MUCU ADOLESCENT HEALTH NEWSLETTER

Young Men's Health in Uganda

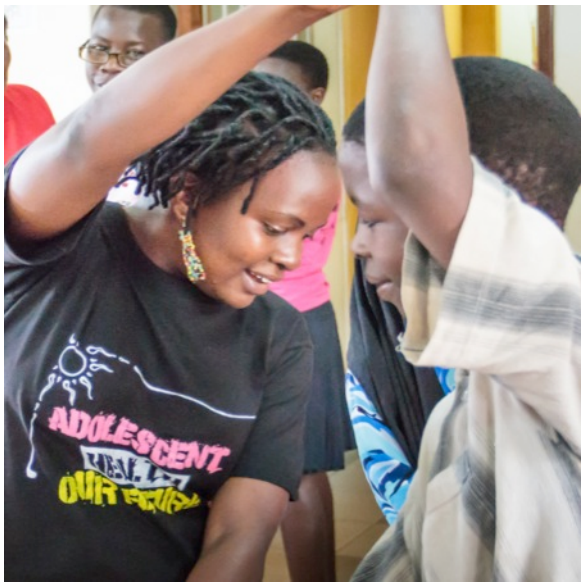

Photo Courtesy of Bryan Watt Humanitarian Photographer

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Makerere University and Columbia University (**MUCU**) are pleased to publish the sixth issue of our newsletter. We are excited to update you on all of the interesting advances that have occurred over the past six months in the area of adolescent medicine in Uganda. We are delighted that you have continued interest in the care of the adolescent patient and look forward to hearing about the work you are doing related to adolescent health.

OUR MISSION is to provide a forum to share member news, interesting program updates, clinical cases, and discuss the latest in "hot" adolescent topics.

THIS ISSUE is dedicated to **YOUNG MEN'S HEALTH IN UGANDA**.

Every human being has a basic right to health care. Unfortunately, men often face barriers getting the care they need and deserve. This is an evidenced based overview of the state of young men's health, specifically in Uganda.

MISSION of our newsletter is to provide a forum to share member news, interesting program updates, clinical cases, and discuss the latest in "hot" adolescent topics.

FUTURE TOPICS will include: Motivational Interviewing; Bullying; Sexual Coercion/Violence; Taking a Psychosocial History; Managing the Confidential Visit: Parents and Teens; and Substance Abuse. **PLEASE SUBMIT TOPICS OF INTEREST**

ADOLESCENT CASE HISTORY

Submitted by Mr. Lewis Denis Bukenya *

TM is an adolescent boy of 19 years who has recently enrolled in the University to pursue his lifelong goal of becoming a motor engineer. He is an only child who has been brought up by a single mother. In fact, he is the only boy and oldest cousin in his extended family. His mother is very proud of TM and has made many sacrifices in the service of helping her son achieve his dreams. TM has always been an excellent student who has been healthy, happy and enjoyed a close and loving relationship with his family.

Everything had been going well until TM developed painful urination three weeks before University began. Although he tried not to think about it, he knew that just a few weeks ago he made some risky decisions. He was out with some friends celebrating their acceptance to University and, for the first time, he went on a drinking binge. Although he was reluctant to drink so much he wanted to keep up with his friends. What would they say if he didn't? He was so intoxicated that he had unprotected intercourse with a girl he met that night.

He was aware that pain with urination could be a symptom of a sexually transmitted disease and kept hoping that the symptom would go away; it did not. TM resisted seeking medical attention. He had been taught that, as a male, he must be strong and set good examples for his cousins. TM thought men are not supposed to be afraid; however, now he was afraid. Fear, embarrassment and despair even invaded his dreams.

He needed to speak to someone. He decided to confide in the two peers he went out with that night. Both friends told him not to worry; he would be fine. They suggested that if he continued to feel stressed they could get him some marijuana...it would help him calm down. One friend even told him that he should be happy because the girl that he hooked up with that night was such a beauty. Although he didn't believe this, he told his friends that they were right and he was going to stop acting like a baby. He began to feel anxious and even lonelier and, although he wanted to speak to his mom or his uncles, he felt like he couldn't. What would he say? The need for support was something for girls, not "men". However, he needed someone to talk to, someone who would listen and understand. Who could he reach out to? TM did not know.

Despite doing his best to avoid thinking about his situation, TM's physical symptoms and stress increased over time. It came to the point where he had no choice; he had to see someone. He went to his university counselor asking if he knew of a place that TM could go for an evaluation. He told the counselor that he wanted to speak to a provider about some personal issues. The counselor appropriately referred him to the youth centre in Kampala. TM decided to go.

HOW TM WAS ENGAGED INTO CARE

TM arrived at the youth centre, was welcomed by the volunteer in the waiting room and taken for registration. There were other young people in the queue, mostly female, and this made TM very nervous. The centre's male social worker, JP, noticed how nervous TM seemed, and called him promptly into the counseling room. JP introduced himself to TM. He asked TM if this was his first visit to the centre and reinforced that often clients feel nervous the visit time they come to be seen. Before asking what brought TM to the centre, JP described all services offered at the centre and explained that information shared during each encounter is kept confidential excluding concerns about safety. JP then asked TM to share his story; he stressed how interested he was in learning about TM and hearing about what brought him in to be seen.

After a few minutes of silence, somewhat hesitantly, TM started to narrate his story. JP listened attentively, expressing his interest and concern mostly through body language.

TM began to cry as he told his story and express his fears. TM said he was embarrassed to be so weak. He felt alone, even his peers were not helpful.

JP and TM spoke for some time. JP listened, validated TM's feelings and also explained that many young men share the same questions and concerns. They spoke about the messages many men are told about how they should act and be. JP normalized that all men have a range of feelings, including fear, sadness, and embarrassment. JP stressed how seeking support is the brave and healthiest thing to do as opposed to trying to ignore issues. They discussed how many individuals make mistakes and how powerful it is to learn from those experiences. They explored ways to cope with peer pressure and how to communicate more effectively with family members. Issues regarding testing for STI`s, HIV/AIDs, and the importance of seeking treatment and preventive methods especially condom use and abstinence were discussed. Finally, TM asked about how to use a condom and the effects of drugs and substance abuse, because he felt he was in a safe place to admit he didn't know.

TM decided he would stay out of bars for now and that the next time he had sex, he would certainly use a condom. He accepted treatment for STI's and was very excited about being invited back to the centre on Saturday to have the chance to meet with other young people, especially men. He hoped that they would have the chance to share their stories and thought that, if they did, he may even discover that someone else had passed through a similar experience to his.

TM was given condoms, reading materials with information on HIV/AIDS, STDs/STIs, growing up (adolescence) and information about contraception. JP thanked him for sharing his story and as TM was leaving the centre he reflected on how relaxed, excited and "manly" he felt about having the strength to come to the centre and take the responsibility for his own care. He was confident that he had learned from his "mistake" and moving forward he felt more empowered to make choices in his best interest.

CASE REFECTION

Submitted by Mr.Lewis Denis Bukenya and Dr. Betsy Pfeffer**

1. ***Understand societal masculinity stereotypes***.

Health personnel who work with this group can benefit from increased awareness and understanding of societal stereotypes about male gender norms and of their own possible assumptions and stereotypes about boys and young men and working with them. Health personnel should strive to understand and empathize with the challenges that can preclude adolescent boys and young men from comfortably accessing health services

Globally, males are typically socialized to be independent and self-reliant and to not be concerned with or complain about their health. Consequently, they are more likely to ignore their health, diminishing its importance, and thus less likely than girls to seek health care when they need it.

Adolescent boys often face pressure from their male peer group to define themselves as "masculine". Adolescent boys may engage in risky experiences that confirm their masculinity to their peer group. Sometimes violating gender norms can have mental health consequences for males leading to ridicule, family pressure and social isolation.

There is an urgent need to revise the stereotypes of a "real man". Views of masculinity should include the expressions of all human emotions and qualities such as fear, sensitivity, emotion, and vulnerability. Adult male role models, those who have broken out of the traditional image of a "real man" and express the range of human emotions and qualities.

2. Know your resources for quality adolescent services.!

Comfortable comprehensive health service delivery for adolescent boys and young men starts with creating "safe spaces". "Safe spaces" include staff who are empathic and sensitive to their needs and deliver confidential non- judgmental care. The staff needs to successfully create comfortable relationships that allow for discussion about concerns and an opportunity for questions. In addition, creating a welcoming environment with waiting areas that have materials that are relevant to males. Accessible hours are a baseline requirement.

Having a humanistic lens aids many to have non-judgmental viewpoints. All humans make mistakes and choices that they regret! It is important to view "mistakes", not as character flaws, but as spring boards for learning. Preaching typically DOES NOT result in behavior change. The most successful way to help individuals alter their behavior is to, together, thoughtfully reflect on the behavior, determine if there is readiness to change the behavior and then to put a plan in place with reasonable and achievable goals.

Follow up is key! During this time behaviors can be reviewed and if goals have not been achieved, reasons for this can be reviewed. New goals can be implemented and of course, ongoing support can be given.

3. Know common issues and concerns of males.

Adolescent males are often left out of conversations and discussions about their health. However, many assume adolescent males should know and blame them for not knowing. It is unfair to assume. They are often supposed to know all about sex, drugs and rock and roll; however, like many they don't. Knowledge is accumulated through education and, just like girls, if boys have not received any education they don't know!

It is important to improve awareness that males, like females, are at risk of gender-based violence and mental health disorders like depression and how they can increase the risk of alcohol use, and STI-HIV/AIDS.

SUMMARY:

Adolescent boys need to be given permission to have a range of feelings and vulnerabilities that can be woven into their sense of "masculinity" and identity. Interacting with role models possessing these characteristics can be extremely helpful. Comprehensive health centres can be one place where adolescent boys and young men can find such mentors. Availability of comprehensive healthcare services for adolescent boys and young men is also essential for their well being. Just like their female counterparts they deserve confidential non- judgmental care, staff that are sensitive to their needs, waiting areas that are welcoming, and accessible hours.

Achievement of these goals will help adolescent boys and young men grow into healthy productive adults capable of partner intimacy and friendship. As adults they will also serve as well-rounded "masculine" role models for our younger generations.

Recommendations for Building an Adolescent Friendly Centre

Approach
Client centered approach (Building rapport, ensuring confidentiality, being empathetic and listening attentively)
Time (it's a process and requires follow up sessions)
Behavioural therapy (knowing how it happened, causes and the consequences)

Treatment plan
Counseling on Adolescent Sexual Reproductive Health issues
Testing for HIV/AIDS, STI`s
Partner involvement & treatment
Prevention methods (abstinence, condom use)

Support given
Counseling on drug and substance abuse
Supporting the clients to achieve their goals
Family involvement (parent- child relationships, rights of adolescents, growing up issues)
Skills on decision-making
Communication skills
Information on Prevention of STI`s.
Career guidance (how to achieve goals)

Other services that might be required
Information on STI`s HIV/AIDs
Information Education Materials
Referral to the Post Test Club
Supply of condoms

THE LATEST IN……

Submitted by David L. Bell, MD, MPH * *and Andrew B. Velasquez, MPH**

Introduction

Adolescent male health does not currently receive the attention it deserves from policymakers, health organizations, and medical practitioners. This deficit is a global phenomenon and spans all ranges of countries' differing economic and developmental statuses. Large amounts of resources and time have been devoted to improving the health indicators of female populations, and rightfully so, as women have unnecessarily high mortality and morbidity due to pregnancy and childbirth. However, this female-centric reproductive health focus has created an atmosphere where men's health, and their reproductive-related issues, is not being adequately addressed. Medical practitioners do not need to "choose sides" when discussing adolescent health. Indeed, it is a proficient practitioner's responsibility to understand the "ins-and-outs" of treating ALL patients entrusted to their care, including male adolescents and young men.

When compared to females, adolescent males have higher mortality, less engagement in primary care, and higher levels of unmet care needs.[1] For this reason, this newsletter will focus on the unique aspects of care and prevention required to appropriately treat and interact with male adolescents and young men in Uganda and Eastern Africa. For the purposes of this publication the population of interest will be males between the ages of 15-24 years. The United Nations has identified this age group as "youth,"[2] and this population requires special focus as the habits and behaviors developed during this period have longitudinal effects that will be carried on throughout their lifetime. In essence, both risky and protective behaviors can be influenced during this period, which offers a

valuable opportunity to positively shape their overall health going into adulthood.

Overview of Adolescent Male Health in the United States

Adolescent male health receives little attention worldwide, despite its potential for positive effects on adult quality and length of life, and in helping to reduce health disparities and social inequalities. After an extensive literature search, most of the prominent articles related to male health stem from US published articles. This section will provide a review of the existing literature on young men's health with special attention on the main gender-specific causes of morbidity and mortality of young men and identify the best practices associated with key areas of interest in young men's health. The U.S. Center informs the areas of interest for Disease Control and Prevention's Healthy 2020 objectives for adolescents and young adults. They will focus on chronic illness, mortality, unintentional injury and violence, mental health and substance use, and reproductive and sexual health.

Terms of Interest Box

Development: Programming and services that wish to include young men should focus on both adolescent and "emerging" or young adult population. The American Academy of Pediatrics (AAP) defines adolescence as up to 21 years of age.[3] However, attention is increasing around 20-24 year olds as "emerging adults" in U.S. society. This is supported by modern research which suggests that developmental challenges, transitional roles, and societal threats to their health are similar to those of traditional adolescents.[4]

Masculinity: Masculinity can be defined as a set of shared societal beliefs about how males should present themselves and behave. Masculinity includes the beliefs that "young men should be self-reliant, physically tough, not show emotion, dominant and sure of themselves, and be ready for sex."[5] These beliefs can lead to detrimental health effects among adults that range from cardiovascular disease to care-seeking (or lack thereof) behaviors. [6]

Mortality, Injury, and Violence

Mortality significantly increases across adolescence. Young males' mortality is unacceptably high. When compared to females, males from high-income countries are more likely to die from all major causes of mortality, including unintentional injuries, homicide, and suicide. Seventy-five percent of mortality in this area is caused by unintentional injuries (which include motor vehicle injuries, unintentional poisoning, drowning, and unintentional discharge of firearms).[7] Males are also at higher risk than their female counterparts from violence related mortality. Males in this age category are twice as likely to die from violence than females.[8] Even among males themselves, there is a marked increase in morbidity and mortality after they enter this age category. Adolescent males are 11 times more likely to be treated in emergency rooms for intentional injury/violence than are younger children. Important causes of intentional injury among adolescents are driving under the influence or texting while driving. Additionally, witnessing violence has negative health effects, including depression and anxiety, post-traumatic stress disorder, distress, aggression, and externalizing behavior.[9] Exposure to violence is significantly more common among males, urban youth, ethnic minorities, and lower income youth. Within studies of urban, low-income youth, approximately 25% have witnessed murder.[9]

Chronic Illness

Adolescence is an important time in the prevention of chronic diseases. The CDC has identified three primary goals for chronic disease prevention: 1) reduce tobacco use, 2) reduce rates of obesity, and 3) increase physical activity. Again, marked disparities exist across gender, age, and ethnic identities. High School

males are more likely to have ever smoked (46% vs 43%).[10] Male adolescents have a higher prevalence of obesity than their female counterparts (20% of males vs 17% of females). This rate of obesity has also increased among males from 1999-2000 to 2009-2010.[11] Rates of physical activity (>60 mins of daily exercise) among males is higher than for females (38.3% for males vs 18.5%for females).[12]

Mental Health and Substance Use

Symptoms of depression are common in adolescent-aged males. 19% of high school males report feeling sad or hopeless.[13] Males are also more likely to die from suicide than females. Sexual minority males have an increased risk for suicidal attempts and ideation compared to heterosexual males.[14] This is believed to be related to social stigma and lack of support.[14]

Alcohol and drug use is also more common among adolescent males. Among high school males, 39.5% reported any alcohol use in the past 30 days. 23.8% report consuming >5 drinks.[10] Drug use is also common among young men. 25.9% reported marijuana use within the last 30 days, 10.5% inhalant use, 9.8% ecstasy use, and 21.5% prescription drug use.[10] Risk factors associated with early drug use are low supervision or parental monitoring. Higher rates of substance use have been reported among sexual minority youth.[15]

Sexual and Reproductive Health

While current guidelines do not support clinician examinations or teaching males self-testicular examinations for the purposes of testicular cancer screening, testicular examinations, not self-examinations, are an important part of assessments that ensure normal growth and development. The Society of Adolescent Health and Medicine recommends that male genital examinations be a part of adolescent primary care annual visits.[16,17] As such clinicians should be familiar with normal male genital development. The time before or after examinations also offer opportunities for engagement with young men who may not otherwise feel comfortable discussing sexual health related topics or questions. Young men may hold unrealistic beliefs about "normal" penis size and shape. Normalization is an important component of the adolescent primary care.

Sexual health includes healthy relationships, health sexuality, and disease prevention. It also encompasses one's ability to appreciate their body, their ability to express love and intimacy in appropriate ways, and to enjoy and express one's sexuality.[19] When compared to common messages in modern media, it may be surprising to learn that many adolescent males choose to delay sexual intercourse, with only about 28% of 15-17-year-olds reporting ever having had sex.[20] Rates of sexual intercourse are much higher among "high-risk" males such as juvenile justice and STI clinic attendees.[21,22,23] While safe sexual practices are not necessarily problematic, those who have sexual intercourse at a younger age are at higher risk of sexual coercion, STIs, and early fatherhood.[24] It should be noted that adolescent males bear a disproportionate share of STIs relative to males in other age groups. Early fatherhood is also common, with 15% of young men fathering a child before age 20.[20]

Overview of the Adolescent Male in Uganda

Demographics

Uganda is classified as having a "very young age structure."[37] Currently, over 69% of the country's 37 million inhabitants are under 30-years old. Of these, almost 3.9 million are males between the ages of 15-24. The median age of all males in Uganda is 15.5 years old,[38]

right at the beginning of adolescence. This youth-dominated makeup is predicted to continue given Uganda's very high fertility rate of seven children per woman.[37] This demographic profile is one of Uganda's most salient developmental challenges, and addressing the healthcare needs of this group should be at the forefront of active and planned health programming.[37]

Mortality, Injury, and Violence

While Ugandan young men face all of the same challenges to their health as their global counterparts, Uganda (and Western Africa in general) has some special considerations that should be identified. Uganda and its surrounding neighbors have a long history of conflict and violence. A higher percentage of young men have witnessed or taken part in acts of violence.[39] These youths will be susceptible to the mental health consequences of witnessing violence discussed above. Within the country, there is currently an uptick of ethnic violence taking place in the western and Northern region of the country. While this type of violence is commonly reported in the news, it is not the most common cause of violent death. Accidents involving motor vehicles, motorbikes, and pedestrians accounted for the most visits to hospitals and clinics.[40]

Mental Health

Uganda's mental health system does not adequately address issues of adolescent mental health. Approximately 80% of people living with mental illness are living in low and middle income countries such as Uganda.[41] In addition, Uganda has a strong history of violence and conflict over the past five decades. This history has resulted in a high prevalence of depression, post-traumatic disorders, and alcohol consumption.[42] As a result of this high burden of mental illness, improving mental health is now a priority for the Government of Uganda and is one of the (retained) components of the national minimum healthcare package for the National Health Policy and Health Sector Strategic Investment Plan (2015).[42]

Despite this strong push for the strengthening of the mental health system in Uganda, few resources have been devoted to the youth demographic. Of the 28 mixed outpatient mental health facilities currently available, none have special clinics for children and adolescents only.[43] This is despite the fact that 16% of new users were children and adolescents.[43] There is also only one day treatment facility available in the country and 36% of its patients were children or adolescents.[44] There is an absence of specialized adolescent mental health services in place. Adolescents and children are treated in the same facilities as adults, an all too common problem in developing countries.[45]

Sexual and Reproductive Health

Relatively speaking, young men are generally healthy, but they face some pressing concerns related to sexual and reproductive health. Ugandan adolescents are more sexually active than their global counterparts.[46] By the age of 18, 47.9% of them have had their sexual debut. Not only are they starting sex at an earlier age, they are also engaging in higher rates of high-risk sexual behaviors.[47] According to data from the Demographic Health Survey (DHS), 74% of young men had high-risk sex within the 12-months preceding the survey.[48] Having multiple concurrent sexual partners increases the likelihood of contracting HIV and 22.7% of young men ages 15-24 reported multiple sexual partnerships.[49]

Transactional sex is also on the rise in Uganda. According to the DHS over 10% of

young persons gave or received money, gifts, or favors in exchange for sex within the past 12 months.[49] In a different study among secondary school students, transactional sex was not viewed negatively; in fact, young women felt that they would be more likely to be viewed as "loose" if they gave away sex "for free." Youths of both genders believed that wiliness to engage in transactionless sex might be an indicator of someone who was HIV positive.[50]

Despite high levels of knowledge of contraceptives, youth in Uganda have low levels of contraceptive use.[46] At last high-risk sexual encounter, only 48% of young men used a condom.[51] Consistent condom use among young men is also a concern. Only 36% of them reported consistent condom use in the three months preceding the survey.[52] Condom use among young males who had multiple sexual partners within the past 12 months was only 31%.[53]

In a 2014 study of barriers to male involvement in contraceptive uptake and reproductive health services five important themes were identified as males' rational for not participating:[54]

1. Perceived side effects of female contraceptive methods which disrupt sexual activity,
2. Limited choices of available male contraceptives, including fear and concerns relating to vasectomy,
3. Perceptions that reproductive health was a woman's domain due to gender norms and traditional family planning communication geared towards women,
4. Preference for large family sizes which are uninhibited by prolonged birth spacing; and
5. Concerns that women's use of contraceptives will lead to extramarital sexual relations.

While this study did not specifically target young men, it offers some possible thoughts and beliefs that may also act as barriers for youth contraceptive uptake.

High Risk Groups and Influencers

According to a just released longitudinal study from Columbia University that looked at the prevalence of sexual experience and initiation of sexual intercourse among adolescents in the Rakai District of Uganda, The single greatest predictor of sexual experience was enrollment in school.[55] Among adolescent males (aged 15-19), 86.8% of those NOT enrolled in school have ever had sex, compared to 67% for those who were enrolled in school.[55]

Sexual experience was also usually higher among orphans (both single and double) than non-orphans. Also, the socio-economic status (SES) of the adolescent's family influenced the likelihood of ever having had sex. Higher SES adolescents had a statistically lower prevalence of ever having had sex than their middle and lower SES counterparts.[55] "Alcohol use in the last 30 days" was also a statistically significant response. 88.9% of those responding "yes" to the prompt had ever had sex, compared to 79.6% of those who responded "no."[55] A difference of 9.3%.

HIV

Youth in Uganda bear a large share of the country's HIV burden. Males between ages 15-24 have an HIV prevalence rate of 2.4 percent.[53] Among this group, HIV prevalence increases with age, with the 20-24 year old age group having a higher rate than the 15-19 group.[46] Youths between 15-24 have a low level of comprehensive HIV knowledge. According

to UNICEF, comprehensive knowledge of HIV is defined as: "correctly identifying the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), rejecting the two most common local misconceptions about HIV transmission and knowing that a healthy-looking person can be HIV-positive." Only 39% of Ugandan youth met this level of knowledge.[53]

Also, knowledge around HIV prevention methods was low. Of the three most common prevention methods targeted to youth in Uganda (abstinence, be faithful, and condom use), knowledge that condoms can protect against HIV transmission was the least well known. Only 82 percent of young men were aware that condom use could prevent HIV transmission.[46] Also, only 68% of men were aware of all three methods of prevention. This knowledge did not translate into safer sexual practices, as indicated by the low and inconsistent levels of condom use. This age demographic also has low levels of HIV testing. Only 24% of young males and 40% of young females have been tested for HIV in the last 12 months and received the results.[53]

HIV-related indicators for young Ugandans are moving in a positive direction. A 2015 study on sexual and reproductive health (SRH) among Ugandans aged 15-24 compared several SRH indicators from 2004 to those same indicators in 2012. Researchers found that youths' knowledge of where to get tested for HIV increased from <40% to 80% among both sexes; the number of youths reporting ever having an HIV test increased from 8% to 48% among males; knowledge of other STIs improved but still remained low, with less than half of respondents knowing what action to take when infected; and 93% of males reported knowing where to obtain condoms.[56]

Other Sexually Transmitted Infections

Accurate STI prevalence rates are difficult to estimate but during a study among university students in Kampala, 16% of participants reported having at least one STI at the time of the study.[57] Additionally, a 2011 self-report survey found that 18% of sexually active males (aged 15-24) reported having STI-like symptoms (a bad-smelling or abnormal discharge or a genital sore or ulcer) in the 12 months preceding the survey.[58]

Overview of Scaling-Up Services for Adolescent Males in Uganda

Services and coverage must continue to improve in Uganda in order to meet the current and expected demands of adolescent young men. In order to accomplish this, successful and proven services must be scaled-up to reach previously unmet needs. The World Health Organization's ExpandNet, a community of practice for promoting best practices at scale, defines scaling-up as: "deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis."[59]

Efforts to expand the levels of coverage of a specific intervention are sometimes referred to as "horizontal scale-up." Efforts to institutionalize an intervention at all levels of a local implementing partner (e.g. ministry of health) in order to facilitate and sustain an intervention at a high level of horizontal scale-up is sometimes termed "vertical scale-up."[60] This section of the newsletter is not intended to be used as a comprehensive guide to scaling up context-specific health services, but rather as a general guide that can introduce ideas and share possible barriers to scaling up services.

See Box 1 for 12 principles that can guide practitioners in scaling-up effective heath services.

BOX 1

12 principles of scale-up used by Jhpiego and Partners[60]
A. Actions related to the STRATEGY for scale-up 1. Build evidence and engage in evidence-based advocacy (globally and nationally) 2. Coordinate/partner with other donors and technical agencies 3. Mobilize resources 4. Promote country ownership by integrating and harmonizing intervention with current system
B. Actions related to the INTERVENTION to be scaled up 5. Simplify and standardize intervention 6. Make intervention cheaper (i.e. more cost-effective)
C. Actions related to the IMPLEMENTING ORGANIZATION AND BENEFICIARIES of the scaled intervention 7. Identify and work with champions 8. Advocate for and develop needed policy/guideline changes 9. Build capacity of implementing organization(s) for training, management, and logistics 10. Use data for management, including strengthening monitoring and evaluation 11. Support institutions, such as pre-service education sites and professional organizations, that are agents of scale-up 12. Engage and empower clients and communities

The scale-up process itself happens in phases similar to a product introduction.[61] The first phase is called the "introduction" phase, and it consists of the introduction of the intervention or service (product). During this phase the "product" is piloted and tested on a small scale to gauge its relative effectiveness at accomplishing its intended output or outcome (i.e. health promotion increase, improvement of an indicator, etc.). During this phase the practitioner or health manager will learn what factors are necessary to make it successful on the local scale. The second phase of scale-up is called the "early expansion" phase. During this phase the intervention's coverage is expanded and the intervention continues to be adapted and modified as new evidence is produced from pilot experiences. As the coverage expands to a national scope, the intervention or service enters the "mature expansion" phase. During this phase, the focus becomes on how to institutionalize and maintain the quality and fidelity of the intervention on a large scale.[60]

Scaling up the availability and accessibility of quality health and reproductive information, services, and programs for young men is critical for meeting their current needs.[46] For this age demographic, the media (television, radio, newspapers, and the internet) are key sources of SRH information. Accessing these information sources are all more common among the youth in Uganda than those over the age of 25.[49] Radio is currently the most popular source of SRH health information.[49] However, the increase in access to the Internet and the increasing saturation of smart phones are creating new opportunities for health outreach and engagement. As of 2014, 18% of Ugandans had access to the Internet and over 50% had mobile phone subscriptions.[62] Of these, a large majority of users were under 25 years of age.[47]

Existing Needs and Opportunities for Increased Programming and Scaling-up

While increased health-related information access is a movement in the right direction, numerous barriers to youth receiving comprehensive and high-quality SRH information and services still exist. Many youths still rely on adults in their community for SRH-related advice. These adults include: parents, teachers, aunts and uncles, and community elders. There is some evidence that adults' own lack of knowledge and/or

discomfort with sex-related information may provide inaccurate information to the adolescent.[63,64] While SRH school-based programs have found success in educating adolescents on SRH information, there is a disconnect in reaching the adolescent population who are not enrolled in school or education programs. This is also the population that is more likely to be sexually active, and some sort of SRH engagement with this population could have beneficial downstream effects.[46]Additionally, information related to local services is not adequately being communicated to local community adolescents. In focus group discussions (FGD) with adolescent youth many were unaware of existing and under-utilized services in their nearby surroundings.[46] This is clearly hindering overall service utilization and SRH engagement efforts.

The services in Uganda, in all levels of health facilities, need to be "youth-friendly" in nature. Characteristics that contribute to the "youth-friendliness" of a health facility include its hours of operation and location, staff preparedness in interacting with youth, the availability of peer education/counseling, the facility's environment, including privacy and confidentiality communicated to youth, affordable fees, and supportive administrative services.[46,65] While youth in general expressed desire for more information about SRH, FGD responses specifically mentioned wanting more information about preventing STIs and HIV, preventing pregnancy, and use of family planning methods.[46]

Conclusion

It is clear that there are many factors in Uganda that have the potential to positively contribute to youths' health outcomes. The positive steps taken by the government to identify health disparities and shortcomings demonstrates movement in the right direction. A takeaway from this newsletter should be the need for a greater focus on actionable information around family planning, and sexual and reproductive health. While SRH messaging does exist, there also needs to be an increase in detailed information that young males' can use to make informed health decisions and that better guide them to nearby appropriate services.

Ugandan male youths live in a society that presents both opportunities and challenges for advancements in their health. Youth norms around sex, marriage, and childbearing are at tension with the traditional norms of their elder generations. Newfound desires of this youthful generation to reach educational and financial goals previously unattainable may act to delay the formation of families and early parenting. Healthcare workers and clinical practitioners in Uganda need to be aware of the fluid nature of the modern cultural climate affecting the sub-25 generation. As health providers, parents and family, teachers, and community elders come together to create male friendly adolescent health services, young men will have the best chance of achieving their potential and growing into healthy, happy and responsible adults.

Recommendations

General [25–27] **

1. Engage male youth in care. Assess and build upon strengths.
2. Provide time and a safe space for confidential conversations about sensitive topics.
3. Approach sensitive topics in respectful 2-way conversations, rather than in a lecture style. Motivational interviewing–based approaches are recommended for engaging with all adolescents, despite the focus of its use with specific risk behaviors.
4. Involve parents; they can support healthy adolescent development.

Chronic Diseases [28–30]

1. Screen for tobacco use.
2. Recommend smoking cessation.
3. Screen for obesity, using BMI-for- age.
4. Screen for diabetes for adolescent males who are overweight and have 2 risk factors.
5. Screen for hyperlipidemia.
6. Recommend healthy lifestyles.

Mortality, Violence, and Unintentional Injuries [31–33]

1. Screen for weapon ownership.
2. Screen for interpersonal violence and domestic violence.
3. Screen for suicide.
4. Discuss driving safety with parents and teens: seat belt use, risks of having passengers in the car, and night driving.
5. Know whether your state has a Graduated Licensing Program.

Mental Health and Substance Use [34,35]

1. Screen for depression and suicide.
   a. With positive screen, treat and/or refer for treatment.
2. Screen for alcohol use and binge drinking.
3. Screen for substance use, particularly marijuana and steroid use.

Sexual and Reproductive Health [36]

1. Screen for sexual activity.
   b. Promote abstinence for adolescents age 17 years and younger.
   c. Assess personal assumptions about boys and masculinity, particularly around care-seeking and relationships.
   d. Engage adolescents in conversations about healthy relationships and safer sexual behaviors, be- yond simple messages about abstinence and condom use.
   e. Encourage the adolescent to adopt a definition of masculinity that allows and promotes health and respectful relation- ships and genuine communication.

2. Discuss and appropriately screen for STIs.
   a. Screen based on the adolescent's sexual behavior.
   b. Include Hepatitis A, Hepatitis B, and human papilloma virus vaccinations as primary prevention efforts for males.
3. Promote condom use. Advise males to sample and choose the condom that feels and fits best rather than propose that 1 size fits and functions for all.
4. Educate males about emergency contraception.
5. Educate and promote dual contraception with males; educate and dispel myths about hormonal methods and long-acting contraceptive methods.

**** References in this section are suggested readings**

RESOURCES:

Uganda:
http://ntihc.org/about-us/
http://www.sahu.ug
http://www.aidsuganda.org
Youthmap, Uganda:
http://www.iyfnet.org/sites/default/files/YouthMap_Uganda_Vol1.pdf

Male Involvement Strategy:
http://www.docdroid.net/lysfwG0/male-involvement-strategy.pdf.html

Useful Websites:
http://www.youngmensclinic.org/
http://youngmenshealthsite.org/

Guttmacher Institute: Men's Health:
https://www.guttmacher.org/sections/men.php

CURRENT SERVICES AVAILABLE FOR MALE HEALTH IN UGANDA

- Information and education on adolescent growth and development for the young male adolescents; this is done in all youth centres distributed throughout the country and also in some school health programs through clubs.
- HIV counseling and testing in all public and private health facilities
- Safe male circumcision
- Uganda MenEngage Network (UGAMEN) is a national group of twenty three non-governmental and community based organizations involved in research, interventions and social mobilization initiatives that engage men and boys in effective ways to reduce gender inequalities and promote the health of women, men and children. The network was established in 2010 following the MenEngage Africa Guidelines and National Stakeholders Meeting.
- In some areas of the country there are male action groups against gender based violence that are charged with the various roles below:
  - Mobilize communities at the grassroots to change attitudes and behaviors that perpetrate Violence Against Women and girls
  - Build solid communities to create an environment supportive of women's rights
  - To build capacity of community citizens to identify, manage and appropriately refer gender based violence survivors

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