study suggested that within micro-

communities, gender equality is not practiced, it would be important to do research that investigates how young people outside school and not married or married grapple with the issues that were under investigation in this study.

In general, the larger study is on-going and new research agendas investigating ICT use in teacher education programs in Uganda (Drs. Norton & Kendrick) and communication in child-headed households in Uganda (Drs. Kendrick and Kakuru) have begun. I will continue collaborating with Drs. Norton and Kendrick. More insights on the challenges people face in Uganda with reference to education, gender and health remain an urgent need.

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Appendix 1: Letters of consent

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NOVEMBER 22, 2004

Dear Parent
We are researchers in the faculty of education at the University of British Columbia (UBC) in Vancouver, Canada. We have invited your child to participate in our research study on health literacy in Uganda schools, titled "Health literacy and Ugandan adolescents: A longitudinal study" The study will take place over the next four years i.e. from Jan 2005 to December 2008. This will coincide with class S.3, S.4, S.5 and S.6. During this period, the researchers will pay the student's fees and any other additional academic charges as compensation for taking part in the study. The objectives of the research are to improve our understanding of health literacy practices that young people in Uganda encounter in class, in school, at home, and in the community. By "health literacy practices" we refer to all the materials, written and oral, that address issues of adolescent health like HIV/AIDS, SEXUALLY TRANSMITTED DISEASES (STDs), pregnancy, hygiene, nutrition and general reproduction. To protect their privacy, the students' real name will not be used.

What we hope the students will do is to keep a written journal in which they record their observations and personal reflections on a regular basis. At the end of each month they will summarize their findings in a report of at least two pages, to be submitted to the Headmistress. All the stationary YOUR CHILDREN need will be supplied by the researchers.

It is important to know that participation in this study is voluntary. Students are free to withdraw from the study at any time. If you have any questions or concerns, please do not hesitate to contact Dr. Bonny Norton at bonny.norton@ubc.ca or Harriet Mutonyi at hmutonyi@interchange.ubc.ca. We look forward to your child's participation in this research project.
Yours sincerely,

Ms. Harriet Mutonyi   Dr. Bonny Norton

Consent

1. I ________________________ **consent/do not consent** (delete one) to my child's participation.
   (Parents'/guardian's name)

   Sign ______________________ Date______________________

Department of Language & Literacy Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: (604) 822-5788
Tel: (604) 822-3154

October 18, 2004

Dear ________________________

We are researchers in the faculty of education at the University of British Columbia (UBC) in Vancouver, Canada. We would like to invite you to participate in our research study on health literacy in Uganda schools, titled "Health literacy and Ugandan adolescents: A longitudinal study" The study will take place over the next four years i.e. from Jan 2005 to December 2008. This will coincide with class S.3, S.4, S.5 and S.6. During this period, the researchers will pay your fees and any other additional academic charges as compensation for taking part in the study. The objectives of the research are to improve our understanding of health literacy practices that young people in Uganda encounter in class, in school, at home, and in the community. By "health literacy practices" we refer to all the materials, written and oral, that address issues of adolescent health like HIV/AIDS, STDs, pregnancy, hygiene, nutrition and general reproduction. To protect your privacy, your real name will not be used.

The materials that are relevant to the study include, for example, classroom textbooks, community posters, student newspapers like Straight Talk and national newspapers like New Vision, The Monitor, Bukedde, and the Sun. The materials also include radio talk shows in any language, visiting speakers, community events, television dramas, school dramas, and the AIDS Challenge Youth Club (ACYC) activities.

What we hope you will do is to keep a written journal in which you record your observations and personal reflections on a regular basis. At the end of each month we ask that you summarize your findings in a report of at least two pages, to be submitted to the Headmistress. You are also asked to keep a folder in which you store any documents or materials that you think are relevant to the study, as described above. All the stationary you need will be supplied by the researchers.

You are encouraged to join the ACYC in order to be better informed of adolescent health issues in your community. You are also encouraged to read Straight Talk every month and to report on one or two articles that you find particularly interesting. At the end of each term, your reports will be sent to the researchers at UBC, who will provide feedback on your

contributions. The researchers will also make personal visits to the school over the course of the four year study.

It is important to know that participation in this study is voluntary. You are free to withdraw from the study at any time. If you have any questions or concerns, please do not hesitate to contact Dr. Bonny Norton at bonny.norton@ubc.ca or Harriet Mutonyi at hmutonyi@interchange.ubc.ca. You may also contact the Director of Research Services at UBC. (www.orsil.ubc.ca). Your signature below signifies that you have agreed to participate in this study and that you have received a copy of this letter.

We look forward to your participation in this research project.

Yours sincerely,

______________________ ________________

Ms. Harriet Mutonyi Dr. Bonny Norton

The University of British Columbia
Office of Research Services
Behavioural Research Ethics Board
Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL- MINIMAL RISK RENEWAL

PRINCIPAL INVESTIGATOR:	DEPARTMENT:	UBC BREB NUMBER:
Maureen Kendrick	UBC/Education/Language and Literacy Education	H03-80769

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:

N/A
Other locations where the research will be conducted:
N/A

CO-INVESTIGATOR(S):

Juliet Tembe
Harriet Mutonyi
Judith Eiyo
Shelley K. Jones
Bonny N. Norton

SPONSORING AGENCIES:

Social Sciences and Humanities Research Council of Canada (SSHRC) - "The Literacy Ecology of Three African Communities" - "The Literacy Ecology of Three Ugandan Communities"
UBC Hampton Research Endowment Fund - "The Literacy Ecology of Three Ugandan Communities" - "The Literacy Ecology of Three African Communities"

PROJECT TITLE:
The Literacy Ecology of Three Ugandan Communities

EXPIRY DATE OF THIS APPROVAL: July 10, 2008

APPROVAL DATE: July 10, 2007

The Annual Renewal for Study have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board

Department of Language & Literacy Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: (604) 822-5788
Tel: (604) 822-3154

October, 2006

Dear Parent,

We are researchers in the faculty of education at the University of British Columbia (UBC) in Vancouver, Canada. Your child has been participating in our research study on health literacy in Uganda schools, titled "Health literacy and Ugandan adolescents: A longitudinal study" As a reminder, we would like to let you know that the study will continue until December 2008. The objectives of the research are to improve our understanding of health literacy practices that young people in Uganda encounter in class, in school, at home, and in the community. By "health literacy practices" we refer to all the materials, written and oral, that address issues of adolescent health like HIV/AIDS, SEXUALLY TRANSMITTED DISEASES (STDs), pregnancy, hygiene, nutrition and general reproduction. To protect their privacy, the students' real name will not be used.

In December, Ms. Harriet Mutonyi will be traveling to Uganda to continue with the research process. We are therefore requesting your child to be available for a week of December, 18th 2006, and the months of January to April 2007 to participate in further data collection. We know that it is their vacation time and which will be convenient for us to engage them in further dialogue over the work they have been doing with out the pressure of school.

It is important to know that participation in this study is voluntary. Students are free to withdraw from the study at any time. If you have any questions or concerns, please do not hesitate to contact Dr. Bonny Norton at bonny.norton@ubc.ca or Harriet Mutonyi at hmutonyi@interchange.ubc.ca.
We look forward to your child's participation in this research project.

Yours sincerely,

Ms. Harriet Mutonyi Dr. Bonny Norton

Appendix 2: Questionnaires

Q 1

Department of Language & Literacy Education
2125 Main Mall
Vancouver, BC, Canada V6T 1Z4

Tel: (604) 822-5788
Tel: (604) 822-3154

February, 2006

Dear student,

Thank you for participating in our research study on health literacy and adolescents in Uganda. It has been a pleasure to get to know each of you a little better, and to gain insight into your experience of health literacy in your school and community.

It has been approximately 16 months since you completed your first questionnaire for this study, and we would like to gain some sense of how your ideas have developed over the past year. Would you kindly answer the following questions in preparation for interviews that will take place over the next few days.

NAME. Surname ______________________ First name________________

AGE______________________________ GENDER: Girl Boy (please circle)

1. HIV/AIDS CLUB

1.1. In the past year, did you participate in activities of the HIV/AIDS club at school?

Yes No (please circle one)

1.2.If yes, which activities did you find MOST interesting and helpful?

____

____

1.3 If yes, which activities did you find LEAST interesting and helpful?

____

____

2. HEALTH CHALLENGES

2.1 Over the past year, did you or anybody you know experience a health challenge? If yes, what was the challenge and what action was taken to address this challenge?

____

2.2. What health challenges do girls face as they grow older? Please explain with examples.

2.3. What health challenges do boys face as they grow older? Please explain with examples.

---

3. HEALTH INFORMATION

Over the past year, what means of communication have you found most helpful in learning about health issues for young people? Please explain with examples.

---

4. PROJECT PARTICIPATION

4.1.What aspects of this project do you most enjoy?

4.2. What are some of the challenges of being part of this project?

---

5. ADDITIONAL COMMENTS: please feel free to add any other comments you would like to share with the researchers.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Bonny Norton and Harriet Mutonyi

Q2 **January 25th 2007**

Questionnaire on health literacy, HIV/AIDS, and gender research with adolescents in Mbale, Uganda

This is our third year together on this research project looking at health literacy, HIV/AIDS, gender, and adolescence in Uganda. I want to take this opportunity to thank you for creating time to write in your journals and also for the quarterly reports for the past two years. The information you have provided has given us an overview of what kinds of information you access, are interested in, and scope of health literacy information is provided to the Ugandan adolescents. We have also learned that Straight Talk newspaper seems to provide the bulk of health information to adolescents. In addition, all of you seem to be more attuned to health related issues in your communities and families ever since you started participating in this project.

I need to remind you that although I would like you to answer all the questions, you reserve the right not to answer a question you are not uncomfortable with. Also, remember that participation in this study is voluntary and you are free to leave the project anytime. Furthermore, remember that there is no right or wrong answers but each response is treated as representative of your thoughts on a given question.

Name: ________________ **Gender:** _____________

Theme: Adolescent health and Identity in Uganda

1. What (if any) is the sexual health information you have received as an adolescent in Uganda? Give examples

   ____
   ____
   ____

2. In your view, do you think this sexual health education is inclusive or selective? Give reasons for your response.

   ____
   ____
   ____

3. Do you think adolescent girls and boys in Uganda who are sexually active have adequate sexual health information to maintain their well being? Give reasons for your response

   ____
   ____
   ____

4. What sexual health information do you think adolescents in Uganda need to maintain their sexual well-being?

___

5. In Uganda, abstinence is promoted especially among young people who are under 18 years of age. However, most of the youth at school turn 18 while still in secondary where abstinence is promoted. Do you think that adolescents in Uganda have enough sexual health information by the time they turn 18? Why?

___

6. Do you think adolescents in their early teens have different health information needs compared to those in their mid or late teens? Give reasons for your response

___

7. It is stated that adolescent girls receive less sexual health information compared to boys which puts them in greater disadvantage than boys? Do you agree?

___

8. Do you think boys and girls in Uganda have unique sexual health needs? Why?

___

9. You have perhaps seen the adverts advocating for men to be equal partners in reproductive health of woman. Do you think that men and woman should be given the same sexual health information? Give reasons

___

10. Uganda is said to have high teenage pregnancies. What in your view should be done to curb teenage pregnancy?

___

11. Is it easy for adolescents in Uganda to access sexual health information?

___

12. What do you think is the general public's perceptions of adolescents in Uganda?

___

13. Do you think the rites of passage like circumcision impacts how an adolescent views himself?

____

____

____

14. As an adolescent, do you consider yourself more as a child or an adult? Why

____

____

____

15. What responsibilities are assigned to adolescents in your community?

____

____

____

16. In your opinion, do you think adolescents are given enough audience when it comes to discussing their sexual health needs in their community? Why?

____

____

____

17. In Uganda, there are youth representatives at district and village levels. Imagine you are a youth representative and you are addressing an adult audience on adolescents and sexuality. Write down a speech highlighting your major points.

____

____

____

18. Is there any other information you would like to add? Use the space provided below:

Thanks for answering these questions.

Harriet Mutonyi

Q3 Feb 16th 2007

Name: ___________ **Gender:** ______________

Theme: Gender, Health, and Equality

Some of the research we have done in this project suggests that gender equality is central to health literacy. For example, it is argued that girls are six terms more vulnerable to infection to HIV/AIDS and other STDs. You may have heard of the campaigns for partnerships in health between men and women. This campaigns advocate for partnership in reproductive health, recognition that women too have rights and need not be coerced to having sex if they are not ready, men to take more active role in ensuring the health of their wives and children and open communication between men and women. What is of interest to us in this whole gender, health and equality campaign is your opinion on these subjects. The following questions will help guide me in understanding what your thoughts are on issues of gender, health and equality.

1. What is your understanding of the term equality?

   ____
   ____
   ____

2. What do you understand by the term gender equality?

   ____
   ____

3. What do you think about the allegation that advocating for gender equality has led to more broken homes, violence in families and strife in homes? In your experience, do you think gender equality leads to this, explain?

   ____
   ____
   ____

4. If you are to provide advice on gender equality, what would be the key areas that you would advocate for in equality promotion?

   ____
   ____
   ____

5. Do you think that women's health is poorer than that of men? Why?

   ____
   ____
   ____

6. How do you think partnerships in marriage and health can be achieved in men and women?

   ____
   ____
   ____

7. Do you think there is partnership in marriage and health in your own families? Explain your response

____

____

____

8. Do you think you would emulate your family in the way they treat boys and girls? Explain

____

____

____

9. Do you think your family maintains a cultural understanding of what the roles and men are in the community or is more progressive? Explain

____

____

____

10. What changes would you love to see in the community if gender, health and equality for all are to be achieved?

____

____

____

11. How involved is your father or brothers in the health of your mother and the children? Are they very involved or hardly involved?

____

____

12. Do you think there is gender equality in your family? Explain

____

____

____

13. How involved would you want to be in your own families' health if you get married and have children?

____

____

14. Would you at times take care of your younger siblings when they are sick? Why or why not?

____

____

____

15. Do you think in order to achieve partnership in health and family life, women and men should be taught about health jointly and openly? Explain

____

____

____

16. Are there some things men and women need to know about each other that could enhance partnership in marriage and family life? Explain

____

17. Do you think schooling is modeling gender equality for better health? Explain

18. Do you think schools should take the lead in gender equality promotion?

19. Do you think gender equality can really be achieved? Explain

20. In what ways can women's health be improved in your community?

Thanks for your responses

Harriet Mutonyi

Q4 **March 22, 2007**

Dear student,

Thank you for again for participating in our research study on health literacy and adolescents in Uganda. It has been approximately 13 months since you completed your second questionnaire for this study, and, in this third questionnaire, we would like to follow up on how your ideas have developed over the past year. Would you kindly answer the following questions? However, if there is any question that makes you uncomfortable, you have the choice not to answer it.

NAME. Surname ______________________ First name________________

AGE_______________________________ GENDER: Girl Boy (please circle)

1. S4 EXAMINATIONS

1.1 Please provide the results of your S4 examinations

____

____

1.2 Are you happy with the results you achieved? Please explain.

____

____

1.3 How have the results of your exams influenced your plans for the future?

____

____

2. HEALTH CHALLENGES

2.1 Over the past year, did you or anybody you know experience a health challenge? If yes, what was the challenge and what action was taken to address this challenge?

____

____

2.2 Do you think the health challenges that young women face are different from the health challenges that young men face? Please explain.

2.3 What advice would you give to young women about staying healthy?

2.4 What advice would you give to young men about staying healthy?

3. HEALTH INFORMATION

Over the past year, what means of communication have you found most helpful in learning about health issues for young people? Please explain with examples.

4. RECOMMENDATIONS FOR THE FUTURE

If you are to provide advice on gender equality for policy-makers, what key areas would you address?

What changes would you like to see in the community if gender, health and equality for all are to be achieved?

How do you think husbands and wives can develop a partnership that promotes health for women and children?

Do you think gender equality can really be achieved? Explain.

5. ADDITIONAL COMMENTS: please feel free to add any other comments you would like to share with the researchers.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Bonny Norton and Harriet Mutonyi

Q5 **May 28, 2007**

Dear student,

Thank you for again for participating in our research study on health literacy and adolescents in Uganda. The 4 months we spent together were very informative and interesting. However there are some issues we would like you to address in this questionnaire. First we would like to get a feel of your day's activities from the time you wake up, when you are at school and after school. The second part of the questionnaire will focus on your views on various issues related to adolescent health.

Another thing is the choosing of an alternative name by which you will be identified in the research reports we will write. You had already suggested some names but just for consistency, will you please re-write those names on this questionnaire? We will appreciate your not selecting a fancy name that doesn't capture the serious nature of this research. However, if there is any question that makes you uncomfortable, you have the choice not to answer it.

NAME: Surname ______________________ First name ________________

Alternative (False) name: ____

1. Rhythm of your day

1.4 Please provide some information on what you do before you head to school

____

____

1.5 Please fill in the table below what you do while at school

Time	Monday	Tuesday	Wednesday	Thursday	Friday

1.6 Provide a brief description of what you do after school

2. Adolescent's perceptions on contraceptives

2.1 Over the past month, the *New Vision* has run an article suggesting abortion should be legalized in Uganda. What is your view about this suggestion?

a) The advantages of allowing abortion in Uganda

b) The disadvantages

2.2 Do you think contraceptives like condoms and pills should be readily available for adolescents in Uganda?

a) Why

b) Why not?

2.3. What challenges would Uganda face in providing contraceptives for youth in Uganda?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Harriet Mutonyi