BARRIERS TO COMMUNITY SUPPORT FOR SCHOOL BASED COMPREHENSIVE SEXUALITY EDUCATION IN UGANDA

58th- Master of Public Health/ International Course on Health Development

SEMPTEMBER,2022

KIT- ROYAL TROPICAL INSTITUTE (VRIJE UNIVERSITEIT)
AMSTERDAM, NETHERLANDS

Word count: 13,096

Barriers to Community Support for Comprehensive Sexuality education in Uganda

A thesis submitted in partial fulfilment of the award of the degree of Master of Science in Public Health: A review of Literature.

By Robert Ocaya

Uganda

Declaration:

Where other people's work has been used (from either a printed source, internet, or any other source), this has been carefully acknowledged and referenced in accordance with the departmental requirements.

The thesis: **Barriers to Community Support for School-based Comprehensive Sexuality Education in Uganda,** is my own work.

Signature: 

58th Master of Public Health/International Course in Health Development (MPH/ICHD)

13th September 2021-2nd September 2022

KIT (Royal Tropical Institute)/ Vrije Universiteit Amsterdam)

Amsterdam, The Netherlands.

September 2022.

Organised by:

KIT (Royal Tropical Institute)
Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam (VU)

Amsterdam, The Netherlands.

Word count: 13,096

TABLE OF CONTENTS

Word count: 13,096

Word count: 13,096

Word count: 13,096

LIST OF TABLES

LIST OF FIGURES

Word count: 13,096

ACKNOWLEDGEMENT

In a true reflection of the church hymn that "*God will make a way where there seems to be no way*," God has done it again. It would not have been possible without God.

While I worked to ensure that this dream comes true, countless people prayed for me and wished me well. To them I am eternally grateful.

In a remarkable way, I would like to thank my lovely wife Ms. Josephine Aneno and my lovely boys Kaka, Edwin, and Victor. You all encouraged me to keep focused even when the journey looked insurmountable.

I cannot forget to appreciate the generosity of the Government of the Netherlands through Nuffic for offering me a scholarship that enabled me to obtain this qualification. This would never have been possible without your support.

And to my academic and thesis supervisors at KIT, your support has been invaluable throughout the process of undertaking this course and during the writing of this thesis, I will forever pray for God's protection for you and your families.

Finally, I would like to appreciate the selfless support I got from all my fellow students during this course. I would like to say that the journey of togetherness in the pursuit of our professional advancement has just begun, let us all remain resolute as we march forward.

Word count: 13,096

DEDICATION

I dedicate this thesis to my Late father Hillary Okeny, my mother Joska Auma, and my Uncle Honorable Anthony Akol.

Word count: 13,096

ABBREVIATIONS AND ACRONYMS

ABC	Abstinence Be Faithful and Condom Use
AIDS	Acquired Immune Deficiency Syndrome
CAB	Community Advisory Board
CEHURD	Center for Health, Human Rights and Development
COVID	Coronavirus Disease
CSE	Comprehensive Sexuality education
DRC	Democratic Republic of Congo
ESA	Eastern and Southern Africa
ESARO	Eastern and Southern Africa Regional Office
FBO	Faith Based Organization
GEM	Girl Education Movement
HIV	Human Immune Deficiency Virus
HPT	Health Policy Triangle
ICPD	International Conference on Population and Development
ICT	Information and Communications Technology
IPPF	International Planned Parenthood Federation
LMIC	Low- and Middle-Income Countries
MDA	Ministries, Agencies and Departments
MoES	Ministry of Education and Sports
MoH	Ministry of Health
NCDC	National Curriculum Development Center
NDP	National Development Plan
NGO	Non-Governmental Organization
NSEF	National Sexuality education Framework
PEPFAR	Presidential Emergency Plan for AIDS Relief
PIASCY	Presidential Initiative on Aids Strategy, and Communication for Youth
SBCSE	School-based Comprehensive Sexuality Education

Word count: 13,096

SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
SSA	Sub Saharan Africa
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TGSE	Technical Guidance on Sexuality Education
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
UN	United Nations
UNAIDS	United Nations Programme on HIV and AIDS
UNESCO	United Nations Education, Scientific and Cultural organization
UNFPA	United Nation Population Fund
UNICEF	United Nation Children Fund
WHO	World Health Organization
WSWM	World Starts With Me

Word count: 13,096

GLOSSARY

Barriers to CSE: These are bottlenecks that challenge effective delivery of Comprehensive sexuality education programmes. These include systemic challenges such as restrictive policies, religious and cultural resistance, misconceptions about CSE by members of the community, human resource and financial constraints and competing priorities (1)

Community: A group of people or institutions that share a sense of solidarity, such as common identity, shared norms and values, shared place of residence, and where people attach significance to belonging (2)

Building & Harnessing Community Support: Working with, and consulting with members of the community, policymakers, technocrats, religious and cultural leaders, etc., to find ways of talking about Comprehensive Sexuality education in ways that are culturally sensitive and use evidence and statistics to reassure parents that CSE is not damaging (3).

School-based Comprehensive Sexuality Education: A curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes, and values that will empower them to: realize their health, well-being, and dignity; develop respectful social and sexual relationships; consider how their choices affect their well-being and that of others and understand and ensure the protection of their rights throughout their lives (4).

Health system: A combination of all organizations, people, and actions whose primary intent is the promotion, restoration, and maintenance of health (5).

Policy: A law, regulation, procedure, administrative action, incentive, or voluntary practice of a wide range of stakeholders in public life such as public officials, elected representatives, activist, experts, etc. to shape and organize public life (6).

Young people: Persons aged between 10 and 24 years of age (7).

Adolescents: Persons aged between 10 and 19 years of age (7).

Context: This relates to systemic factors such as political, economic, social, or cultural, both national and international which may influence CSE policy. This may include elements such as political system, the economy, demographic features, and cultural factors such as religion, gender, international or exogenous factors relating to policies that are influenced by international norms and frameworks (8).

Actors: These are individuals, organizations, the state, and their actions that affect policy. (“METHODOLOGICAL APPROACHES OF HEALTH POLICY ANALYSIS IN DEVELOPING COUNTRIES”) Actors have different interests and agendas. Actors include individuals, international NGOs, national NGOs, Pressure groups, international organizations bilateral agencies, funders, private sector, media etc. (8).

Processes: is the steps through which policies are made, implemented, disseminated, or reformulated, negotiated, implemented, and evaluated etc. (8).

Content: refers to the topics or issues covered in a policy which details the subjects and the topics covered (8).

Word count: 13,096

ABSTRACT

Study Objectives

In Uganda, School Based Comprehensive Sexuality Education (SBCSE) receives limited support from the community. What most parents and other community stakeholders prefer is a less comprehensive sexuality education notably the abstinence-based sexuality education. While much is known about the benefits of SBCSE, little is still known about the barriers to community support for the subject in the context of Uganda.

Study Design and Setting

This study was conducted through a literature review. The author searched literature from online databases and the VU online library using google scholar search engine. Peer reviewed and published literature written in English between 1994 to 2022 on the subject were searched. Findings were then synthesized and presented in themes guided by Walt and Gilson's Health Policy Triangle framework covering context, actors, processes, and content.

Findings

Findings revealed that gaining community support for SBCSE is complex. Several processes and actors influence community support for SBCSE. Key barriers include the influence of religion, culture, limited community sensitization, limited participation of young people in curriculum design, inadequate funding, non-formalization of SBCSE into the school curriculums and attempts to implement school based CSE according to internal norms in total disregard of contextual factors.

Conclusions

Findings show that for SBCSE to gain community support, the following issues need to be addressed; multistakeholder involvement in CSE curriculum design and implementation processes, adaptation of CSE content, adoption of proven approaches such as the 'Whole School Approach' and sensitization of stakeholders on the goals of SBCSE. Findings also suggest that achieving full community support for SBCSE is unlikely, however there should be continuous sensitization of stakeholders and efforts to discuss adaptation to SBCSE curriculum to suit the Ugandan context.

Keywords:

School-based Comprehensive Sexuality Education, Community support, Young people, and Uganda

CHAPTER ONE

1.0 Introduction

Over the past ten years I have been working in field of Sexual Reproductive Health (SRH) as a civil society actor. I have particularly focused on adolescent sexual reproductive health and rights and as an advocate. Some of the Sexual Reproductive Health and Rights (SRHR) issues that affect young people in Uganda include limited access to School Based Comprehensive Sexuality Education (SBCSE), low access to contraception (9), restrictive legal and policy environments for abortion (10), unsafe abortions (11), high mortality related to abortion (12), restrictive laws against LGBTQ (13), Sexual Gender based violence, and uneven and poor SHR service delivery for young people (12).

Several SRHR issues affecting young people are considered controversial in Uganda due to the influence of religion and culture. Religious and cultural contexts inform how the country addresses several SRHR issues that affect young people including access to contraception, condom use, SBCSE, and abortion. Religious actors use their ownership of most of the school and health facilities as a tool to promote their values regarding young people's SRHR.

Over the last six years I participated in advocacy for a conducive SRHR policy environment for the young people in Uganda with a focus on access to SBCSE, access to SRHR services, human rights as well as capacity strengthening and Civil Society Organization's movement building.

One of the challenges I have met as an advocate is the limited involvement of communities in policy influencing. On many occasions, policy makers challenged advocates to show that the issues they were raising were important to communities as community voices were less prominent in demanding for them. Yet several surveys conducted by CSOs, and academicians have shown that many community stakeholders support several aspects of young peoples' SRHR including SBCSE.

Many SRHR policies in Uganda are restrictive and do not address the SRHR of all young people. For instance, the current National Framework for Sexuality Education (NSEF) mostly focusses on abstinence, yet evidence shows that many young people are sexually active. The 2016 National Demographic health survey showed bad negative SRHR indicators including 25% prevalence of teenage pregnancy (14).

To understand barriers and facilitating factors of community support for SBCSE, this study on barriers to community support for SBCSE in Uganda was conceived.

1.1 Organization of the thesis

This thesis is organized in several chapters including background, problem statement, justification, methodology, results, discussions, conclusion, and recommendation. In chapter one, I describe the background of Uganda with a focus on contextual factors that affect young people's SRHR. Factors such population structure, health and education systems, religion, culture, and other socio pollical factors have been briefly described. In chapter two, I focus on the objectives, justification, and objectives of the study. In Chapter three I describe the methodology and the conceptual framework used in the study. In chapter four I highlight major findings from the literature review in relation to school based Comprehensive sexuality education and community support for it in Uganda. Key factors influencing community support for SBCSE programmes in Uganda have been highlighted.

Chapter four focusses on discussions around the key findings of the study. In chapter five I present the discussions of the findings and finally in chapter six I present conclusions and recommendations of the

1.2 Background

This Chapter describes background information about demographic, sociocultural, religious, economic, SRHR, and the health system in Uganda.

1.2.1 Demographic, Sociocultural, and religious information

Uganda is a country in East Africa bordered by Kenya to the East, Tanzania to the South, Rwanda to the Southwest, the DRC to the West, and South Sudan to the North. Uganda's population is estimated to be 41.6 million, which is expected to reach fifty-five million by 2030 (15). Uganda's population is youthful, with young people under 30 years of age constituting 75% of its population. The country's population growth rate is 3.31%, while the total fertility rate is at 5.4 children per woman (9). Thirty percent (30%) of Uganda's population are classified as vulnerable to poverty (16). The Government of Uganda considers strategic investments in health and education as important for empowering young people and accelerating the demographic transition necessary for harnessing the demographic dividend. These are emphasized in the country's National Development Plan III and its Vison 2040 (17).

Uganda is home to 1.4 million refugees, making it the largest refugee hosting nation in Africa, and the third largest in the world. While its open-door refugee policy is one of the most progressive in the world, this situation causes tremendous pressure on existing amenities and stresses the health service delivery in host communities (18).

Uganda is a diverse country in terms of religions, ethnic groups, traditions, cultures, beliefs, value systems, languages etc. This diversity plays a critical role in determining how people behave in the country and how they perceive their social, political, and economic realities. Some of the customs and traditional values are gradually changing due to internal, and external migrations, and integration because of intermarriages.

The population of Uganda is religious i.e., Roman Catholic Church (40%), Church of Uganda or Anglican – (32%), Islam (14%), and others (10%) (9), unelected leaders such as religious and cultural leaders play a critical role alongside the government in deciding how the Uganda society is governed (19).

1.2.2 Status of SRH

Most SRH outcomes in Uganda are still bad, for example, despite a decline in unmet need for modern contraceptives over the years, it is still high, i.e., at 30.5% among married women (9) Unmet need for modern contraceptive among adolescents aged 15-19 years stands at 30%. (20). The modern contraceptive prevalence rate among women 15-49 years is 35% (9). The Modern Contraceptive prevalence use among unmarried women aged 15-19 stands at 9.4% (21). Adolescent pregnancy rate has stagnated at 25% among girls aged 15-19 years, with 12 % of adolescent girls being married and contributing to 23% of school dropouts. The SRHR status of Ugandan is still challenged by limited supplies, staffing inadequacies, restrictive policies and general inefficiencies of the health system (9). Deeply entrenched socio-cultural and religious beliefs shape policies, social norms, and practices, negatively influencing women and young people's access to sexual and reproductive health (22).

The Government of Uganda has recommitted to the Family Planning 2030 pledge to continue promoting universal access to all methods of family planning and to reduce the unmet need for family planning to 10% by 2022 (20). Even though Uganda increased the budget allocation for reproductive health supplies from $2.1 to $4.3 million for the 2019/2020 budget year, this still fell short of the required $9.8 million needed to achieve universal access to family planning (23).

The maternal mortality ratio decreased slowly between 2006 and 2016 (from 435 to 336 per 100,000 live births), with 28% of maternal deaths occurring among young women aged 15-24 years. Despite improvements in skilled birth attendance rates (74%) and health facility deliveries (73%), the shortage of health workers, inadequate emergency obstetric care, especially at referral points, gender inequality, and socio-cultural factors inhibit access to high-quality care. Perinatal and death reviews are still not effectively conducted in Uganda at the lower-level health services provision points (24).

1.2.3 Uganda's Health System

The health system, together with the education system play a critical role in the promotion of adolescent sexual reproductive health through provision of services, information, education, and communication interventions targeting young people. The Ministry of Health IN Uganda has decentralized the national health system while incorporating the public and private sectors, the public sector keeps control of 44% of the overall health service provision. The private sector is composed of private not-for-profit health care providers, private health practitioners, and traditional and complementary medicine practitioners. The modal of health service delivery in Uganda is a decentralized system where local government units are the frontline organizers at the district level.

The Government of Uganda's share of health expenditure as a percentage of the Gross Domestic Product (GDP) has stagnated between 5.07% in 2000 and 3.83% in 2019 (25). The country is highly dependent on external support, accounting for about 45% of the health expenditures and raising concerns about sustainability. Patients in Uganda must meet up to 37% of their own medical bills. This goes beyond the globally recommended 20% and this could expose poorer patients to unbearable financial risks (26). Interventions to address the various SRHR information needs in Uganda have been through the village health teams, peer educators, counseling at health delivery service points, community health outreaches, expert clients of young people living with HIV/AIDS, radio programmes, and other health experts (27).

1.2.4 Uganda's Education System

The constitution of Uganda mandates the Ministry of Education and Sports (MoES) to provide quality education to every Ugandan child to the highest possible attainable quality (28). The constitution mandates the local governments with the responsibility of delivering education in Uganda. These units manage the delivery of education in all government public learning institutions as well as the provision of oversight to all private learning institutions. Religious institutions own up to 75% and 56% of all primary and secondary schools in Uganda, respectively. In May 2016 when one hundred schools were accused of teaching same-gender relationships under guise of teaching CSE, the government banned CSE in all schools in Uganda (29). When Sexuality education was reintroduced in Uganda in 2018, religious leaders under their umbrella group of the Uganda Joint Christian Council (UJCC) objected to its teaching in their schools. This objection was significant given the high numbers of primary and secondary schools controlled by religious institutions in the Country (30).

1.2.5 Ownership, funding, and school enrollment trends

Much of the delivery of education in Uganda is done through government public and private schools. The private schools include community, individually, Faith based organizations (FBOs,) NGOs, and other informally owned schools and other non-formal educational centers such as the Alternative Basic Education for Karamoja., Child Centered Alternative Non-Formal Community Basic Education and others. Most privately owned schools prioritize examinable subjects over school-based sexuality education (31).

The government of Uganda provides funding to the tune of 64% for primary schools, and 43% for secondary education in the country. FBOs control 40% of pre-primary, 75% of primary, 56% of secondary, and 44% of tertiary institutions. The government on the other hand controls a paltry 2% of pre-primary, 6% of primary, 9% of secondary and 26% of tertiary institutions, respectively. The others are owned by communities and private individuals, companies, and NGOs (32).

In tandem with the country's population growth rate of 3%, the school enrolment especially at preprimary and primary levels have also rose for both girls and boys from 63.2% and 75.7% in 1995 to 104.1% and 101.3% in 2017 for girls and boys respectively (33).

CHAPTER TWO

2.1 Problem Statement

There is growing appreciation of Comprehensive Sexuality Education (CSE) by stakeholders including young people of the contributions of CSE to the realization of their SRHR and wellbeing. Even though sexuality education has evolved and has been referred to by different names, its main concerns of helping young people to make informed, healthy, and responsible decisions about their sexual lives and relationships have never been in question (34).

Global health data shows that CSE is important for helping young people to improve their sexual reproductive health outcomes by addressing sexually transmitted infections, unintended pregnancy, and new HIV infections among other (35).

Despite the demonstrable benefits of CSE to young people, only 85% of the 155 countries report having some form of policies or framework for its delivery in schools. Even where laws, policies, and frameworks are in place, several barriers inhibit community support for its implementation in schools. Some of the barriers relate to the school setting, SBCSE curriculum content, delivery modalities, teacher preparedness, the school environment, community support, and the wider social and political environment within which the SBCSE curriculum is delivered (36).

Policies and administrative frameworks have been touted as important for the successful delivery of SBCSE programmes and many countries have proactively enacted policies and frameworks to support its delivery in their schools. However, some countries including Uganda still lack policies and administrative frameworks to support the delivery SBCSE. Consequently, the delivery of SBCSE in the country has not been systematic. There have been variations in SBCSE contents and delivery methodologies leading to confusions about their goals and outcomes among many parents (36). In 2016 in Uganda, debates about SBCSE evolved into cultural and political crises, leading to protests which forced the government to freeze the delivery of SBCSE in the country (29).

Teacher preparedness, competence, and motivation are important for the effective delivery of SBCSE, however pre-service and in-service levels trainings have been inadequate to prepare most

teachers to deliver SBCSE in Uganda (37). In sub-Saharan Africa, a regional study revealed that only nine out of thirty-two countries had a preservice training curriculum on sexuality education for teachers but even these were found to be inadequate (4). Cultural norms, values, and religious beliefs were cited by teachers in Zambia and Uganda as some of the impediments that make them shy to teach some topics in SBCSE despite having been trained (38).

Multistakeholder involvement in the design of SBCSE curriculum and sensitization of communities on the goals of SBCSE are important for debunking misinformation and gaining trust and support of community members towards SBCSE. Important stakeholders include local leaders, policymakers, religious leaders, media influencers, the MoES and CSOs supported multistakeholder consultations which led to the passing of a new National Framework for Sexuality Education (NSEF) in 2018 (40). However, despite these efforts, the framework still faces opposition from sections of religious leaders (41).

In a qualitative study involving teachers and students in seven secondary schools in Uganda in 2011, students expressed a desire to receive a package of SBCSE that would include safety measures such as condoms use, birth control and skills for interaction with the other sex. The students viewed the focus of the current sexuality education as being too biological and more concerned with restricting their freedoms to learn about their sexuality. They noted that much of the focus is on the 'familiar stuff' while leaving out what they referred to as the "hard stuff," like the meaning of sex etc. (42). Uganda's NSEF does not meet these aspirations because it promotes principles such as 'God-fearing,' religious & cultural values, morals, and abstinence till marriage, among others (43).

There is growing consensus that CSE content should be adapted to local contexts, however, this must be done without losing essential and desirable components that are internationally recognized (44). In Uganda, there is an emphasis on a "home-grown sexuality education developed in line with existing national policies and commitments" (43). However, this so-called homegrown sexuality education is problematic because it excludes topics like sexual rights, sexual tolerance, sexual choices, sexual differences, and non-judgmental attitude (41). Health care providers on the other hand favor providing information according to the needs of young people. According to a study conducted in Uganda in 2019, health care providers observed that young people need to be given information before they start having sex if they are to be protected from unwanted pregnancies (45).

Most parents take the safety of their children very seriously, some worry about how much information is given to their children through SBCSE or the age appropriateness of the information, some fear that young people may experiment with sex because of SBCSE, (46) and others have misconceptions about the scope and purpose of SBCSE, these concerns make SBCSE divisive and controversial (47). Opposition to CSE is known to create resistance and backlashes that negatively affect policymakers and public servants and lead to reduced efforts towards supporting SBCSE or even to its pause (48). To address the controversies, fears, and misconceptions about SBCSE and create community support, social opposition needs to be addressed (49).
Particularly, there is need to gain more understanding on factors related to context, actors, processes and CSE content that affect community support for SBCSE in Uganda (50).

2.2 Justification of the study

Evidence of the benefits of SBCSE are in abundance, some of the benefits include promotion of good sexual behaviors such as reduction in the number of sexual partners, delayed sexual debut, reduction of new HIV infections, avoidance of teenage pregnancies, STI transmission, promotion of gender equality, self-efficacy, and critical thinking (51;52). SBCSE plays an important role in

keeping young people in healthy and in school, it also fosters positive intellectual, social, physical and emotional capabilities of young people to safely navigate through puberty (53). For SBCSE to impact young people at scale, it needs to be delivered through the school system because young people spend most of their time in schools, CSE programmes may also be integrated into ongoing programs such as health talks at points of health service delivery (47).

The importance of SBCSE has been recognized in three of the Sustainable Development Goals i.e., goals 3, 4, and 5, on good health and wellbeing, quality education, and gender equality, respectively. Goal 3 focuses on ensuring access to sexual reproductive health services including family planning, information, and education, Goal 4 focusses on the acquisition of knowledge and skills needed to promote human rights, a culture of peace, appreciation of cultural diversity etc., and Goal 5 focusses on universal access to SRHR as agreed in the International Conference on Population and Development (ICPD) and the Beijing Platform for Action and the outcome documents and its review conference (38).
Evidence from Kenya, Zambia and Uganda consistently shows that young people consider SBCSE as important, and that young people trust schools as the best place for its delivery (54).

Reviews of SBCSE in low and middle-income countries show that it is one of the effective interventions for reducing HIV related risk behaviors and that students who have undergone these programs often have higher knowledge and self-efficacy for refusing unsafe sex or using condoms (55).

Evidence shows that for SBCSE programs to be effective, they need to have stakeholder support, be consistent with the needs and values of the community, have health goals, address specific behaviors, address multiple risk and protective factors, create a safe and supportive environment, use sound instructional methods, have the support of the authorities, use appropriate drivers, and be implemented with fidelity (56). When communities are not in support of SBCSE, it becomes prone to neglect by civil servants and policy makers limiting the appropriation of resources and policies needed for its success (48). It can also lead to structural challenges that affect young people's SRHR including weak linkages and referrals of adolescents to SRHR service points, financial constraints, and lack of coordination and collaboration among sectors etc. (49).

The importance of the participation of young people in informing SBCSE curriculum is also appreciated by many. However, in real life, there are mixed findings with regards to the levels of participation of young people in these processes, with some countries not involving young people at all, others only consulting but not integrating their inputs and a few genuinely involving and considering their inputs (57).

Given all the benefits of SBCSE to young people, and the awareness of the conditions necessary for its successful delivery, it is important to understand the reasons why SBCSE does not have widespread community support and remains effectively banned in Uganda. This research explores the reasons behind the lack of community support for SBCSE and to identify facilitating factors for community support for SBCSE in Uganda.

2.3 OBJECTIVES OF THE STUDY

To analyze barriers and facilitating factors for community support for SBCSE and make recommendations for building and sustaining community support for the subject in Uganda.

2.3.1 Specific objectives

1. To identify cultural, religious, political, and economic factors that influence community support for SBCSE in Uganda
2. To identify actors that influence community support for school based SBCSE in Uganda
3. To identify CSE programme processes that promote community support for SBCSE in Uganda
4. To discuss CSE content related factors that influence community support for SBCSE in Uganda
5. To make recommendations for gaining and sustaining community support for SBCSE

CHAPTER THREE

3.0 In this Chapter, I describe the methodology and conceptual framework used to address the research objectives in this study.

3.1 Research Design

This study employed a qualitative research design through a literature review. The literature search covered published materials, peer reviewed journals, and unpublished materials from websites of the Government of Uganda, UN agencies, International Non-Governmental organizations (INGOs), reports from National and local NGOs. Some unpublished materials from blogs, and newspapers were also used. Where the newspapers or blogs were determined to be associated with particular interest groups, these relationships were mentioned as these influences the contents of such reports. To situate the problem into the broader global perspectives, some internation level data were used in the study.

Literature review was chosen as a methodology of the study because of the wealth of information in literature that can help in making valuable additions to the subject of community support for SBCSE in Uganda. Other factors that influenced the choice of the study method related to resource and time constraints.

3.2 Search Strategy

The search strategy involved the use of strings of words and word combinations related to the study focus (Community support for SBCSE). Materials used were those published in English and covering the period from 1994 to 2022. The period from 1994 was chosen as the starting year based on the importance of the resolutions of the ICPD and the identification of the Gilson and Walts' Health Policy Triangle (HPT) framework which was published in that year. In this study, I used the HPT framework to guide the analysis and presentation of the study findings. Where historical perspectives were needed, I pushed as far back as possible. This was due to the realization that changes in the field of CSE and young people's SRHR are interconnected and tend to build on each other. The word combinations, databases, search engines, and other web-based sources have been summarized in the table below.

Word count: 13,096

Table 1. Search strategy summary

Search strategy	Objective 1	Objective 2	Objective 3	Objective 4	Recommendations
Databases: VU online Library, PubMed, Scopus, Cochrane Search Engines: Google Scholar, Google Organization' websites and related literature: UNESCO, WHO, UNFPA, IPPF, UN, World Bank, Rutgers, Guttmacher Institute, etc. Grey Literature: MoH, UDHS, NGO reports, The New Vision News Paper, The Daily Monitor News Paper, etc.	Community Support, School-based CSE/SE OR Culture, Religion, Political, Economic Reproductive Health Education, Sexual Reproductive Health, Adolescent Sexual Reproductive Rights, Uganda, Low- and Middle-Income Countries, Sub Saharan Africa, Global, United Nations, Reproductive Rights, Human Right	Community Support, School-based CSE/SE OR CSE content, CSE focus, schools, training institutions, teachers, "religious institutions" Uganda, Low- and Middle-Income Countries, Sub Saharan Africa, Global, United Nations, Reproductive Rights, Human Right	Community support, School-based CSE/SE OR approaches, strategies, promotion of community support, Policies support, frameworks, funding mechanisms, Parents, Young people, Policy making, Norms setting Uganda, Low- and Middle-Income Countries, Sub Saharan Africa, Global, United Nations, Reproductive Rights, Human Right	Actors on CSE OR Parents, Schools, Parent Teacher Associations, Ministry of Education, Religious Leaders, Cultural Leader, Media, Religious institutions, Parliament, local leaders and politicians, young people. Uganda, Low- and Middle-Income Countries, Sub Saharan Africa, Global, United Nations, Reproductive Rights, Human Right	To be generated from all relevant literature reviewed.

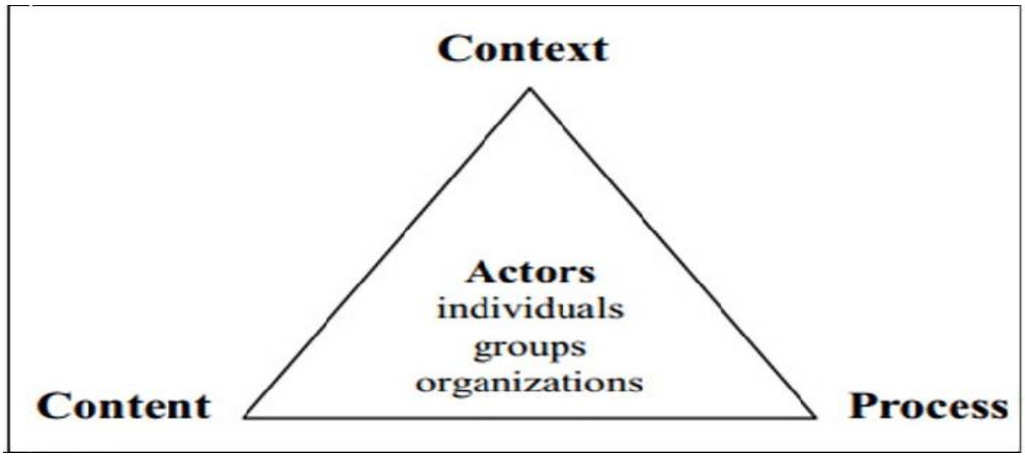
3.3 Analytical Framework

The Health Policy Triangle (HPT) framework by Walt and Gilson (8) was adapted to guide presentation of the findings of this study. The HPT provided a suitable framework for the analysis of the context, actors, processes, and contents related to the design and implementation of SBCSE programmes in Uganda. Contextual factors related to objective one of this study and focused on structural factors such as history, culture, religion, politics, and the economy. Actors related to objective two and focused on individuals, groups, or institutions that play a role in SBCSE. Processes related to objective three and focused on factors such as design of SBCSE, consultation and engagement of communities, sensitization of parents, teacher training etc. Contents of SBCSE curriculum related to objective four and focused on the topics included in SBCSE curriculum or the approaches and focus of SBCSE curriculum and how they influence community support for SBCSE in Uganda.

The HPT framework has been mostly used to analyze health policies at International, and national levels. However, due to its flexible nature, it was adapted and used in this study even though the study related to community support for SBCSE in Uganda. According to Gary O'Brien et al, in their systematic review on the applicability of the HPT Framework in health policy analysis between 2015 and 2020, the applicability of the HPT extends beyond the health sector. They recommended that more novel studies needed to apply the HPT at local and regional level policy analysis (58).

Word count: 13,096

Figure 1. The Health Policy Triangle (Walt and Gilson 1994)



3.3.1 Contextual factors and influences on policies/ programs

The table below shows contextual factors and their influences on policy/programme processes. For this study, the following contextual factors was discussed, historical context, national economic condition, administrative capacity, international context, cultural, and religious factors.

Table. 2, (Gilson. L et al, (2018)

Contextual features	Influences – for example
Sociopolitical pressures and interests e.g. electoral cycles, socioeconomic structures, gender relations, dominant or contesting ideologies	• Which interest groups have what level of power • Policy elite perceptions of what is feasible • Other actors' perceptions of their interests and concerns • Use of State resources for patronage • Timing of policy • Implementation feasibility
Historical context e.g. legacy of colonialism	• Forms of governance • Nature and functioning of civil service • International alliances • Collective memories – what public policy action is deemed appropriate • Legitimizing values
The national political and legal system e.g. State governance structures, systems of accountability	• Policy elite perceptions of what is feasible • Who participates in formal decision-making processes • Which actors have which levels and forms of power • Levels and forms of accountability • Legitimacy of State action
National economic conditions and policy e.g. macroeconomic situation and policy, state role in national economy	• Timing of policy change • Resource support for policies • Social policy options
Administrative capacity (skills, structures)	• Capacity to marshal the range of necessary resources to support implementation
International context e.g. international events, agreements, resources	• Economic conditions (and policy) • Dependency relationships with external actors • Norms driving policy change

3.3.2 Actors

These are individuals, groups or institutions that are important in SBCSE processes at the community and national levels. Their influence extends across all aspects of SBCSE programmes. In this study, actors include young people, parents, teachers, religious leaders, cultural leaders, politicians, bureaucrats, among others. There are international level actors who work through proxies such as NGOs, advocates etc. and influence SBCSE. The nature of relationships between actors are important in SCBCSE processes because some possess power that they can use knowingly or unknowingly to shape the behavior of others towards the programme (8).

3.3.3 Processes

In this study, process related to school settings, community consultation, teacher training, sensitization of parents, administrative capacity, and coordination, monitoring and evaluation of SBCSE, among others. The actors exercising decision-making power in SBCSE processes include not only school administrators, teachers, parents, young people, religious and cultural leaders but also various governmental entities, CSOs, and development partners such donors and UN agencies (58). Community participation in SBCSE processes can be ensured through community consultations, sensitization, or establishment of community structures to support the implementation of SBCSE programmes.

The table below shows examples of how actors may influence SBCSE processes by advancing their agenda from international, and national to community levels, sometimes working through proxies at community levels on policies/programmes such as SBCSE.

Table 3. Adapted from Gilson, et al, (2018)

Pushing states to guarantee human rights and address stigmatization of marginalized populations
Offering new strategies to address a longstanding problem
Distorting National Health Priorities-National health priority setting
Limiting the scope of policy debate e.g., Global neoliberalism, Religion, culture, etc.

3.3.4 Content

In this study, content refers to topics, approaches or focus of SBCSE curriculum. SBCSE curriculum focus relates to the choice between the abstinence only approach, Abstinence plus condom or ABC-plus, and CSE. SBCSE content has been selected because they usually generate contentious discourses about SBCSE by different stakeholders in Uganda. An analysis of the influence of contents considered topics such as abortion, sexual orientation, contraception as some of the contentious contents that affect community support for SBCSE.

3.4 Study limitations

Some of study limitations related to inadequacy of literature on components of the study such as SBCSE processes. Some studies accessed were qualitative in nature and were small in terms of sample sizes. This study also missed the rich insights of communities on the subject which would have been obtained through primary data sources. In some cases, the study relied on newspaper

articles, some of which report from a biased point of view hence posing a challenge to the veracity of some of their claims on the subject. However, the researcher triangulated the findings by searching for information from different studies which were undertaken with diverse groups of young people and from different geographical areas of the country.

CHAPTER FOUR

4.0 Results

In this chapter, I present findings from the literature reviewed in four subsections as per the themes identified in the analytical framework. In section 4.1, I focus on contextual factors such as historical legacy, history of CSE in Uganda, the politics of CSE, culture, religion, and the economy. In section 4.2, I focus on actors such as young people, teachers, parents, religious leaders, cultural leaders, bureaucrats, politicians, government ministries, agencies, and departments, INGOs, CSOs, Advocacy/pressure groups, etc., and the roles they play in shaping community support for CSE in Uganda. In section 4.3, I focus on SBCSE processes such as community sensitization, community involvement, community consultation, school settings etc., and how these influence community support for SBCSE in Uganda. In section 4.4, I focus on SBCSE curriculum content with attention to how content related contestations affect community support for SBCSE in Uganda.

4.1 CONTEXTUAL FACTORS

4.1.1 Historical context and history of sex education in Uganda

Sexuality education in Uganda has been influenced by the historical legacies of colonialism. Contestations around SBCSE in Uganda is rooted in the country's history with colonialism, missionization and international aid. A situation which situates SBCSE in the realms of anticolonial sentiments and project it as a tool for continued ideological imposition by the former colonial heads (29). Open discussions about sexuality were promoted in Uganda in the early 1990 to tacking the rising HIV infection rates. There was a strong political will at that time by the government to frankly engage communities to change their behaviors to curb the spread of HIV/AIDS pandemic. This period also saw a rise in transnational funding for HIV AIDS with funding largely coming from the USA to support Uganda's fight of the HIV pandemic. This nevertheless came along with an ideological orientation in favor of a moralistic approach to address the HIV pandemic (60;61;62).

In 2009, Uganda came to the limelight as result of a proposed Anti Homosexuality Bill that sought to criminalize homosexuality and suggested harsh punishments for gay people including death (63). This period saw a rise in homophobia and emboldened sections of religious groups, non-state actors and citizens to attack people suspected of being gay (64). Whenever politicians debated the issue, they framed their resistance using anticolonial rhetoric, often citing political, economic, and social sovereignty (29). This rise in homophobia also affected community support for SBCSE since it was equated by its opponents as a tool for promoting same-gender relationships and LGBTQ rights in Uganda (41).

Sex education in Uganda was traditionally done in an indirect way, through expressions, or proverbs. Talking about sex was done differently in distinct cultures. Sex education was traditionally offered in secrecy and by a family member of the same sex as the young person (65). The family members that provided sex education included paternal aunts (for girls), uncles (for boys), mothers (for girls) and sometimes peers (66).

According to research on adaptation and implementation challenges for CSE in Sub Saharan Africa (SSA), community resistance to SBCSE is sometime a result of resentment from the community towards the loss of their traditional ways of instructing their children about sexuality to new western methods (67). Even though research shows that issues around sexual health communication are dynamic and local contexts within which they are offered change (68). The Ugandan society has been rigid and slow in adjusting from the way it communicated about sexuality, while holding suspicion that SBCSE promotes promiscuity and immorality among adolescents in a 'morally upright' society (65). In 2016, a newspaper reported that one hundred schools were tricked into teaching homosexuality, religious leaders mobilized communities to complain to the speaker of parliament to ban SBCSE (69).

4.1.2 The politics of sexuality education

Politically, majority of voters in Uganda conservative due to their cultural and religious beliefs. This then sways politicians towards the voters' preferences. Despite the government being aware of its commitments towards SBCSE such as under the East and Southern African (ESA) inter-ministerial commitment, politicians are afraid of backlash from the electorates. As a result, politicians support the less contentious approaches such the abstinence only approach (40). To show this position, the current President of Uganda had this say on the occasion to celebrate the World Population Day in 2016,

> '*Do not engage children in Sex Education in school? […]. My view of bringing up children is that there is a time for everything, as shown in the book of Ecclesiastes,'* referring to a Christian philosophy of abstention from earthly pleasure (29).

Comments such as this by a head of state deter communities from supporting SBCSE in Uganda.

4.1.3 Cultural context

In an evaluation of implementation of SBCSE in resource poor settings, it was found that in conservative societies, culture can be a barrier to the implementation of sexuality education (70). The Technical Guidance on Sexuality Education (TGSE) emphasizes the need to promote cultural appropriateness in sexuality education (4). A study on culture as an object of ethical governance in AIDS prevention postulated that culture need not only be seen as barricade to the transfer of information about sexuality as it can offer an access point for initiating behaviour change communication (71). In the case of Uganda, qualitative research on cultural schemas of teachers and delivery of SBCSE showed that teachers struggled to teach topics of SBCSE that are contrary to their long-held cultural values, norms, and religious beliefs (72). The TGSE prescribes adequate teacher preparation through training as solutions for addressing teachers' biases while delivering SBCSE. (4).

4.1.4 Religious context

In Uganda, society is shaped by religion in many aspects including by forming and enforcing morals and by providing a basis for associations separate groups of people (73). Most issues related to SBCSE are also influenced by religious factors. An example of the influence of religious context on SBCSE in Uganda was shown when members of Christian churches under their umbrella of Uganda Joint Christian Council (UJCC) rejected the new NSFE as soon as it was launched sue to concerns about its lack of adherence to Christian values (29).

Religion is so entrenched in people that teachers find it difficult to get out of the shadows of their religious beliefs and values when teaching about moral issues such as sexuality. Very few teachers

have managed to break these barriers while delivering SBCSE, with a few examples still being able to teach about some of the sensitive topics such as condom use and contraception (65).

4.1.5 Economic context

According to an economic update report on Uganda, Uganda was one of the countries that struggled due to lack of systems and resources to ensure that investments in education, health and other service delivery reached their intended users (74). As a result, earlier programmes such as the PIASCY and the National Adolescent Health Policy suffered due to lack of funding. Most of the funds for these programmes came from development partners such as UNICEF, UNFPA, and other NGOs (40). NGO funding usually come from sources other than the public or government and are usually not sustainable. One teacher in a qualitative study on institutional and contextual obstacles to sexuality education in Uganda observed that *'When the government is boasting about SRH programmes in Uganda, I wonder which curricula? [...] NGOs do all the work on adolescent SRH. They should then leave us to do what we want.'(40)* The limited funding for adolescent health programmes causes lack of consistency in programmes as different donors promote different interests. This breeds confusion among stakeholders in the community such as students, teachers, parents, among others.

4.1.6 Regional and International context

In terms of regional and international commitments relating to CSE, Uganda has signed or ratified several instruments which mandate it to deliver SBCSE. Key among them is the ESA inter-ministerial commitments, which acknowledge the role of CSE in promoting the health of young people including with respect to HIV/AIDS. A review of the ESA commitments appreciated ongoing efforts in the delivery of HIV education, it also highlighted gaps that could be addressed through CSE including on gender inequality, child marriage, violence, and intolerance. One of the targets of the commitments was for countries to expand access to CSE by integrating it into the school curriculums and expand the number of schools delivering it by 2017(75). However, the operationalization of this commitment only happened in Uganda in 2018 (43). Even then, the SBCSE that was approved in Uganda in May 2018, promoted the abstinence only approach. In December 2021, Uganda was however among the countries that did not recommit to ESA goals, asking for more time (76).

4.2 ACTORS

Actors are influential individuals, groups, and organizations (59). Actors are important in determining community support for SBCSE through making inputs during SBCSE curriculum design, participating in SBCSE as teachers or learners, reinforcing SBCSE messages in communities, promoting enabling environment for SBCSE, influencing policies for SBCSE, and approval of SBCSE curriculum.

The table above shows different actors in SBCSE and their main interests and concerns

Table 4: A summary of key CSE actors and their main concerns- (source-author)

Actors	Their concerns
Young people	Need a wide range of information about sexuality
Parents	Safety of their children, morality, some parents support SBCSE
Teachers	Skills and attitudes to deliver CSE, concerned that CSE is inappropriate, appropriate school settings and Policies
Religious leaders	Preservation of religious believes and values
Cultural leaders	Preservation of cultural values and norms
Technocrats & Politicians	Compliance with standards and regulations, political power
Advocacy/pressure groups	Protection of young peoples' rights to SRHR, concerned that CSE is inappropriate for young people

4.2.1 Young people

The participation of young people in SBCSE is important for getting their inputs into the curriculum, determining their preferences and needs, and determining their perceptions of the relevance of SBCSE. Meaningful involvement of young people in SBCSE is not only important for understanding their needs but also for fulfilling their right to participation in their sexual agency (77;78). Participation inspires young people to take control and an active role in promoting their SRHR. Meaningful involvement of young people in SBCSE curriculum development processes has been rare in in the East African region (54). Lack of involvement of young people in design of SBCSE curriculum often result into fear based, and normative SBCSE curriculums that are preoccupied with the promotion of abstinence only against the lived realities of young people in Uganda (42).Such curriculums are often unpopular with young people as revealed by a study involving four secondary schools in Eastern Uganda where young people indicated that they had less trust in SBCSE delivered by teachers even when they had many myths and misconceptions about their sexuality that teachers needed to clarify (79).

4.2.2 Parents

The role of parents and caretakers in SBCSE is critical. Parents are important gatekeepers to young people, and they play a critical role in influencing attitudes, norms, and values related to sexuality and the position of young people in society (36). A study conducted in four countries in SSA found that perceptions of parental support or lack of it influences the delivery of SBCSE since teachers fear clashing with parents (80). The same study found that when parents are opposed to some topics in CSE, this can form a big challenge to its acceptance and effectiveness. The same study recommended the need to align contents of SBCSE with the values of the parents if SBCSE is to gain community support. This however risks weakening the reliability of SBCSE curriculums since teachers may omit important components of the (80).

An evaluation study on implementation of SBCSE in resource poor context, revealed that when SBCSE messages conflict with what children get from their parents, the efforts of teachers become futile (70).

A study conducted in Wakiso district in central Uganda showed that some parents in Uganda were a bad example to their children. To buttress this point, a teacher who took part in the study had this

to say '*We believe that young people see these things from the environment at home . . . if [the mother] brings men over and over, what do you expect the daughter to do? . . . some parents are shy telling their children, what sex is all about . . . they feel . . . it will open the eyes of the children and they [will] start [being sexually active' (81).*

Another qualitative study on teenagers' assessment of sexuality education revealed that parents considered talking to their children about sexuality as a taboo. Subsequently, they reprimanded children who asked questions related to sexuality instead of supporting them (42). Parents only talked to their children about sexuality when dealing problems such as teenage pregnancy, or STIs (82).

4.2.3 Teachers

Teachers play a critical role in the delivery of school based SBCSE. UNESCO considers SBCSE as the most feasible, efficient, and scalable form of intervention for addressing young peoples' SRHR (83). A qualitative study involving adolescents 14-19 years in Kampala city and rural Mbarara district revealed that teachers were considered by student as important referral sources of SRHR information for them (84). However, teachers in Uganda face several contextual and institutional obstacles in their efforts to deliver SBCSE. These the obstacles include socio-cultural and religious values, religious beliefs, lack of support from school administrators and communities 85). A study on teachers' beliefs and attitudes towards young peoples' SRH in Ugandan secondary schools, found that teachers preferred to emphasize to students to control themselves and abstain until marriage (86).

In another study on obstacles to SBCSE in Uganda, it was found that teachers considered SBCSE as mostly necessary for girls since girls are more vulnerable to SRH challenges. This was highlighted by some of the teachers in the study as follows; '*Girls have more challenges; they need to be locked up'* … Senior woman teacher. While a senior male teacher reported that '*girls need sexuality education [more] than boys because girls mature faster and have risks of getting pregnant'* (40).

4.2.4 Religious Leaders/Institutions

Religious groups and institutions are important actors in SBCSE in Uganda because they own majority of primary and secondary schools in the country. They therefore dictate the kind of SBCSE they allow in their schools i.e., the abstinence only approach (43). In May 2018, the UJCC, a group of Christian churches including the Roman Catholic Church, Church of Uganda and the Orthodox Church rejected the new NSEF as soon as it was launched by the government (87). This objection to the policy was noteworthy because faith-based organizations oversee most educational institutions in Uganda, including 75% of primary schools and 56% of secondary schools (29).

According to Wekasa et al, (84), when religious leaders mobilize societal resistance against the implementation of SBCSE, young peoples' access to SRH services and the effectiveness of SBCSE are challenged. Contradictory information from religious leaders undermines the fidelity of SBCSE curriculum. Teachers may sideline contents that are inconsistent with the values of religious groups. In the case of Uganda, religious leaders' influence led to the approval of a new NSEF that does not conform to the TGSE (40).
Earlier SRHR communication programmes for young people in schools in Uganda such as the Presidential Initiative on Aids Strategy for Communication to Youth (PIASCY) was influenced by religious groups to focus on the abstinence only approach (40).

However, on the issue of condom education for young people, religious groups in Uganda lack harmony. While some groups favor talking about condom to young people to reduce new HIV & STI infections, others fear that advocating for condom use counteracts the abstinence until marriage message which they have been promoting (88).

4.2.5 Traditional actors

Uganda is a culturally diverse society; this implies that there are different traditional actors when it comes to sexuality education for young people. The most common actors among the many groups are paternal aunts ("Sengas"), maternal uncles ('kojjas"), grandparents, elderly women, and older siblings (65).

The "sengas" were central in providing sexuality education for girls. This was usually done in preparation for marriage. They taught girls how to behave and be good wives, make their husbands sexually happy, cook well etc. (89). Much as this role persists and is highly regarded, it is slowly fading out due to societal changes such as urbanization, the rise of nuclear families, working parents etc. (90). Maternal uncles instructed boys about their roles as men in marriage. There was however not a lot of focus on boys as it was assumed that they did not need sexuality education and that they would somehow get to know about sexuality issues (65).

In the absence of both the "senga" and the "kojja," elders in the family assumed their role and instructed young people about sexuality. Some of the methods used included use of riddles, stories, folklores etc. most of which were aimed at creating fear in young people so they would not engage in sexual activity until marriage. Young people in Buganda were for example told that there is "fire" between the legs of women and "snakes" between men's legs. This was intended to scare them from doing "adult things" (65).

For the girls in Buganda, Bugisu, Teso and the Luo ethic groups, virginity until marriage was emphasized. This was intended to make the girls more valuable in terms of dowry and to bring pride to their families. This focus however brought a lot of shame to girls who could not keep their virginity. Also, across most of the Ugandan cultures, all actors emphasized sexuality education for girls because they were considered to need it more (90).

What came out from literature shows that traditional actors had some commonalities; for example they saw sex as a biological need that should be practiced only in marriage, sex as a taboo which should not be discussed in public, valued the limiting of interactions between boys and girls, sex education encouraged sexual activity, young people as innocent and not to be exposed to sexuality education early, valued virginity and sex education for girls etc. All these also informed the view among some parents and teachers that sexuality education should not to be taught in schools but from homes through family members (65).

The institutions of the "sengas" and the "kojja" have however been made less efficient due to society changes posing a risk of young people missing sexuality education if it is not given in schools (72).

4.2.6 Politicians and Technocrats

In Uganda, Politicians view SBCSE as an imposition by donors. In a study on contextual and institutional obstacles to CSE in Uganda, a politician interviewed had this to say '*We are opposed to CSE in the Ugandan setting, the 'C' is inconsistent with African values. Even the president has said we will implement international resolutions within our beliefs. And that is abstinence only'* (40). The moral orientation of voters and their conservatism towards SBCSE could be influencing both the politicians and the technocrats in backing the abstinence only SBCSE.

Technocrats tend to give undue credence to consultation of religious actors in Uganda. For instance, the National Curriculum Development Center consults religious leaders from the Inter-Religious Council in all SBCSE curriculum development processes. To confirm this, a member of the Inter-Religious Council interviewed for the study on institutional and contextual obstacles to CSE had this to say, *'we are custodians of morality, we must be consulted when anyone wants to teach issues of morality.'* Such consultations delay the completion of SBCSE curriculums and breeds conflicts on the contents and focus. In all these, it is worth noting that the views of the politicians and the technocrats against SBCSE is often supported by the community (40).

In Uganda, there are also contradictions between policies on access to information by young people. For instance, the MoH promotes information on contraceptives while the MoES does not do that (91).

4.2.7 Advocates

Following the ban of SBCSE in Uganda, envoys publicly voiced their concerns by condemning the government for this act. The envoys from Netherlands and other donors supported local NGOs to organize and protest the ban, these protests also attracted many young people (92). Other advocacy and pressure groups including CSOs joined forces to challenge the ban of SBCSE. For instance, Center for Health, Human Rights and Development (CEHURD), a local organization working on behalf of other local and international NGOs filed a court case challenging the ban of SBCSE citing it as a violation of the rights of young people to information. This made the government to begin the development of the NSEF. Other advocates for SBCSE continued to engage with religious leaders following the backlash after the launch of the NSEF from sections of religious leaders (29).

4.3 PROCESSES

Curriculum development and adoption processes such as curriculum design, community sensitization, community involvement, community consultation, sensitization of parents, teacher training, monitoring and evaluation of SBCSE programmes, and how these processes influence community support for SBCSE in Uganda.

4.3.1 Implementation of SBCSE programmes & school settings

When SBCSE lessons are given limited time for lessons, this presents a challenge to both teachers and pupils. In an evaluation study of SBCSE programmes in Southwestern Uganda conducted in 2019, pupils reported that the time given for SBCSE lessons were inadequate for them to ask questions and get feedback (30). Headteachers prioritized time for examinable subjects and did not allow candidate classes to take part in SBCSE. A headteacher had this to say in the study, *'no, you do not have to enter my time! Am having pupils in candidate [end of primary level national*

examination preparation] class!' (30). Where schools made SBCSE classes mandatory for pupils and teachers, this promoted attendance by pupils and delivery by teachers. In the same evaluation study, it was found that making SBCSE lessons mandatory raised attendance to 70% of the targeted pupils in eight schools, and 55-65% in four schools, while low attendance was registered in three schools i.e., 33%. (30). The same study found that school settings influenced how learners and teachers perceived SBCSE. At least 80% of the schools that took part in the evaluation indicated that delivering SBCSE in overcrowded classrooms or under trees (shades) were not ideal for both teachers and learners. This is because such environments were prone to interruptions and affected learners' concentration (30). According to a study on adaptation challenges of SBCSE in SSA, where SBCSE were not part of the curriculum, they were usually given insufficient and peripheral hours which made it appear as extra workload for teachers who already had so much work to do, and the overworked teachers did not support it (67).

According to Iyer and Aggleton, school settings and attitudes may contradict the values of CSE by perpetrating the view that sex is only meant for procreation in marriage, and the promotion of the abstinence only approach which is unpopular with many young people (87).

4.3.2 Consultation and community participation

A study on adaptation and implementation challenges of SBCSE in SSA indicated that stakeholder participation in the design of SBCSE curriculums is important for their effective adoption and implementation (67). An evaluation study in Southwestern Uganda, showed that the creation of a community advisory board (CAB) made up of parents, inter-religious leaders and policy representatives helped the successful delivery of SBCSE programmes in the region. The CAB provided insights on age, cultural, and content appropriateness of the SBCSE curriculum. This helped for obtaining approval from the authority as well as for providing guidance during joint programme review meetings where contents were edited in light with culture and religion. Community stakeholder participation however challenges curriculum developers as some topics such as sexual orientation, contraceptives, etc., maybe omitted hence affecting the fidelity of SBCSE curriculums (81).

4.3.3 Linkages between schools and SRHR resources and services

Literature could not be found on official policy, guidelines, or a structured way of creating linkages between schools and health services in Uganda. However, an evaluation of SBCSE program in Southwestern Uganda revealed that parents appreciate linkages between schools that offer SBCSE and Health care, legal, or psychosocial service providers. This was because children who received SBCSE became aware of SRHR violations and reported to their parents any abuses. One parent who participated in the study wondered what the children were being taught after noticing increased rates of reporting of violations by the children (30). In the evaluated SBCSE programs, the CAB provided guidance on how to create these linkages.

4.3.4 Training for teachers

According to an evaluation of SBCSE programmes in resource poor settings, inadequate training of teachers to deliver SBCSE affects their perceptions of the subject. Teachers with inadequate training reported difficulty in delivering certain contents of SBCSE (70). Where SBCSE programmes were delivered in a disjointed manner and by several teachers some of whom were untrained, they failed to apply appropriate methodologies such as dramatization by peer educators, games, and audio-visual materials and failed to respond appropriately to learners' questions leading to perceptions that this SCBCSE were boring and making them less attractive to learners (70). Where teachers were appropriately trained, they felt more comfortable delivering SBCSE lessons, a

teacher who took part in an evaluation study of SBCSE in Southwestern Uganda remarked that; *'Society was condemning sexuality education. What we were hearing about sexuality education is not what we are seeing'* (30). Training made teachers to view SBCSE more positively. One teacher in the same study reported that SBCSE increased consultation on sexuality issues between teachers and pupils, mutual respect, and support for girls during menstruation by fellow pupils. Another teacher in the same study noted that; *'Previously, a male teacher discussing menstruation would generate murmurs and contention in the classroom but now when you speak those words that were previously thought of as taboo, the children do not even blink; they are informed'* (30).

4.3.5 Sensitization of parents

An evaluation study of CSE programmes in southwestern Uganda showed that parents needed sexuality education too. Parents wanted to be trained on CSE so that they would be in position to respond to questions from their children and to reinforce information that learners received from schools. Pupils shared whatever information they received from SCBSE with their parents. One pupil shared her experience as follows; *'When I reached home, I told my mother everything that was taught to us, and she said that I should continue attending because they are helpful to me*' (30). In response, parents asked to have their own capacity strengthened, one parent had this to say '*Now that you have tutored our children, you need to teach us parents. 'Some of the challenges our children face, come from our homes.' […] you should think of teaching parents as well because what you speak with the children at home should relate to what the teacher says ….' ("Process evaluation of a comprehensive sexuality education intervention ...") When they relate those three, they [pupils] may be helped better", (30).* Sensitization of parents and communities as well as their involvement in the design and delivery of SBCSE curriculum is one of the recommendations in the ESA commitment for avoiding contradicting messages about SBCSE coming from parents (75).

4.3.6 Monitoring, and evaluation of CSE programmes

Monitoring and evaluation are central to improving CSE programmes both during and after their delivery, yet in many Sub-Saharan African contexts, this is poorly done due to poorly designed implementation guidelines which may lack clarity on indicators for evaluation. Even in situations where some forms of evaluations are done, they usually focus on the mode of delivery by educators as opposed to the attainment of the learning outcomes among the learners (57).

Monitoring of CSE programmes helps to inform programme or curriculum adaptation. A case was shown in a Uganda internet based CSE programme which was renamed to a mixture of English and a local language as "Cybersenga," a reference to paternal aunts that provided sex education to girls. This adaptation helped to improve acceptability of the CSE curriculum, a feat which was helped by discoveries made during monitoring (67).

4.4 SBCSE CONTENT

Content in this study refers to the topics included in the SBCSE curriculum. For instance, topics which have been included in the TGSE such as "relationships, values, rights, culture, and sexuality, gender, violence, and safety, health, and wellbeing, among others" (4). In Uganda, there are contestations around topics included in SBCSE curriculum such as sexual rights, sexual pleasure, sexual and gender diversity, contraception abortion, condom etc. Consequently, the current NSEF aligns with the abstinence only approach to sexuality education. It is silent on topics such as condom education, contraception, abortion, gender diversity and sexual rights.

4.4.1 Contested topics in CSE in Uganda

The content of the SBCSE curriculum matters a lot to the people of Uganda. A study on teenagers' assessment of sexuality education in Uganda highlighted several content issues that learners consider important. These included depth, comprehensiveness, and gender (42).
The same study found that teenagers were less interested in SBCSE programmes that were only aimed at addressing their perceived SRHR vulnerabilities, morality, and abstinence. Rather they preferred SBCSE curriculums that would empower them to positively control their sexuality (42). The abstinence only SBCSE curriculum was described by teenagers as prescriptive, authoritarian, theoretical and oblivious of their lived SRHR realities. Concerning depth of the contents, young people did not favor a shallow curriculum, only focused at promoting moral values, heterosexuality, and procreation. They favored a more detailed and comprehensive SBCSE programme that would address most issues they experience in their daily lives such as relationships, contraception, safer sexual practices etc. The balance in terms of gender in SBCSE content for boys and girls were also found to be of importance to teenagers. Teenagers found that some SBCSE programmes focused more on girls without much attention to the boys. Girls were concerned that content such as hygiene and pregnancies were aimed at them ignoring the role of boys in those topics and exempting boys from responsibility as well as encouraging boys to treat girls as sex objects as opposed to equal partners (42).

A recent study in Uganda revealed that some teachers were uncomfortable teaching topics in SBCSE such as contraception, abortion, sexual diversity etc. as these conflicted with their cultural values and were perceived to negatively affect their social standing in society (72).

In a study on institutional and contextual obstacles to CSE in Uganda, religious leaders indicated that they "detested" CSE because some topics in it are offensive, for example teaching 10-year-olds that there are some people who are naturally attracted to the same sex and that this is natural and normal!" This appealed to the parents who considered religious leaders as protecting their children from unfiltered information (40).

4.4.2 Abstinence Only Approach

Sexuality education is usually delivered in many forms and approaches with some focusing on the promotion of abstinence only and others being more holistic. The abstinence only sexuality education curriculum is delivered with emphasis on morality, prioritizing premarital abstinence and morality (93). This approach assumes that young people are "innocent" on matters of sexuality and that exposing them to SBCSE encourages sexual activity amongst them. Under this approach, information about certain topics such as contraception, condom use, sexual pleasure, sexual orientation, and gender identity are omitted (72).

In Uganda, the abstinence-only sexuality education is favored (94). Earlier programmes such as the PIASCY have been abstinence only programmes (95). The abstinence only approach is consistent with the culture, religion, and moral values of the country (96).

A study on teachers' perception and attitudes towards SBCSE revealed that professionalism is challenged by their inherent attachment to the abstinence only education which is informed by religious and cultural foundations (87). When teachers are unable to challenge their attachment to the abstinence only approach of teaching SBCSE, they become incapable to offer in-depth and more inclusive information about sexuality to their learners (97;98).

The abstinence only approach to sexuality education has been faulted for being blind to the lived experiences of some young people and for presuming that young people are homogenous and are not sexually active (95).

Cohen and Tate in their study on the effectiveness of the abstinence only HIV programs in Uganda faulted that strategy for being driven by dogma as opposed to science. According to them, this approach also pays no attention to the realization of the human rights of young people to information and the highest attainable standard s of health and life (95).

Backers of the abstinence-only sexuality approach fear that SBCSE may encourage young people to become sexually active (65). On the other hand, according to a qualitative study on teachers' interpretation of the influence of context on sexuality discourses, young people prefer an honest and open approach to sexuality education which provides comprehensive and real-life information about sexuality (99).

The Abstinence-Plus approach, also known as the ABC model (which presents condom and contraceptives in a medically correct way as alternatives for sexually active teenagers (100) has been pushed as a middle ground to the abstinence only approach. Some writers have synonymously used the term to mean CSE, but the ABC differs from CSE due to its lack of attention to gender and power relations (101). The Abstinence Plus approach is more comprehensive in that it includes information about condoms based on the acknowledgment that there are cases when abstinence may not be possible. The approach is also aware of the connection of relationships, sexuality, and sexual activity among young people (102). One of the major deficiencies of the abstinence only approach is its failure to promote gender equality and empower girls discuss safer sexual practices with their partners (103).

4.4.3 Comprehensive Sexuality Education

CSE has been perceived differently in Uganda by different actors, religious leaders for instance see it as synonymous with promiscuity, pro-gay, pro-abortion. They further perceived it as an infiltration into the Uganda way of life being promoted by international agencies and rally people to reject it (29). This view is also in line with the perception that CSE is foreign to Uganda. Young people on their part view CSE positively as source of information about puberty, self-esteem, decision making etc. (104).

Politicians represented by the Minister of Education and Sports see CSE as a threat to school going children in Uganda which must be firmly rejected. The threats according to the Minister comes disguised as sexual rights, sexual tolerance, sexual choices, sexual differences, and nonjudgmental attitudes to sexual orientation (41). This also aligns with the so-called threats from the west to Ugandan values that dominated gender and sexuality discourses in Uganda in the past years. For instance, in 2016, while announcing the ban of sexuality education, the Minister of Gender Labor and Social Development commented that the version of CSE being promoted in Ugandan schools by the development partners was un-African, and unwelcome (105).

CHAPTER FIVE

5.0 Discussions

In this chapter, I present discussions on major findings from the literature review on barriers to community support for SBCSE in Uganda. Discussions will highlight findings about the importance of context on SBCSE curriculum, the importance of school settings, policy environment, and SBCSE

actors in promoting community support for SBCSE. A reflection on the HPT framework and limitations of the study has also been presented in this section.

Using the HPT model, the analysis found contextual, actor related, SBCSE curriculum process related, and content related factors affecting community support for SBCSE in Uganda (8). Knowing about these factors is important as it highlights how community support for SBCSE is affected by several factors that demand attention if these barriers are to be addressed. The findings show that religious conservatism plays a dominant role in barring community support for SBCSE in Uganda. In many ways applying the moral panics and relying on their control of educational institutions to exert influence on communities and policy makers in favor of the more moralistic and abstinence-based sexuality education and against SBCSE.

As British criminologist Cohen asserted, moral panic relates to a situation in which hyperbolic fear is fabricated about a matter considered or "claimed" to have a moral significance (106). The claimed threats then become objects for coalescing the society to call for actions to end the presumed threats, which usually subside once the authority effects change (107). This was the case in Uganda when a moral panic was prompted about the "teaching" of 'homosexuality' in schools "disguised" as SBCSE. As a result, the government halted SBCSE in 2016. What followed was a process of curriculum revision which resulted into the abstinence only sexuality education as well as the creation of community resistance to SBCSE by religious leaders. This resistance was also supported by some bureaucrats and political leaders (40). In 2011, the government of Ghana tried to address the increasing HIV infections rates among the men who have sex with men (MSM) by developing a national policy for addressing HIV infections and care for the Most At-Risk Populations (108). This effort was thwarted by a moral panic instigated by a falsified newspaper report that claimed that there were over 8,000 gay people in two regions of Ghana and that most of them were infected with HIV/AIDS and STDs. The MSM were described as gay people who were spreading HIV/AIDS in Ghana and recruiting students from schools into homosexuality (109). This resulted into a moral panic where the population feared that their children were being recruited into same sex relationships and exposed to the risks of HIV infections. The backlash created a lot of protests that forced the key populations' technical committee to keep the policy out of the public (108). Moral panics related to sexual rights, same sex sexualities, and HIV preventions have increasingly become common in many African countries including, Senegal, Tanzania, and Nigeria (110;111;112;113). Just as was the case in Ghana and Uganda, these usually galvanize the communities against the subject in question.

5.1 Context and SBCSE Curriculum content

Contextual factors such as religion, culture, history, politics etc. affect how SBCSE is perceived in a community. SBCSE curriculum contents therefore require adaptation to integrate cultural and social issues that are relevant to the specific contexts and circumstances of young people in the context (53). Adaptation of SBCSE content however comes with tradeoffs that may result into 'sensitive' topics being omitted from SBCSE curriculums if they are considered unacceptable in a particular environment. According to Le Mat, even when some SBCSE contents are at odd with specific contexts, it is important to keep focus on addressing gender and power inequalities as they have been shown to propagate vulnerabilities among girls and women in relation to their sexuality (114). In the case of Uganda, some of the literature reviewed revealed gender imbalance in delivery of sexuality education, for example where traditional actors and some teachers felt that SBCSE should be prioritized for girls because they are more vulnerable, or where virginity was only expected among girls, maintenance of hygiene as a girls' thing etc. These absolved boys from responsibilities related to sexuality, hence perpetrating gender inequalities and making SBCSE unpopular among some young people (65;90).

According to Villa-Tores and Svanemyr, successful SBCSE programmes are those designed with inputs from young people (115). Keogh et al, expand on this to include not only involvement of the young people but also that of other stakeholders in the community (57). Involving young people in SBCSE curriculum design ensures that the content and delivery methodologies meet the needs of young people while the involvement of other stakeholders addresses other social concerns and promote ownership and support for SBCSE programmes (70). It also ensures that community stakeholders understand the goals of SBCSE, which in turn promote community support for such programmes (116;117). The review of the literature revealed that young people in Uganda were hardly involved or consulted during design of SBCSE curriculum. Subsequently, some of the contents in SBCSE curriculum were not per their needs. Young people felt that programmes were shallow or were too focused-on biology and morality, yet they preferred to get more comprehensive information about their sexuality. This is in line with findings from an evaluation of SBCSE programs in Uganda which revealed that more comprehensive SBCSE curriculums were 50% more effective than the less comprehensive options in addressing young people's SRHR demands (118).

5.2 School setting, policy environment, and CSE actors

Supportive school settings, policy environment, and CSE actors are instrumental for the promoting community support for SBCSE. This can be achieved through addressing curriculum fidelity, teacher performance, and overall programme effectiveness. When educational policies and school settings are supportive, SBCSE may be integrated into the school curriculum and not delivered as extracurricular activities. A promising approach for promoting a positive school environment for SBCSE is the Whole School Approach. A pilot evaluation of this approach in Uganda and Kenya has shown positive results in terms of increasing ownership and participation in SBCSE programmes by all stakeholders including learners, teachers, school administrators, Parent Teacher Associations, political actors as well as the promotion of linkages between schools and SRHR service providers (70). Parental and community participation is critical for forging partners with external players including those whose support are essential for promoting community supports such as religious and cultural leaders (4).

Positive cultural and religious environments play a critical role in determining community support for SBCSE. However, negative cultural and religious contexts are common both in developed and developing countries (109). In the USA just like in Uganda, conservative actors at the state and community levels are the main barriers to the delivery and effectiveness of SBCSE. The anti SCBCSE activists in the conservative environments are often motivated by religion or culture and usually effectively find a moral issue which they effectively use to stoke fear and create moral panics; most common issues they use include abortion, sexual orientation, and even SBSCE. (120;29). Even where a substantial proportion of the population supports SBCSE, there can be a small but vocal and influential group that continues to oppose SBCSE and negatively influencing communities against it. This requires stakeholders to constantly engage in advocacy and activism to reduce the impact of their opposition on community support for SBCSE (32). Svanemyr et al, assert that in conservative settings, SBCSE needs to be implemented with tact and care as proven in a SBCSE programme implemented by Rutgers in conservatist Pakistan and in Uganda by the Institute for Reproductive Health Georgetown University (121). In Pakistan, Rutgers identified and tactfully engaged different community stakeholders such as religious groups, schools, healthcare and education officials, parents, and young people in designing and review of SBCSE curriculum. This ensured the adoption of applicable and acceptable terminologies and respect of traditional values to avoid inflaming the community. Training and value clarification exercises were also undertaken for teachers to address teacher skills inadequacies.

A similar approach also worked in Uganda during the revision of the sexuality education framework where intensive multistakeholder consultations were undertaken to obtain approval of a new framework by the government and sections of religious leaders. This however came at a cost as tradeoffs had to be made by leaving out key topics considered sensitive (40).

Processes such as teacher training, inclusion of SBCSE in school timetable, and making SBCSE classes mandatory for both teachers and pupils have been proven to be critical for improving the effectiveness of SBCSE (37). Evidence from South Africa shows that allowing teachers who are untrained to deliver SBCSE can be counterproductive. Untrained teachers may fail to challenge entrenched negative gender inequalities and may promote moralistic and abstinence only messages which are not popular among adolescents (122;123). To improve teacher preparedness and address skills gaps, confidence and methodological deficits, Zambia has integrated SBCSE into the curriculum of teacher training institutes. This combined with the integration of SBCSE into school curriculum and adoption of favorable education policies has been shown to help learners to receive age and culturally appropriate SBCSE that has been integrated into several examinable subjects (37).

5.3 Reflections on the application of the HPT framework

To reflect on the application of the HPT framework, the researcher found the framework to particularly useful for the analysis and presentation of contextual factors and actors. Processes and content however had to be adapted to fit the purpose of this study, i.e., processes and content related to design and implementation of SBCSE. The researcher focused on only processes and content that relate to community support for SBCSE in Uganda. The researcher found the HPT to be more attuned to analysis of direct health policies and not policies that fall in-between such as SBCSE that cover a wide range of issues, some of which are outside the domains of health. Future researchers should be encouraged to adapt the HPT framework to speak to context, actors, processes content related to community level policies or programmes. A similar recommendation has been made by O'Brien et al ,2020 where they identified the need for the application of this framework in lower-level studies as recommendation for future studies. The use of the HPT in this study showed that much as religion and culture play a key role in propagating community resistance to SBCSE, there are also other equally important factors such as community sensitization, consultation, involvement of young in curriculum design, and funding that contribute to resistance to SBCSE if not carefully managed (30;24).

5.4 Limitation of the study

The researcher considers the following as the limitations of this study.
Inadequacy of literature on some of the topics such as SBCSE curriculum processes in the context of Uganda. While conducting literature search, it was clear that data on SBCSE processes were scarce. Another limitation relates to the missed opportunity to obtain fresh insights from primary sources through interview and other data collection methodologies to triangulate findings from the literature review. Most of the studies accessed were small qualitative studies which may affect generalizability of the study findings. Some literature used in the research were from agencies that have interests on SBCSE, for example UNESCO, UNFPA, WHO, Rutgers whose positions on SBCSE is obviously that of support, as a result, the study may have missed the opportunity to find alternative opinions on sexuality education. To address some of these limitations, the researcher tried to find studies from a wide range of groups and areas to obtain a variety of opinions.

Word count: 13,096

CHAPTER SIX

6.0 Conclusions and Recommendations

In this chapter, I present conclusions and recommendations to different stakeholders based on findings from the literature review and following the objectives of the study. The objectives of the study are presented below.

1. To identify cultural, religious, political, and economic factors that influence community support for SBCSE
2. To identify actors that influence community support for SBCSE
3. To identify CSE programme processes that promote community support for SBCSE
4. To discuss CSE content related factors that influence community support SBCSE
5. To make recommendations for gaining and sustaining community support for SBCSE

6.1 Conclusions

Overall, community support for SBCSE was found to be low. Several contextual barriers such as religion, culture, politics, and the economy were found to be responsible for this situation. Communities were found to pay more attention to factors such as religion, culture, and politics than the SRHR of young people. Young people currently do not play a key role in informing the design of SBCSE curriculums despite having serious concerns that require attention. Overall, young people were found to be more supportive of SBCSE. The government pays too much attention to appeasing religious actors to the extent that they have a strong influence in deciding the focus of SBCSE curriculum. This was proven by the inclusion of religious actors in SBCSE curriculum development processes. The study found that limited state funding for SBCSE was also a crucial factor in influencing community support for SBCSE as most SBCSE programmes were shown to be funded by external donors which breeds suspicion on the goals of these programmes. Nevertheless, study found that the government still plays a critical role in giving a final approval of what content and focus SBCSE in Uganda takes. For example, in the new NSEF, the government approved the narrower focused abstinence only programme. Processes such as community participation in SBCSE design and others were also found to be important for promoting community support for SBCSE.

6.2 Recommendations

In this section, I present recommendations to different stakeholders per the findings from the study.

Recommendations for Government Ministries, Agencies and Departments.

1. The government of Uganda through the MoES should continue engaging with religious groups who own most schools in the country to accept the implementation of SBCSE in their schools.
2. The National Curriculum Development Centre (NCDC) should disseminate information and clarify to stakeholders that SBCSE is cognizant of age, culture and development stages of children and communities. This will address concerns about the exposure of young children to sexually explicit content through SBCSE.
3. The government of Uganda through the Ministries of Finance and the MoES should prioritize funding of SBCSE to ensure proper resourcing, teacher training, scalability, and sustainability of SBCSE in the country.

4. The MoH and MoES should improve coordination at national and district levels and create linkages between SBCSE programmes and SRHR service delivery.
5. The MoES and the NCDC should integrate components of SBCSE into the regular and examinable subjects such as biology, science, social studies etc. This will enable all learners to benefit from the subject.
6. The MoES should conduct value clarification exercises on sensitive CSE contents such as condom, contraception, sexual rights, abortions etc. for key stakeholders such as religious leaders, cultural leaders, politicians, parents among others to reduce their opposition to some of these topics and then to SBCSE. The MoES and can enlist the support of NGOs to lead this effort.
7. The MoES should build the ability of traditional actors such as paternal aunts “sengas” to and maternal uncles “kojjas” to deliver more comprehensive sexuality education from home to compliment SBCSE. This will address the concerns the role of families in the provision of sexuality education as well as the fear that SBCSE promotes foreign agenda.

Recommendations to NGOs and other stakeholders.

7 Advocate for the decriminalization of SRHR issues such abortion and same sex relationships so that they can be integrated into the SBCSE curriculum to guarantee the rights of all young people.
8 Advocate for the adoption of promising approaches such as the Whole School Approach which have been proven for generating community support for SBCSE.

Recommendation for research

8. More research should be undertaken on how to deal with the influence of religious conservativism on SBCSE at the community level. This is important because conservative religious groups are increasingly becoming influential in Uganda’s public spheres including on issues of sex, sexuality, politics etc. using the pretext of promoting morality (125). Studies should also explore adapting and applying the HPT framework the analysis of this topic at the community level.

Word count: 13,096

REFERENCES

1. UNESCO. Emerging evidence, lessons, and practice in comprehensive sexuality education: A global review.2015
2. Bhattacharyya J. Theorizing community development. Community Development. 2004 Mar 1;34(2):5-34.
3. The PACT.2016-2017 Progress Report. 2017 July.
4. UNESCO. International technical guidance on sexuality education. An evidence informed approach.2018.
5. "Puteh SE, Almualm Y. Catastrophic health expenditure among developing countries." (":: JKMS :: Journal of Korean Medical Science") Health Systems and Policy Research. 2017;4(1):0-.
6. Haverkamp W, Breithardt G, Cammm AJ, Janse MJ, Rosen MR. Policy Conference. European Heart Journal. 2000 Aug;21(15):1216-31.
7. WHO and United Nations. Definition of adolescents. Public Health. September 2019.
8. Walt G, Shiffman J, Schneider H, Murray SF, Brugha R, Gilson L. 'Doing'health policy analysis: methodological and conceptual reflections and challenges. ("'Doing' health policy analysis: Methodological and conceptual ...") Health policy and planning. 2008 Sep 1;23(5):308-17.
9. Uganda Bureau of Statistics (UBOS) and ICF. Uganda Demographic and Health Survey Key Findings. Kampala, Uganda, and Rockville, Maryland, USA. UBOS and ICF. (2017. 2016
10. Moore AM, Kibombo R, Cats-Baril D. Ugandan opinion-leaders' knowledge and perceptions of unsafe abortion. Health Policy and Planning. 2014 Oct 1;29(7):893-901.
11. World Health Organization. Unsafe abortion incidence and mortality: global and regional levels in 2008 and trends during 1990-2008. World Health Organization; 2012.
12. Atuhairwe S, Gemzell-Danielsson K, Byamugisha J, Kaharuza F, Tumwesigye NM, Hanson C. Abortion-related near-miss morbidity and mortality in 43 health facilities withdifferences in readiness to provide abortion care in Uganda. BMJ global health. 2021; 6(2): e003274. https://doi.org/10.1136/bmjgh2020-003274 PMID: 33547174
13. GoU. The Penal Code Act (Cap. 120), as amended through the Penal Code (Amendment) Act, 2007 (Act No. 8 of 2007).
14. Uganda Bureau of Statistics (UBOS). Statistical Abstract.2017
15. Uganda Bureau of Statistics (UBOS). Statistical Abstract.2019
16. Uganda Bureau of statistics (UBOS). Uganda National Household Survey Report.2019
17. The National Planning Authority Uganda. Third National Development Plan (NDPIII) 2020/20201-2024/2025.June 2020
18. UNHCR. Global Trends in Forced Displacement in 2020.Technical report United Nations High Commission for Refugees.2020
19. Uganda Bureau of Statistics. The National Population and Housing census 2014 Main Reports.2016.
20. Jane Ruth Aceng Ocero H. Government of Uganda Declaration of the FP2030. Family Commitments. 2021
21. Sserwanja Q, Musaba MW, Mukunya D. Prevalence, and factors associated with modern contraceptives utilization among female adolescents in Uganda. BMC women's health. 2021 Dec;21(1):1-7.
22. Partnership For Evidence Based Response to COVID19.Finding the Balance: Public Health and Social Measures in Uganda. 2021 September.

Word count: 13,096

23. United Nation Population Fund. The UNFPA Strategic Plan,2022-2025.14Th July 2021.
24. Ministry of Health. Maternal and Perinatal Death Surveillance and Response Guideline.2017 August.
25. World Bank Group. World and National Data, Maps and Ranking.2022.
26. World Health Organisation. Country Cooperation Strategy for Uganda at a Glance. 2018
27. IntraHealth. Report on use of Community Health Workers in HIV/AIDS care an activity report by IntraHealth Strengthening Human Resources for Health Project. IntraHealth Office; 2017. https://www.intrahealth
28. Government of Uganda. The Constitution of the Republic of Uganda.1995.
29. "Moore EV, Hirsch JS, Spindler E, Nalugoda F, Santelli JS." ("Jennifer Hirsch | UCSD Profiles") Debating sex and sovereignty: Uganda's new national sexuality education policy. Sexuality Research and Social Policy. 2022 Jun;19(2):678-88.
30. Kemigisha E, Bruce K, Ivanova O, Leye E, Coene G, Ruzaaza GN, Ninsiima AB, Mlahagwa W, Nyakato VN, Michielsen K. Evaluation of a school based comprehensive sexuality education program among very young adolescents in rural Uganda. BMC Public Health. 2019 Dec;19(1):1-1.
31. Ministry of Education and Sports. Sector Strategic Plan 2017-2020. 2017 September
32. The Journey towards Comprehensive Sexuality Education. Global status Report. 2021
33. UNESCO.UNESCO Institute of Statistics. Annual Report, 2020.
34. UNESCO. Comprehensive Sexuality Education. The Challenges and Opportunities of Scaling Up.2012 July.
35. UNAIDS. Confronting Inequalities. Lessons for Pandemics Response from 40 years of AIDS. Global AIDS Updates.2021.
36. UNESCO. The Journey Towards Comprehensive Sexuality Education. Globa;l Status Reports.2021
37. O'Brien H, Hendriks J, Burns S. Teacher training organisations and their preparation of the pre-service teacher to deliver comprehensive sexuality education in the school setting: A systematic literature review. Sex Education. 2021 May 4;21(3):284-303.
38. UNESCO. The Journey Towards Comprehensive Sexuality Education. Globa;l Status Reports.2021.
39. Chau K, Traoré Seck A, Chandra-Mouli V, Svanemyr J. Scaling up sexuality education in Senegal: integrating family life education into the national curriculum. Sex Education. 2016 Sep 2;16(5):503-19.
40. Ninsiima AB, Coene G, Michielsen K, Najjuka S, Kemigisha E, Ruzaaza GN, Nyakato VN, Leye E. Institutional and contextual obstacles to sexuality education policy implementation in Uganda. Sex education. 2020 Jan 2;20(1):17-32.
41. Ahimbisibwe P. Government drafts policy on teaching sexuality. Daily Monitor. 2018:688334-45637.
42. Muhanguzi FK, Ninsiima A. Embracing teen sexuality: Teenagers' assessment of sexuality education in Uganda. Agenda. 2011 Sep 1;25(3):54-63.
43. Ministry of Education and Sports. National Sexuality Education Framwork.2018
44. UNESCO. Sexuality Education Review and Assessment Tool (SERAT).Paris Unesco.2013.
45. Nalwadda G, Namutebi M, Volgsten H. Health care providers' perceptions of family planning and contraception education for adolescents in Kampala, Uganda - A qualitative study. Sex Reprod Healthc. 2019 Oct; 21:15-20. doi: 10.1016/j.srhc.2019.05.001. Epub 2019 May 10. PMID: 31395228.

46. Goldman, J. D. (2011). An exploration in health education of an integrated theoretical basis for sexuality education pedagogies for young people. Health education research, 26 (3): 526-541
47. UNESCO, UNFPA. Sexuality education: A ten-country review of school curricula in East and Southern Africa 2012. http://unesd oc.unesco.org/images/ 0022/002211/221121e.pdf. Accessed August 5, 2022.
48. GEM Report Team. Facing the facts: the case for comprehensive sexuality education. 2019.
49. UNESCO.UNESCO and Gender Equality in Sub-Saharan Africa. Innovative Programmes, visible results.2017.
50. Plesons, M., Khanna, A., Ziauddin, M. et al. Building an enabling environment and responding to resistance to sexuality education programs: experience from Jharkhand, India. Reprod Health 17, 168 (2020).
51. Haberland N, Rogow D. Sexuality education: emerging trends in evidence and practice. Journal of adolescent health. 2015 Jan 1;56(1): S15-21.
52. Goldfarb ES, Lieberman LD. Three decades of research: The case for comprehensive sex education. Journal of Adolescent Health. 2021 Jan 1;68(1):13-27.
53. International Planned Parenthood Federation. Deliver +Enable Toolkit. Scaling Up Comprehensive Sexuality Education.2017.
54. Panchaud C, Keogh SC, Stillman M, Awusabo-Asare K, Motta A, Sidze E, Monzón AS. Towards comprehensive sexuality education: A comparative analysis of the policy environment surrounding school-based sexuality education in Ghana, Peru, Kenya, and Guatemala. Sex Education. 2019 May 4;19(3):277-96.
55. Fonner VA, Armstrong KS, Kennedy CE, O'Reilly KR, Sweat MD. School based sex education and HIV prevention in low-and middle-income countries: a systematic review and meta-analysis. PloS one. 2014 Mar 4;9(3): e89692.
56. Kirby, D, Laris B, Rolleri L. (2005a), Impact of sex and HIV education programs on sexual behaviours of youth in developing and developed countries. Washington, DC, Family Health International, pp. 1-45
57. Keogh SC, Stillman M, Awusabo-Asare K, et al. Challenges to implementing national comprehensive sexuality education curricula in low- and middle-income countries: case studies of Ghana, Kenya, Peru, and Guatemala. PLoS One. 2018;13(7): e0200513.
58. "O'Brien GL, Sinnott SJ, Walshe V, Mulcahy M, Byrne S. Health policy triangle framework: narrative review of the recent literature." (“The impact of social determinants of health on early childhood ...”) Health Policy Open. 2020 Dec 1; 1:100016.
59. Gilson L, Orgill M, Shroff ZC, World Health Organization. "A health policy analysis reader: the politics of policy change in low-and middle-income countries." (“Marsha Orgill - Google Scholar”) World Health Organization; 2018.
60. Boyd L. Preaching prevention: Born-again Christianity and the moral politics of AIDS in Uganda. Ohio University Press; 2015 Oct 29.
61. Epstein H. The invisible cure: Africa, the West, and the fight against AIDS. Macmillan; 2007 May 15.
62. Parikh S. Regulating romance: Youth love letters, moral anxiety, and intervention in Uganda’s time of AIDS. Vanderbilt University Press; 2016 Apr 11.
63. Osborne, S. “Uganda announces ‘Kill the Gays’ law imposing death penalty of homosexuals.” Retrieved from the https: independent.co.uk.uk/news/world/Africa/Uganda-death-penalty-killgays-homosexuals-lgbt-a9151411.html
64. Tamale S. Controlling Women’s Fertility in Uganda. SUR-Int’l J. on Hum Rts.. 2016; 24:117.

65. de Haas B. Sexuality education in Uganda: Teachers' reasoning in a 'morally upright 'context.2017
66. Kinsman J, Nyanzi S, Pool R. Socializing influences and the value of sex: the experience of adolescent schoolgirls in rural Masaka, Uganda. Culture, health & sexuality. 2000 Jan 1;2(2):151-66.
67. Cynthia Khamala Wangamati (2020) Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents, Sexual and Reproductive Health Matters, 28:2, 1851346, DOI: 10.1080/26410397.2020.1851346
68. WHO. Review of the Education, Lessons, and Practice in Comprehensive Sexuality Education. A Global Review.2015.
69. Ssengendo, A. (2016, Jul 12). Museveni speaks out on sex education in schools. New Vision.
70. "Vanwesenbeeck, Ine, Judith Westeneng, Thilly De Boer, Jo Reinders, and Ruth Van Zorge." ("(S)exclusion in the sexuality education classroom: young people on ...") 2016. "Lessons Learned from a Decade Implementing Comprehensive Sexuality education in Resource Poor Settings: The World Starts With Me," Sex Education 16 (5): 471–486. https://doi.org/10.1080/14681811.2015.1111203
71. Geary T, McNamara PM. The involvement of male post-primary teachers in relationships and sexuality education: An exploratory study of attitudes and perceptions. Department of Education and Professional Studies; 2007
72. De Haas B, Hutter I. Teachers' conflicting cultural schemas of teaching comprehensive school-based sexuality education in Kampala, Uganda. Culture, health & sexuality. 2019 Feb 1;21(2):233-47.
73. Agardh A, Emmelin M, Muriisa R, Östergren PO. Social capital and sexual behavior among Ugandan university students. Global Health Action. 2010 Dec 1;3(1):5432.
74. World Bank Group. Uganda Economic Update, 11th Edition. Financing Growth and Development: Options for raising more domestic revenues. ("Uganda economic update, 11th edition : financing growth and development ...") May 2018 https://openknowledge.worldbank.org/bitstream/handle/10986/29916/126184-WP-PUBLIC-FinalReportUgandaEconomicUpdate.pdf?sequence=1&isAllowed=y
75. UNESCO. Eastern and Southern Africa Commitment. One year in Review 2013-2014.2014
76. Young People Today. Leaders from ESA recommit to the education, health and wellbeing of adolescents and young people. ("BLOG | Young People Today") December 2021.
77. Allen L. Young people and sexuality education: Rethinking key debates. Springer; 2011 Jan 19.
78. Rijsdijk LE, Bos AE, Lie R, Leerlooijer JN, Eiling E, Atema V, Gebhardt WA, Ruiter RA. Implementation of The World Starts With Me, a comprehensive rights-based sex education programme in Uganda. Health education research. 2014 Apr 1;29(2):340-53.
79. Mutonyi H, Nashon S, Nielsen WS. Perceptual influence of Ugandan biology students' understanding of HIV/AIDS. Research in Science Education. 2010 Aug;40(4):573-88.
80. Wekesah FM, Nyakangi V, Onguss M, Njagi J, Bangha M. Comprehensive Sexuality Education in Sub-Saharan Africa. African Population and Health Research Center.; 2019.
81. Kibombo R, Neema S, Moore AM, Ahmed FH. Adults' perceptions of adolescents' sexual and reproductive health: qualitative evidence from Uganda. New York: Guttmacher Institute. 2008 Feb 29.
82. Muhwezi WW, Katahoire AR, Banura C, Mugooda H, Kwesiga D, Bastien S, Klepp KI. Perceptions and experiences of adolescents, parents, and school administrators regarding adolescent-parent

communication on sexual and reproductive health issues in urban and rural Uganda. Reproductive health. 2015 Dec;12(1):1-6.
83. Kivela J, Ketting E, Baltussen R. Cost and Cost-Effectiveness Analysis of United Nations Educational, Scientific and Cultural Organization School-Based Sexuality Education Programmes in Six Countries.
84. Darabi L, Serumaga K, Bankole A, Neema S. Protecting the next generation in Uganda: new evidence on adolescent sexual and reproductive health Needs.2008.
85. Rijsdijk LE, Lie R, Bos AE, Leerlooijer JN, Kok G. Sexual and reproductive health and rights: implications for comprehensive sex education among young people in Uganda. Sex education. 2013 Jul 1;13(4):409-22.
86. Iyer P, Aggleton P. 'Sex education should be taught, fine… but we make sure they control themselves': Teachers' beliefs and attitudes towards young people's sexual and reproductive health in a Ugandan secondary school. Sex Education. 2013 Jan 1;13(1):40-53.
87. Senyonga A. Churches reject sexuality education in school. 2018.https://www.newvision.co.ug/new_vision/news/1479030/churches-reject-sexuality.
88. Okware SI. Review of Social Challenges of Heterosexual Transmission of HIV/AIDS in Uganda. AIDS Updates-Recent Advances and New Perspectives. 2021 Sep 21.
89. Lewinger S, Russell SG. Embodied experiences of abstinence-only education: a case study of women in Uganda. Gender and Education. 2021 Oct 3;33(7):898-913.
90. Muyinda H, Nakuya J, AG Whitworth J, Pool R. Community sex education among adolescents in rural Uganda: utilizing indigenous institutions. AIDS care. 2004 Jan 1;16(1):69-79.
91. Perehudoff K, Kibira D, Wuyts E, Pericas C, Omwoha J, van den Ham HA, Mantel-Teeuwisse AK, Michielsen K. A comparative human rights analysis of laws and policies for adolescent contraception in Uganda and Kenya. Reproductive health. 2022 Dec;19(1):1-4.
92. Kato, J. 2016. "Netherlands Envoy Condemns Ban on Sexuality Education." *Daily Monitor*, 30 October.
93. Alford S. Sex education programs: Definitions & point-by-point comparison. Advocates for Youth. 2001.
94. Cohen, Jonathan, and Tony Tate. *The Less They Know, the Better: Abstinence-only Hiv/aids Programs in Uganda*. New York: Human Rights Watch, 2005. Print.
95. Barnett T, Parkhurst J. HIV/AIDS: sex, abstinence, and behaviour change. The Lancet infectious diseases. 2005 Sep 1;5(9):590-3.
96. The four PIASCY policy documents are: a 'Training Manual', 'Teacher Resource Book on HIV/AIDS', 'Student Handbook on HIV/AIDS (Lower Post Primary)' and'Student Handbook on HIV/AIDS (Upper Post Primary)'– MoES (2006a, 2006b, 2006c, 2006d)
97. Ahmed N, Flisher AJ, Mathews C, Jansen S, Mukoma W, Schaalma H. Process evaluation of the teacher training for an AIDS prevention programme. Health education research. 2006 Oct 1;21(5):621-32
98. Gallant M, Maticka-Tyndale E. School-based HIV prevention programmes for African youth. Social science & medicine. 2004 Apr 1;58(7):1337-51
99. Tushabomwe A, Nashon SM. Interpreting Teachers' Perceptions of Contextual Influences on Sexuality DiscoursesWithin the School Curriculum: Lessons from Sex Health Education Teachers in Kampala, Uganda. Canadian Journal of Science, Mathematics and Technology Education. 2016 Oct;16(4):331-44.
100. Davis M. Curriculum: Big Decisions: Making Healthy, Informed Choices about Sex. American Journal of Sexuality Education. 2009 Nov 30;4(3-4):248-51. Abstinence Plus curriculum

101. Underhill K, Montgomery P, Operario D. Sexual abstinence only programmes to prevent HIV infection in high income countries: systematic review. Bmj. 2007 Aug 2;335(7613):248.
102. Miedema E, Le Mat ML, Hague F. But is it comprehensive? Unpacking the 'comprehensive' in comprehensive sexuality education. Health Education Journal. 2020 Nov;79(7):747-62.
103. Fine M, McClelland S. Sexuality education and desire: Still missing after all these years. Harvard educational review. 2006 Sep 1;76(3):297-338.
104. Kemigisha E, Bruce K, Ivanova O, Leye E, Coene G, Ruzaaza GN, Ninsiima AB, Mlahagwa W, Nyakato VN, Michielsen K. Evaluation of a school based comprehensive sexuality education program among very young adolescents in rural Uganda. BMC Public Health. 2019 Dec;19(1):1-1.What young people think
105. Nabimanya, H. Young people losing out with back-and-forth sex education 'bans.' New Vision. (2018, July 21). Retrieved from https:// www. new vision. co. ug/ new_ vision/ news/ 14818 20/
106. Rasmussen ML. Revisiting moral panics in sexuality education. Media International Australia. 2010 May;135(1):118-30.
107. Fairley, K. 'Start Safe Sex Education Young, Say Experts,' Media Release, Faculty of Medicine Dentistry and Health Sciences, University of Melbourne, 2009. www.mdhs.unimelb.edu. au/news/start_safe_sex_education_young_say_experts_08/05/2022.
108. Sandfort T. Male Same-sex Sexuality and HIV in Sub-Saharan Africa. In Male Same-sex Sexuality and HIV in Sub-Saharan Africa 2021 (pp. 1-30). Springer, Cham.
109. Graphic D. 8,000 gays in 2 regions; Majority infected with HIV/AIDS. Daily Graphic. 2011.
110. Santos GM, Beck J, Wilson PA, Hebert P, Makofane K, Pyun T, Do T, Arreola S, Ayala G. Homophobia as a barrier to HIV prevention service access for young men who have sex with men. JAIDS Journal of Acquired Immune Deficiency Syndromes. 2013 Aug 15;63(5):e167-70.
111. Poteat T, Diouf D, Drame FM, Ndaw M, Traore C, Dhaliwal M, Beyrer C, Baral S. HIV risk among MSM in Senegal: a qualitative rapid assessment of the impact of enforcing laws that criminalize same sex practices. PloS one. 2011 Dec 14;6(12):e28760. Senegal
112. Honan E. How Tanzania is cracking down on lgbt people—And getting away with it. Tanzania
113. Pierce S. "Nigeria Can Do without Such Perverts" Sexual Anxiety and Political Crisis in Postcolonial Nigeria. Comparative Studies of South Asia, Africa, and the Middle East. 2016;36(1):3-20. Nigeria
114. Stark J. Sounds Good, but Does Sex Ed Actually Work?. The Age. 2009 Jan 18; 18:9.
115. Le Mat ML. Beyond the facts: addressing gender-based violence through comprehensive sexuality education in schools in Ethiopia
116. Villa-Torres L, Svanemyr J. Ensuring youth's right to participation and promotion of youth leadership in the development of sexual and reproductive health policies and programs. Journal of Adolescent Health. 2015 Jan 1;56(1):S51-7.
117. Kirby D, Answers E. Research findings on programs to reduce teen pregnancy and sexually transmitted diseases. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy. 2007 Jul 23.
118. UNFPA. Comprehensive Sexuality Education: Advancing Human Rights, Gender Equality and Improved Sexual and Reproductive Health.

Word count: 13,096

119. Rijsdijk LE, Lie R, Bos AE, Leerlooijer JN, Kok G. Sexual and reproductive health and rights: implications for comprehensive sex education among young people in Uganda. Sex education. 2013 Jul 1;13(4):409-22.
120. Wood L, Rolleri LA. Designing an effective sexuality education curriculum for schools: Lessons gleaned from the South (ern) African literature. Sex Education. 2014 Sep 3;14(5):525-42.
121. Cavazos-Rehg PA, Krauss MJ, Spitznagel EL, Iguchi M, Schootman M, Cottler L, Grucza RA, Bierut LJ. Associations between sexuality education in schools and adolescent birthrates: a state-level longitudinal model. Archives of pediatrics & adolescent medicine. 2012 Feb 6;166(2):134-40.
122. Chandra-Mouli V, Svanemyr J, Amin A, Fogstad H, Say L, Girard F, Temmerman M. Twenty years after International Conference on Population and Development: where are we with adolescent sexual and reproductive health and rights?. Journal of Adolescent Health. 2015 Jan 1;56(1):S1-6
123. Ngabaza S, Shefer T, Macleod CI. "Girls need to behave like girls you know": the complexities of applying a gender justice goal within sexuality education in South African schools. Reproductive health matters. 2016 Nov 1;24(48):71-8
124. Shefer T, Kruger L, Macleod C, Baxen J, Vincent L. '… a huge monster that should be feared and not done': Lessons learned in sexuality education classes in South Africa. African Safety Promotion: A Journal of Injury and Violence Prevention. 2015;13(1):71-87.
125. Bompani B, Brown ST. A "religious revolution"? Print media, sexuality, and religious discourse in Uganda. Journal of Eastern African Studies. 2015 Jan 2;9(1):110-26.