MUCU ADOLESCENT HEALTH NEWSLETTER

Sexual Activity in Ugandan Adolescents

Issue 2, Nov 1st 2013

Makerere University and Columbia University, (**MUCU**) is pleased to publish the second issue of our newsletter. We are excited to update you on all 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 sexual activity in Ugandan adolescents.

FUTURE TOPICS will include: Mental Health; Contraception; Sexual Coercion/Violence; Taking a Psychosocial History; Managing the Confidential Visit: Parents and Teens.

Meet the Newsletter Editorial Board

Co-Editors in Chief:

Sabrina Kitaka M.D., *Senior Lecturer & Paediatric & Adolescent Health Specialist, Department of Paediatrics and Child Health, Makerere University College of Health and Sciences Kampala, Uganda. Dr. Kitaka is passionate about promoting adolescent health and medicine in East Africa. For the past 11 years, she has taught Adolescent Medicine at Makerere University College of Health Sciences. Since 2006 she has collaborated with Dr. Betsy Pfeffer and her colleagues at Columbia University and since 2010 they have conducted three annual in-service adolescent health workshops for East African health providers. She is the director of the Adolescent Program at the Paediatrics Infectious Diseases Clinic at the Mulago National Referral Hospital.*

Betsy Pfeffer, M.D., *Assistant Professor of Pediatrics at Columbia University Medical Center and New York Presbyterian Hospital, New York, U.S.A. Dr. Pfeffer is an adolescent medicine clinician who sees teens in an outpatient and inpatient setting, teaches medical students and residents and lectures internationally on multiple topics related to adolescent health care. She has been working together with Dr. Kitaka for over six years and is committed to their efforts to help improve health care delivery to teens in Uganda.*

Editorial Team Kampala, Uganda

Nicolette Nabukeera-Barungi, M.D.*, Affiliation is Department of Paediatrics and Child Health, School of Medicine, Makerere College of Health Sciences*

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Kilonzo Richard Mutua*, Children and Youth program supervisor, Reach Out Mbuya Parish HIV/AIDS Initiative*

Emmanuel Mugalanzi , *Counselor, The AIDS Support Organization (TASO)*

Christine Seremba *Nursing Sister, Mulago Hospital*

NEWSLETTER SUBMISSIONS: The next newsletter will focus on Mental Health issues in Ugandan adolescents and will be published in May 2014. SAHU members are encouraged to submit member news, program updates and interesting cases related to this newsletter topic with all patient identifiers removed. The editorial board will conduct a peer review process for all submissions. Submissions will be accepted from Jan 15th – March 30th, 2014. Please e-mail all submissions to: sabrinakitaka@yahoo.co.uk
Thank you beforehand for your participation.

The Makerere-Mulago-Columbia-Adolescent Health Clinic (MMCAHC) at Ward 15, Mulago National Referral Hospital

Submitted by Dr. Sabrina Kitaka

The **MMCAHC** opened on May 3, 2013, with the aim of providing comprehensive services to Ugandan adolescents. The clinic is supported by: the Department of Paediatrics at Makerere University College of Health Services; and the Directorate of Paediatrics and Child health at the Mulago National Referral Hospital; as well as the Department of Pediatrics at Columbia University. The clinic is run by: two Ugandan paediatricians with specialist skills in adolescent health; five nurses; a mid wife; a social worker; and a psychologist. There is a proposed plan to include the Department of Obstetrics and Gynaecology, as well as the Department of Psychiatry of Makerere University to promote a comprehensive approach. The support staff includes an administrator, and a records clerk. Services offered include: immunizations; sexual and reproductive health care; psychosocial counseling services; school health reviews; nutrition counseling and monitoring; life skills training, career guidance; family planning; HIV testing and referrals. By the 30th of September 2013 the clinic had registered 208 clients, with a high female to male ratio of 7:1.The re-visits are mostly for vaccinations and follow-up of psychosocial problems. The clinic recruits patients through self-referrals; referrals from the hospital as well as from the village health team members of Mulago and Makerere parishes. Announcements about the clinic are shared via fliers and posters and through social media interaction on Facebook. The majority of clients come from the Kampala area; but, one client traveled two hours from the Luwero District, and another client travelled eight hours from the Oyam Sub County. The clinic also receives referrals from the Uganda Youth Development Link (UYDEL), which runs a community service. The MMCAH has received several visitors and volunteers, and had the pleasure of hosting the reigning Miss Uganda 2013, Miss Stella Nantumbwe on August 23, 2013. Miss Uganda gave hope to the young people and gave them a talk on 'Good hygiene practices'.

The MMCAHC is proud to announce that it has received its FIRST GRANT SUPPORT.

The Friedland Foundation has agreed to support the operational services of the MMCHAC for three years. The funds from the grant will be administered through the Uganda Paediatrics Association.

Adolescent patients can be seen at the MMCAHC on a walk-in basis.

Clinic registration occurs between 8:30AM-9:30AM every Friday morning on Ward 15, Mulago Hospital

Tell your adolescent patients to ARRIVE EARLY – ONLY twenty patients will be registered per day.

Filling the Gap: A Needs-Assessment of Adolescents in Kampala, Uganda July, 2013

Maya Koenig-Dzialowski, Columbia College of Physicians and Surgeons Class of 2016

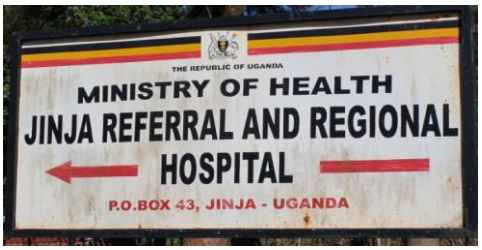
Presented at the New York Academy of Medicine Aug 21, 2013

The Makerere/Mulago/Columbia Adolescent Health Clinic (MMCAHC) opened this May to fill the gaps in healthcare services for adolescents in Kampala, Uganda. It is the first clinic in Uganda to deliver comprehensive adolescent healthcare in a "medical-home" format and it is uniquely positioned to serve as a model for future clinics that will service this population. To ensure that the clinic functions optimally and efficiently allocates its resources, it was critical to better define the needs and desires of its adolescent patients. It is for this reason that I came to Kampala in July 2013. The results from this needs-assessment project will be essential for establishing a specific and prioritized list of services that should be offered at the MMCAHC.

For 5-weeks this summer, I administered a 5-page questionnaire to adolescents at the MMCAHC and the Naguru Teenage Health and Information Center in the Kiswa neighborhood of Kampala. The document included questions on the adolescent's self-reported medical, reproductive, and psychosocial history, behavioral patterns, and personal desires. 119 adolescents were interviewed (66% female) and the mean age was 16 years old. A sample of preliminary results shows that malaria is a major concern for the adolescents. At school, more than half report having been the victim of bullying. Of those sexually active, just under half had started at or before 16 years old. Nutrition, counseling, and HIV-testing ranked high on the adolescent's list of desired services. I hope to use these results to offer recommendations to the MMCAHC. Through formal publication, I also hope to raise awareness on the topic of adolescent medicine in low-resource settings and lay the groundwork for further, more detailed research in this field.

Breaking News…
Adolescent Clinic to open at Jinja Regional Referral Hospital

Submitted by Dr.Vanessa Rippon, United Kingdom



Another Adolescent Clinic will soon open at the Jinja Regional Referal Hospital in Eastern Uganda! This was made possible because of support from the organization Global Links Volunteers; a link between the Ugandan Paediatric Association and the Royal College of Paediatrics and Child Health in the UK (UPA/RCPCH (UK)). Dr. Sophie Namasopo, a Consultant Paediatrician and a member of the Global Links Volunteers, works at the Jinja Regional Referral Hospital and recognized the unique needs of this age group after attending the Third Annual Columbia University-Makerere University Collaborative Workshop in Kampala, Uganda (Nov 28-30, 2012) on "*Integrating Psychosocial Development into the Clinical Evaluation of an Adolescent* ". For the next six months, Dr. Namasopo will be working in Jinja with her colleague, Dr. Vanessa Rippon, a Paediatrician from the UK who decided to come to work at Jinja Regional Referral Hospital as part of Global Links Volunteers. They met when Dr. Namasopo was working in London during the pre-placement training as part of the link. The two doctors share an interest in adolescent health and together are breaking new ground in Jinja by starting its first Adolescent Clinic. The need for an Adolescent Clinic is evident: during the past three months, nearly 300 young people aged 10-19 years were seen as outpatients at Jinja Regional Referral Hospital. Many had sickle cell disease, epilepsy and tuberculosis but more suffered from HIV. Jinja's clinic will provide confidential care services to the teenagers with chronic conditions. Additionally, it will also be widely advertised to encourage ALL adolescents to come for a variety of services including: vaccinations; family planning; sexually transmitted infection screening and pregnancy testing; voluntary counseling and HIV-testing; mental health support; and nutritional assessments.

STAY TUNED FOR OUR PROGESS!!

Naguru Teenage Information and Health Center (NTIHC)

Submitted by Mr. Bukenya Lewis Denis, Training Manager

For close to two decades, Naguru Teenage Information and Health Center (NTIHC) has implemented a youth friendly Services (YFS) model for Adolescent Sexual Reproductive Health service delivery in Uganda based in Kampala, the Ugandan capital ! Born in 1994 as a small teenage mothers' clinic, NTIHC has evolved tremendously, though gradually, to an Adolescent Sexual Reproductive Health (ASRH), Youth Friendly Center (YFC) over the years. In 2010, NTIHC, in partnership with local governments through district health departments and in collaboration with other local and international Non Governmental Organizations (NGOs), started rolling out integrated YF-SRH through public and private not for profit (PNFP) health facilities in central regions covering 9 districts, including Kampala. With success in establishing and supporting 22 YFC, providing technical and logistic support and building capacity of organizations and individuals the "Centre of Excellence" status was obtained. By end last year, the program had provided clinical services to over 113,000 young people and, thousands more were reached with health information and messages. The program trained 42 health workers, 248 peer educators and 160 trainer of trainers in youth friendly services planning and delivery. The program is proud to be contributing to government programs for health system strengthening and also to partner with a number of institutions both locally and internationally, including Makerere University College of Health Sciences and Columbia University, key educational institutions that have contributed a lot to the success of the program. The focus is now on rolling out the model to cover 31 fully functional youth friendly corners integrated into public health facilities by September 2014, with the projected target to reach 500,000 individuals, about 70% of Uganda's young people population. The goal of scaling up services is to help reduce teenage pregnancies, Sexually Transmitted Infections and HIV, through increased awareness, STI and HIV screening, and provision family planning commodities.

SAHU'S First Clinical and Scientic Meeting

The Society of Adolescent Health in Uganda, SAHU, is please to announce its first Scientific and Clinical Meeting. The theme of the meeting is promoting adolescent health in Africa. The meeting will be held at the Protea Hotel in Kampala, Uganda in December 4th and 5th. Makerere and

Columbia University Departments of Pediatrics, SAHU, The Makerere University School of Public Health and The Rakai Project are proud sponsors of the meeting. Although this is SAHU's first Scientific and Clinical Meeting this is the continuation of the Makerere University and Columbia Universities (MUCU) collaboration to help scale up Adolescent Health in Uganda. This is the **FOURTH** annual conference that MUCU has organized and sponsored; the previous three have been Adolescent Health Workshops in Kampala, Uganda.

SAHU would like to extend **A Special Thank You to: Lawrence Stanberry M.D., Ph.D.,** Chair, Department of Pediatrics, Columbia University Medical Center, New York, U.S.A., **Sarah Kiguli M.D.,** Chair, Department of Paediatrics & Child Health, College of Health Sciences, Makerere University, Kampala, Uganda, for their ongoing support.

MEETING HIGHLIGHTS WILL BE PUBLISHED IN THE NEXT NEWSLETTER

Adolescent Health in Uganda: SAHU

The Society of Adolescent Health in Uganda (**SAHU**) was launched in November 2012, following a regional training in Kampala, Uganda, that was led by experts from Columbia, and Makerere Universities and the Naguru Teenage Center. Uganda is young population with 52% under the age of 15 yrs and 25% aged 10-19 yrs [3]. To help optimize the health of adolescents, reduce their risk-taking behaviors and guide them into thoughtful decision making that can capitalize on their strengths; access to comprehensive health education and reproductive, physical and mental health care is essential.

A Healthy Adolescent: A Healthy Nation!

SAHU's Mission Statement:

SAHU exists to promote comprehensive adolescent health, growth and development in Uganda through knowledge dissemination, research, advocacy and affiliation with other societies and bodies involved in adolescent health.

The Vision of SAHU:

Each and every adolescent will be provided the opportunity to access their potential and grow into healthy, responsible and independent adults.

SAHU'S Web Site: The web site is presently under construction

GOOD NEWS: SAHU membership will initially be **FREE**!

SAHU MEMBERSHIP:

You can join **SAHU** by sending an e-mail to: **adolhealthuganda@gmail.com.** Please include the following information in your e-mail: **Name, title Job title:** Pediatrician; Internal Medicine; Obstetrician; Psychiatrist; Postgraduate Trainee; Medical Officer; Nurse; Social Worker; Community Health Worker; Other City, Country of work, **Institution /Affiliations, E-mail address**

Sexual Activity in a Ugandan Adolescent: Case History

Submitted by Dr. Dina Roma
First Year Adolescent Medicine Fellow, Columbia University Medical Center, New York, U.S.A

Patient M.C.'s history:

M.C. is a 16-year-old female who is from a busy, close knit urban community in an underserved area. She lives with her conservative loving parents and one younger sister. Both parents work and are often out of the house. She is a good student who attends secondary school and would like to become a teacher. MC is a quiet well-adjusted adolescent with a past medical history only significant for one episode of a sexually transmitted infection at age 13; the age that she became sexual activity. Her symptoms included vaginal spotting and an odiferous discharge. Although she was afraid to go see a doctor; her best girlfriend convinced her to go to the local clinic. MC went to the clinic with her girlfriend and was given some pills; within a week her symptoms resolved. By age 16, she had five age appropriate lifetime sexual partners. Although she was never forced to have sex, she "just did it" because the boys asked her to. MC only told her best friend that she was sexually active; she was terrified that her parents would find out. Recently, she began feeling ill with intermittent fevers, a sore throat, vaginal irritation and pain. Once again she and her girlfriend went to the local clinic. She was diagnosed with herpes.

After her first sexually transmitted disease her doctor had advised her to use condoms. She assumed this was to prevent pregnancy but had been practicing the withdrawal method; certain she would not get pregnant. MC also thought if she began washing herself after sex she could prevent herself from getting another sexually transmitted disease. She was not aware of the fact that she was old enough to get contraception but also was not interested in it because she remembered her mother and friends saying that it would lead to infertility. However, she did take her doctor's advice and began using condoms occasionally but only when her boyfriend decided to use a condom. She was unable to buy them on her own; afraid that someone from the community may see her purchasing these items and nervous that her boyfriends might judge her. She had heard boys saying that girls who buy their own condoms are "easy" and "probably prostitutes." She was also afraid her parents might find out about her sexual activity.

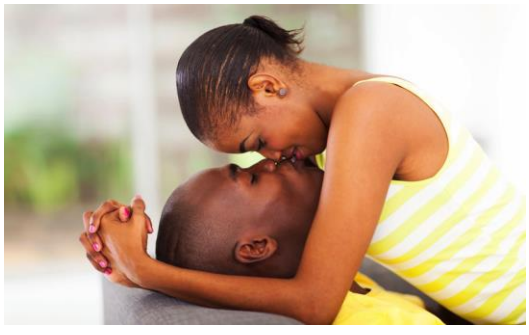
Follow-Up:

At age 18 MC was living with her boyfriend of 2 years and their 9-month-old baby. MC ran away from home to live with her boyfriend once she found out she was pregnant. She was afraid her parents would be disappointed in her and punish her. Since the birth of her baby, she has been unable to finish her studies. She continues to get occasional outbreaks of herpes, which she has successfully hidden from her boyfriend. She thinks he would get upset and kick her out of his home. She also continues to use condoms only when her boyfriend wants to.

If MC. had access to adolescent specific services how might have things turned out differently?

If, M.C. presents to YOU for care:

What are some things you would want to ask her? How might you help her?



Case Discussion : Dr. Betsy Pfeffer

CASE DISCUSSION:

We often see adolescent patients similar to M.C. who deserve adolescent specific care, the goal of which is to optimize the chance of favorable outcomes. For our first visit with M.C., it would be useful to determine our immediate goals, and to allow time during the visit to evaluate M.C.'s risk profile, assess her strengths and address her concerns.

If adolescent specific care had been available, her chances for a better outcome might have been improved.

Immediate first visit goals:

Assuring confidentiality

M.C. is sexually active and it is unlikely that she will discuss this with any provider unless she is certain that the information she shares is confidential. Even though she presents with symptoms of a sexually transmitted disease, she needs to be made to feel comfortable discussing her personal situation. It would be worthwhile creating a safe and respectful opportunity to uncover her complete sexual history. This might be her only chance to be encouraged to reflect on her choices, learn how to practice safe sex or under understand that she still has the choice of abstinence.

Why has she begun sexual activity? Does she know the risks? There are many reasons an adolescent chooses to begin sexual activity. Asking her concrete questions can help elucidate her personal motivation and help define her understanding about the risks of pregnancy and sexually transmitted diseases. Is her sexual activity consensual? Does she enjoy sex? What type of sex does she practice? What is the age of her partner? Is she on birth control, does she use condoms or want to become pregnant? What does she know about birth control?

Dispel Myths!

Withdrawal does not protect against pregnancy and washing after sex does not prevent disease. Contraception use does not lead to infertility. A provider could give useful and accurate information to M.C.

Negotiating Condom Use

Adolescent females may feel that they have little say over whether condoms are used. Some may feel that they are not able to encourage condom use, especially if their partner is unwilling. Adolescents may also equate condom use with mistrust. Do she and/or her partner want to use condoms? Have they discussed this together? How often do they use them? Does she know how to use a condom? Is she comfortable buying them? Does she know that free condoms are available in Uganda at the youth corners in public health facilities?

Parents

It could be helpful to get an understanding of her family situation. Does she get along with her parents? Do they know that she is sexually active? What might they do if they found out? Does she want help telling them? Proper support may open up doors to communication.

Follow-up Goals:

At age 18 M.C is a mother who is coping with herpes, out of school, has poor communication with her boyfriend and is not in touch with her parents. Does she understand what herpes is and know how to manage outbreaks? Does she want to use condoms consistently? Does she have support systems in place? How does she feel about not seeing her parents and her role as a mother? What keeps her with her boyfriend? With a health provider's guidance, and perhaps a referral to a counselor, she may become empowered to advocate for herself. M.C. might develop the skills and confidence that would enable her to share her feelings with her boyfriend, explore the possibility of reuniting with her parents and, if she wants, return to school.

"Nearly all teenagers experience pressure to have sex at some time or other and therefore nearly ALL teens are at risk of pregnancy and sexually transmitted diseases.

When teens become pregnant or contract a sexually transmitted disease, they, their children, and society at large often pay a significant price, both in human and in monetary terms."

The National Campaign to Prevent Teen and Unplanned pregnancies 2007

Latest in…Sexual Activity in Ugandan Adolescents

Facts on sexual activity:

The legal age of consent for heterosexual sex in Uganda is age 18 years[1]. However, many adolescents initiate sexual activity before the age of 18 years. According to the Global School Based Heath Survey (GSBHS) conducted in 2003 among students aged 13-15 years in Uganda, 29% of males and 14% of females in this age range reported having had sexual intercourse [2]. Data from the 2011 Uganda Demographic and Health Survey (UDHS), a nationally representative survey of 10,086 households with 9,247 females aged 15-49 and 2,573 males age 15-54, revealed that at the time of the survey, the median age of first sexual intercourse was 17.5 yrs for females aged 20-24 yrs. The median age of first sexual intercourse for females had increased over the past two decades; from 16.8 yrs for females who were age 45-49 to 17.5 yrs for those aged 20-24 yrs. Males tended to initiate sexual activity later in life than females, the median age for males aged 25-49 yrs was 18.6 yrs and had not changed over the past 30 yrs. Additionally, 12.2 % of females aged 15-19 yrs and 16.1% aged 20-24 yrs and 17.9% of males aged 15-19 yrs and 12.8% of males aged 20-24 yrs reported first sex by the age of 15 years. Finally, 57.9% of females and 42.9% of males in the 20-24 yr age group reported first sex before age 18 yrs [3]. A recent report by Gutmacher in 2013 reveals that more than one in three never-married females aged 15-24 years have had sex [4]. In another survey carried out by the Guttmacher Institute in 2004 that compiled a comprehensive overview of adolescent sexual and reproductive health in adolescents aged 12-19 years found that 16.8% of unmarried males and 8.8% of unmarried females aged 12-14 years reported having had sexual intercourse [5]. This early age of initiation of sexual activity is an interesting finding given that one recent national survey carried out on 6,659 12-19 year olds in Uganda found the median age of menarche at 14.6 years and the median age of male pubertal changes at 14.8 years. To determine pubertal changes in males, growth of pubic hair, voice deepening, and the presence of "wet dreams" was assessed [5]. Although in Uganda, the minimum legal age for a woman to get married is 18 years, according to UDHS 2011, the median age of marriage was 17.9 years for women and 22.3 years for men [3]. As noted in the same survey, the median age at first sexual intercourse for women age 25-49 was 16.8; consequently, many females initiated sexual activity before marriage. Marriages can be contracted for a person younger than 21 with the written consent of a parent [3,6]. The legal age of marriage for males is 16 years and, according to the same 2011 survey, among males aged 25-49 years, only 9% were married by age 18 years and 25% by age 20 years [3,6]

Early onset of sexual activity:

When comparing urban to rural residence, females living in rural areas were more likely than females in urban areas to initiate sex earlier. Keep in mind that 87% of Uganda's population lives in rural areas [7]. Females of the Eastern and East Central regions began sexual activity the earliest [3].

A review by the World Health Organization (WHO) on the risk and protective factors affecting adolescent reproductive health in developing countries, including Uganda, reported that factors associated with early onset of sexual activity included: early onset of puberty; male gender; older age; permissive attitudes towards sex; cigarette smoking in males; drug and alcohol use; males who view pornography; adolescent who have friends who are sexually active [8]. In one paper that focused on sexual debut in out-of-school youth in the Masaka District, the 31 adolescent participants aged 13-19 years all felt that young people begin their sexual lives too early. Females felt that part of what prompted early sexual debut was that males begin to pester them to have sex as soon as they started to develop breasts and, that their friends, who received gifts for sex, convinced them they, too, were ready for sex. The sexually active males in the study reported beginning sexual activity out of fear and claimed that they did not enjoy the experience. As with having multiple sexual partners, many of the males became sexually

active because they felt sexual activity made them masculine and they did not actually begin to have sex because of desire. All participants felt they had begun sexual activity too early and thought it would be helpful to have access to information and skills training that could help assist them to delay sexual debut and resist the social pressures to begin sexual activity early [9]. According to a 2007 Guttmacher report, the most common reason that 15–19-year olds gave for beginning sexual activity was because "they felt like it". Other reasons given included; the influence of friends; expectations of money or gifts; and their partner's insistence. Reasons that females listed for having unwanted sex included: they felt pressured because their partner had given them money or gifts; their partner flattered them, pestered them or threatened to have sex with other partners; they were forced into having sex or passively accepted unwanted sex [10].

Multiple Sexual Partners:

Adolescent sexual relationships are often short lived and unstable so it is fair to assume that many adolescents might be at risk of having multiple sexual partners. The WHO found there are a number of factors associated with an increased risk of having multiple sexual partners [8].Being male was one of the factors and a Guttmacher publication reported that of sexually experienced 15-19 year olds, 11% of males had two or more sexual partners in the past year, compared to only 5% of females. This difference was thought to be partially explained by the fact more females are in a relationship but, it was also thought to reflect that more sexual partners made males feel manly [6]. According to the WHO, other risk factors for multiple sexual partners included: being an older adolescent; using substances; having friends who were sexually active; drinking alcohol with friends; and having begun sexual activity at an early age. The perception that friends are sexually active was found to be one of the strongest identified risk factors for an adolescent to have sex with multiple sexual partners[8]. The same WHO review found that factors that were found to be be protective against adolescents having multiple partners included being married and having had a sexual transmitted infection.

Factors Associated with Delayed Onset of Sexual Activity:

Sexual activity is less common in unmarried males and females aged 15-19 years who have parental supervision and, particularly for females, living with both parents/guardians was found to be more protective than living with only one parent [6]. Unfortunately, 15% of 15-17 year olds in Uganda have lost one or both of their parents [3,6]. A high level of perceived parental monitoring was also strongly associated with decreased onset of adolescent sexual activity [11]. Females with at least some secondary education start sexual activity almost 2 years later than less well educated women [3]. Seventy-five percent of females and 58% of males aged 15-19 years who were in school never had sex compared to 29% of females and 38% of males aged 15-19 years who were not in school [6] . It is important to point out that despite the implementation of the Universal Primary Education program in 1997, 33% of females and 34% of males have never attended school[3]. In January 2007 the government of Uganda implemented nationwide Universal Secondary Education yet, only 12% of female and 14% of males have attended but not completed secondary of higher education [3]. Interestingly the level of household wealth and initiation of sexual intercourse was not found to be strong [3].

Reproductive Health Care Knowledge:

According to the Guttmacher surveys, Ugandan adolescents frequently have inadequate knowledge about reproductive health care and hold many misperceptions related to pregnancy prevention and HIV transmission. Ugandan adolescents know that contraception exists however, among 15-19 year olds who have had sex, 62% of females and 57% of males have ever utilized a method, condoms being most used method [6]. Sadly, less than 50% of Uganda's adolescents have been shown how to correctly put on a condom and many do not know how to use them correctly [6]. Approximately 30% of

females and 20% of males aged 15-19 years do not know that a condom needs to be put on before sex and believe that the condom can be used more than once. Common misperceptions include that a condom can travel to the uterus, and that it contains a fluid that can cause cancer [6,12]. Common misperceptions about pregnancy include thinking that a female can't get pregnant the first time she has sex, if she is standing up, or if she washes herself thoroughly immediately after sex. The majority of adolescents believe that a female cannot get pregnant if the male withdraws before ejaculating and do not know that a woman is most likely to conceive when she ovulates in the middle of her menstrual cycle [5]. Additionally, among Ugandan adolescents knowledge about sexually transmitted diseases other than HIV is very low [5].

Importance of Sex Education:

Straight Talk Foundation (ST Radio, ST and Young Talk papers) in Uganda publicized messages related to abstinence and delaying sexual debut and the adolescents who were exposed to these messages were less likely to initiate sexual activity before the age of 19 years. This finding supports the conjecture that exposing young people to sexual education in the media may influence their sexual behavior [13]. Some Ugandans initiate sexual activity at a very young age. To promote healthy decision-making and to assure accurate reproductive health care knowledge, it would make sense to begin comprehensive sex education early. However, younger adolescents, aged 12-14 years, are less likely than their older adolescents to have talked to a family member about sex: and few have had sex education classes in school [6]. According to surveys, Ugandan adolescents would prefer to receive the information they require regarding sex from health care professional as opposed to from friends or family and also from sources where confidentiality is maintained [6,14]. In-depth interviews with adolescents from the Adjumani District revealed that they wanted information on sexuality from providers whom they had confidence in and who helped them feel relaxed[15]. However, Uganda has few health facilities with services focused exclusively on youth. Additionally, adolescents frequently do not access them because: they don't know they exist; there is a lack of confidentiality; rudeness among providers; and fear of embarrassment [16]. Finally, if sexually active adolescents are able to have open, supportive discussions with parents and they might be better equipped to protect themselves [11]. In the U.S. research has shown that good parent-child communication around sexuality has a positive effect on adolescent sexual health. In Sub-Saharan Africa, parents and young people report a number of obstacles to open discussions about sexuality and HIV/AIDS, including lack of knowledge and skills, as well as cultural norms and taboos [17]. However, it has been shown that if parents in Sub-Saharan Africa are given support and taught how to speak to their adolescents, they can and will communicate with their children about these sensitive topics [17].

REFLECTION:

Adolescents in Uganda are engaging in early sexual activity. They are receiving little reproductive health education, have many misconceptions about the risks related to sexual activity and there are few places they can go for confidential care. Any health provider who treats an adolescent is well positioned to take a confidential history, determine their patient's needs; and, together with the patient, help individualize a treatment plan. As providers, we have the responsibility to assess our patients' risk profile and become well versed on how to best counsel and support our patients. We don't have to be experts in everything, but we do need to know available services so, if necessary, appropriate referrals can then be made. Adolescents want to learn and become empowered to make healthy choices. Providers can both educate their patients and help them reflect on their choices. Health care providers can also group together and create new adolescent programs, educate parents and advocate for improved adolescent services so that the unmet needs of their adolescent population begin to be met.

A HEALTHY ADOLESCENT: A HEALTHY NATION!

Useful Websites

American Social Health Association: http://ashastd.org/
Advocates for Youth: http://advocatesforyouth.org/
YMC: Young Men's Clinic: http://www.youngmensclinic.org/
Center for Young Women's Health, Children's Hospital Boston: http://youngwomenshealth.org/
Go Ask Alice: http://goaskalice.columbia.edu/
Guttmacher Institute: http://guttmacher.org/
Sexually Transmitted Disease Guidelines, 2010 CDC: http://cdc.gov/std/treatment/2010/
WHO: Sexual and Reproductive Health: http://who.int/reproductivehealth/en/
WHO: Sexually Transmitted Infections: http://who.int/topics/sexually_transmitted_infections/en/

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