Teenage pregnancy in Uganda
Making a difference
**USHAPE**  
**Community Report 2016**

**Maggie Challis** - Education and Training Consultant  
**John Gray** - Professor of Education Research, Cambridge  
**Clare Goodhart** - Family Doctor and USHAPE Clinical Lead  
**Jonathan Graffy** - Clinical Researcher, Cambridge University, Honorary Professor, University of East Anglia  
**Amaran Cumarasamy** - Student Doctor, Brighton and Sussex Medical School  

www.ushape.org.uk  
@USHAPE.twit  
facebook.com/ushapetraining/  
USHAPE Clinical Lead clare.goodhart@nhs.net

**USHAPE is supported by:**
Letter from the USHAPE team

USHAPE aims to promote sexual health and pastoral education in Uganda. We offer training for health workers and teachers, working closely with the local community to help young people protect themselves and promote demand for family planning. We have found real enthusiasm among health workers in Uganda for this training, but for them to effectively use their skills, there is a need to create demand for services within the community. For this reason, we have developed a cascade model of training whereby newly trained health workers take responsibility for disseminating positive messages through the community.

USHAPE has evolved over the past 4 years, with contributions from more than 20 UK doctors and teachers, each contributing their time and expertise. The partnership between the Royal College of GPs and Bwindi Community Hospital goes back further than this, and much of the developmental work of USHAPE is credit to the UK GPs who have given their time as volunteers, often for a year at a time, to build strong working relationships with our Ugandan colleagues. The skills exchange between UK teachers and those in Kanungu has been made possible through the social enterprise, Limited Resource Teacher Training, who have coordinated the efforts with Bwindi Hospital health advisors.

Initial funding was provided by Cambridge Reproductive Health Training which uses its profit from Family Planning training in the UK, however in 2015, we were awarded a grant from UKAID through the THET Health Partnership Scheme, which has allowed us to broaden our vision and develop the full USHAPE training cascade. We have had several travel fellowships, small grants and donations.

We are enormously grateful to all those who have supported USHAPE’s efforts both in Uganda and the UK, and hope that this report gives an accurate summary of our work so far, and will provide interesting reading for those who may support us in the future.

Dr Clare Goodhart

USHAPE Clinical Lead
Executive Summary

Unwanted teenage pregnancies, HIV and other sexual health issues present major problems and challenges in Uganda – not least for the young people involved and for their families but also for their communities. This report describes the USHAPE sexual health education project undertaken over the last three years in the Kanungu District, a remote area of Uganda. It is likely to be of wider interest for four main reasons.

⇒ First, it grew from the concerns of the local community. Working with health professionals from the UK, local health care teams designed a strategy which would reach local people and meet their needs.

⇒ Second, the approach adopted is multi-faceted and multi-professional; it brings together health workers, teachers and others working with and concerned about young people in a partnership to deliver initiatives.

⇒ Third, it is responsive to the concerns of young people themselves and builds on the issues they raise.

⇒ And fourth, and perhaps most importantly, it seeks to create communities which own responsibility for the sexual health of their young people by working together. In particular, support from religious leaders who have welcomed USHAPE outreach in their churches has helped to open up broader discussions about prevailing views on contraception based solely on abstinence.

The overall USHAPE strategy has been to disseminate positive messages about sexual health and modern contraception in order to dispel fears and misconceptions, reduce risk of sexually transmitted diseases, and meet the need for family planning.

The USHAPE Community Programme Components

1. Pastoral Lead Network of Teachers
2. Sugar Daddy Awareness
3. Youth Outreach
4. Men’s Outreach
5. Village Health Teams
Uganda is one of the poorest countries in the world and the need for innovative approaches to tackling sexual health issues is increasingly recognised both locally and nationally. Girls marry early; teenage pregnancy rates are high; knowledge of the risks of HIV is limited; the majority of males say they do not use condoms; and inter-generational sex (the so-called ‘Sugar Daddy’ phenomenon) is prevalent. The box highlights some key facts. Some of these outcomes, of course, reflect planned and deliberate choices on the part of young people but many do not.

The Ministry of Health’s Strategy (2011)

The goal of the adolescent sexual and reproductive health policy is to mainstream adolescent health concerns in the national development process in order to improve their quality of life and standards of living.

Its objectives are to:

- provide and increase availability and accessibility of appropriate, acceptable, affordable quality information and health services to adolescents;
- influence positive behavioural change amongst adolescents;
- provide policy makers and other key actors in the social and development fields, reference guidelines for addressing adolescent health concerns;
- create an enabling legal and social-cultural environment that promotes provision of better health and information services for young people;
- protect and promote the rights of adolescents to health, education, information and care;
- train providers and reorient them at all levels to better focus and meet the special needs of adolescents.

Key Facts on Sexual Health in Uganda

- Roughly half the population is under 15 years of age.
- Half of young women are married by the age of 18 (Uganda Demographic and Health Surveys, 2006/11/12).
- In 2001 around 600,000 adults (5% of the population aged 15-45) were living with HIV (UNAIDS 2002).
- Teenage pregnancy rates are high with a mean age amongst mothers of 18.
- Under half of males aged 15-24 who have multiple partners use condoms
- Only around 40% of young people in this age group have a comprehensive knowledge of HIV.
Whilst there has for some years been awareness of the sizeable challenges facing Uganda, policies to engage with the issues have been slow to emerge. There has been a widespread reluctance to explore alternative approaches to sex education. The church’s teaching on contraception, for example, has until recently been one of abstinence as the sole means of avoiding pregnancy and fidelity as the way to avoid sexually transmitted diseases, including HIV.

However, attitudes are changing. There is increasing recognition of the need to take action at national level. The Ugandan Ministry of Health has outlined an ambitious national plan setting out goals and objectives. National concerns are echoed locally.

The local clergy have also started to rethink their attitudes and approach. Crucially, some of them have begun actively to support the need for more intensive work on sexual health issues with young people. As one clergywoman blogged to her peers:

"Every day in Uganda 16 women die during childbirth. Of those 16, four are adolescents. Young girls’ lives snuffed out before they have even begun. Dying because their bodies are too young, or pregnant too soon after their last delivery to cope. These numbers do not even include those who die from unsafe abortions or suicide. What is most tragic is that these deaths are preventable. These pregnancies are poorly planned or even unplanned. Thus what could prevent them? Appropriate, accessible, effective FAMILY PLANNING.”

- Dr Claire Marie Thomas (USHAPE In-Country Clinical Lead), March 2016

"My comrades in ministry, our bodies are weak! ... The bodies of our teenagers are even weaker! The call to abstain almost falls on barren ground. The excitement at a young age makes it even worse.... This makes the need for contraceptives a reality, our Christians must be encouraged to use them! We should not assume anymore that this is evil! I strongly believe the evil of burying teens as they give birth is far greater than the evil of using contraceptives”

- Rev Elizabeth, Chaplain of Bwindi Community Hospital, March 2016

In short, key actors in Uganda have begun to show increased willingness to tackle sexual health issues in recent years. It is this changing situation which provides both the national context and the local opportunity for the USHAPE initiative.

“it’s therefore a clarion call to everyone that for the good of our country, we should all take centre stage in opening up for family planning services in order to protect and harness our demographic dividends and control poverty.”

- Ampumza Rogers, Pastoral Lead Committee Officer, January 2016
The USHAPE Community Programme

This programme is made up of a number of different strands which, in combination, begin to address the need for a comprehensive approach to sexual health issues. The programme aims, at the same time, to promote both cultural and individual change. It is structured around several activities:

- The building of a Pastoral Lead Network of Teachers which works to raise awareness of sexual health issues and contraception at primary school level.

- The introduction of a ‘Sugar Daddy’ Awareness Initiative which addresses issues arising from cross-generational sexual activity.

- The development and mounting of a Youth Outreach programme started in 2016 in collaboration with local churches which uses sessions after church as the main vehicle for contacting young adults and informing them about sexual health issues.

- A Men’s Outreach programme which aims to change attitudes amongst men towards family planning issues.

- Mobilising Village Health Teams to take discussion of sexual health out into the community and to help overcome the barriers which prevent young people being able to attend health care centres.

U-SHAPE Training Cascade

The diagram above shows how a small collaboration between UK and Ugandan professionals has cascaded down across a range of initiatives to reach young people and their communities. The numbers trained are shown in yellow.
At the top of our cascade are the doctors, clinical officers, midwives and nurses (including students) who train as family planning providers and sexual health promoters. We have written about and published our work on family planning training of health workers elsewhere (Graffy et al 2012). Further information can be found on the USHAPE website www.ushape.org.uk, twitter @ushapetwit, and the USHAPE Facebook page.

The professional groups in turn provide youth outreach sessions and men’s engagement evenings. They also facilitate the training of village health teams and teachers and who deliver sex education in schools and the local community. Finally they are responsible for screening women for unmet need for family planning, with the aim of reducing this by offering counselling and methods when wanted.

This report concentrates on USHAPE’s efforts to strengthen the robustness with which local communities develop provision for their young people, and men, related to their sexual health. It also explores the effectiveness of different approaches to addressing sexual health issues with young people themselves. In short, this report concentrates on activities in the lower two layers of the cascade.

Further information can be found on the USHAPE website.

“The course was lively and fun, with a fantastic group of staff putting their heart and souls into the topic. We had many fruitful discussions around women’s rights and empowerment, adolescent and student health and how we can improve the link between screening and actual implementation of family planning methods.”

- Dr Claire Thomas USHAPE trainer January 2016
1. Pastoral Lead Network of Primary School Teachers

Developing the Network

A group of primary teachers interested in pastoral leadership have been meeting in Kanungu since 2013. They have held regular training events and created an organizational infrastructure to build greater awareness in the community about sexual health issues.

The consensus among teachers who met during the early stages of the project was that children should be warned about the dangers of intergenerational sex and that sex education would empower young people to abstain longer, rather than simply lower the age of sexual experimentation. There was however concern that parents might be critical for fear of this. The Demographic Health Survey for Uganda 2011 confirms that whilst opinions differ, the majority of parents (more than 6 out of 10) agree that children aged 12-14 should be taught about condoms to avoid infection with HIV.

Teacher morale in rural primary schools is currently fairly low, and teacher absenteeism is common, not least because pay is low and teachers often have to supplement their main income with subsistence farming or by running small businesses. Despite these constraints, teachers have nonetheless shown enthusiasm for training, and attendance at the quarterly training days has been high, even though only their transport costs can be reimbursed.

Training Topics Covered:

- Myths and misconceptions about HIV and sexual health
- Knowledge and attitudes towards HIV
- Problem of teenage pregnancies
- Issues in providing contraception for teenagers
- Sugar Daddy awareness
- Teachers’ needs for support and training
- The role of the Pastoral Lead teacher
- ‘What is abuse?’
- Provision of safeguarding training

“As a result of other activities of the Pastoral Lead Network, not least the recent hugely successful USHAPE conference in Kanungu, the concerns of the schools and parents are gradually reducing, and we now have a positive atmosphere for sex education.”

- Turyagyenda Frank, Teacher and Sugar Daddy Awareness Co-ordinator
The Role of the Pastoral Lead Teachers

Although the teachers were given the title of Pastoral Lead Teacher at the outset, they have been gradually defining and refining their roles as their training has progressed.

At the recent PLN conference both teachers and head teachers were asked what the role had involved and what they had learnt. They reported being “empowered by knowledge of sex education”; that they had learnt listening and counselling skills; and that they were “helped to engage with pupils” to “make them more aware of their feelings”. They also felt “pupils were better informed of their rights” and more aware of the Sugar Daddy risks. Both male and female teachers described “enjoying work as a senior teacher more” and felt the initiative had brought “great positive change in school”.

Pastoral Lead Network Conference and Future Plans

The Network has its own Executive committee (now in its third year of existence). In 2016 it had progressed sufficiently in terms of its mission and identity to hold its first annual conference involving some 60 teachers, 30 heads and 30 other stakeholders. This year’s conference represented a landmark development providing a means of sustaining interest and action over time. (see report in separate supplement) The Pastoral Lead Network Committee has been an effective structure for identifying learning needs and organisation of local events. They are now ready to establish their own organisational and financial structure so that they can bid for external funding. While they develop as an organisation, the lead team will provide ongoing mentoring, review of funding applications and advice about monitoring and evaluation. To keep the quality of training high, it has been necessary to limit numbers attending training event to 60 teachers i.e. a male and female teacher from 30 primary schools.

However, there are 200 primary schools in the Kanungu district and there is an aspiration to extend the Pastoral Lead Network to involve all of them. It is clear that there is an appetite for teacher training as Pastoral Lead Teachers and the team has built up some expertise among Ugandan health workers and government officers to respond to this. The quarterly training days seem to be a particularly effective model for delivery but, needless to say, further funding will be necessary to support its maintenance and development.
2. Sugar Daddy Awareness

UNAIDS points to cross-generational sex as a significant driver of intergenerational HIV transmission in sub-Saharan Africa. There are differences in how the Sugar Daddy phenomenon operates in urban and rural communities. In large conurbations some university women tend to date wealthy older men in exchange for luxury commodities and entry into Uganda’s booming, and increasingly high-end, nightlife scene. There are numerous sugar daddy dating sites where older men and younger women can ‘meet’ and start their relationship. In rural communities older men may ‘pay’ young women through providing items such as mobile phones, or paying school fees in return for sex.

The USHAPE Sugar Daddy initiative, as it stands at present, is aimed at primary school children and delivered by teachers. Raising the issue of sex between older men and young women/girls also has the benefit of enabling pupils to think and talk about wider issues of sexual health and contraception. So far Sugar Daddy lessons have taken place in 16 schools in the PLN network, reaching out to some 220 girls and 180 boys, making a total of over 400 young people.

‘Sugar Daddy’ awareness lessons start with the showing of the UNICEF film “SARA THE TRAP” which shows how a young girl called Sara avoids being trapped by an older man who wants to exploit her.

A study in Kenya (Dupas 2011) indicated that a single intervention raising the issue of sugar daddies reduced the pregnancy rate in teenage girls by 28% over two years among a group of girls who were informed about HIV prevalence with age statistics, demonstrating the increased risk of HIV from older partners. This group also reported fewer inter-generational sexual relationships and more use of condoms when having sexual relationships with peers. The opportunity to replicate this work rigorously in the USHAPE context has not yet arisen but these findings clearly resonate with those leading the initiative’s Sugar Daddy sessions.

After the film, the Pastoral Lead Teacher in each school encourages the children to talk about the film to ensure that they grasp its main messages. The teacher is then supported to lead a discussion on the real dangers posed by Sugar Daddies (and Mummies), particularly around HIV transmission. Finally, the children provide feedback through a written questionnaire. They have powerful ideas pertaining to their lives, and in particular their need for sex education, which they recognise have not hitherto been addressed. After the lessons, schools have found that there is a need for children to keep exchanging messages and ideas confidentially; indeed, there have been calls for an ‘anonymous question box’ to be put in every school which could be answered in class from time to time.

Further thought needs to be given to how best to take this initiative forward. There are some practical challenges: it is not an easy task, for example, to show films in rural schools with no electricity and where it is difficult to blackout classrooms. The initiative has managed using battery run micro-projectors, speakers and curtains. However, the bigger barrier has been attitudinal - the need to overcome concerns that some heads of schools, teachers and parents have about welcoming sex education for young people. There is a real fear of the taboo content and a worry that children might practise what they are being encouraged to talk about. However, as a result of various activities of the Pastoral Lead Network, not least the recent hugely successful USHAPE conference in Kanungu, such concerns amongst schools and parents are gradually diminishing. A more positive atmosphere for sex education is slowly taking root.
3. Youth Outreach

Early in 2016, health workers started an unfunded outreach programme in collaboration with local churches, offering Sunday afternoon sessions as their means of contacting young people. This initiative sprang from the statistical evidence relating to the high rate of teenage pregnancy and prevalence of HIV, indicating that current health education programmes focusing on abstinence and sexual fidelity were not making a significant difference. The team worked in locations across Bwindi Community Hospital’s catchment area. These locations were chosen because they represented a range of settings from more heavily populated areas (Butagota) to very remote (Mpungu).

A pilot project was set up to explore the feasibility of using church outreach to educate youths aged 14-20 years on sexual and reproductive health issues. A series of outreach events has been held with talks aimed at young people of both sexes on topics of “HIV”, “Teenage Pregnancy” and “Periods and Personal Stuff”. Delivery strategies have encouraged young people to explore their own issues in a sensitive manner. A pre-session questionnaire indicated a significant lack of awareness among participants of the facts about HIV, contraception and sexual health, as well as many myths which were discussed and corrected.

Programme for a Youth Outreach Session

- Introduction and Circulation of Anonymous Question Box
- Quiz
- Periods and Personal Stuff
- HIV Talk and Condom Demonstration
- Teenage Pregnancy Talk
- Personal Testimony (video)
- Quiz/answers
- Discussion

The decision of some churches to facilitate the initiative represents a significant development as it indicates the recognition of a need to explore alternative options in relation to sexual health and contraception. The data collected throughout this pilot programme demonstrated significant gaps in baseline knowledge in the target group and the need for intervention to address these. Whilst the initiative has made progress, the questions raised at the end of the session indicate that there is still an underlying set of misconceptions and beliefs to be tackled that might act as a barrier to safe sex among young people. The pilot programme has provided a useful needs assessment for structuring educational intervention to prevent HIV infections and teenage pregnancies. Monitoring and evaluation is at the core of this programme from the outset. The evidence generated by this means is used to improve the sessions for the future and ensure they continue to meet the current needs of the target group.

Early evaluations of the Youth Outreach project have been encouraging. But changes in young people’s sexual behaviours are hard won. USHAPE provides a strategy which local communities can be encouraged to own: crucially it is low-cost, provides a vehicle for raising key issues about sexual health and is an activity around which local participants can continue to organise. On its own, however, it is unlikely to be sufficient - knowledge needs to be utilised; attitudes need to be consolidated; and ‘safer’ behaviours need to be continually encouraged.

The hope is that the team will be able to continue to roll out the events through more churches, in partnership with local communities, but in view of the transport costs and staff time, this will require secure funding.
4. Men’s Outreach

In many developing countries gender inequality contributes to the continuing problem of unwanted pregnancies and unmet contraception needs. Traditionally family planning programmes have been directed towards women, largely due to their contact with health and maternity services. It is, however, increasingly recognised that women’s lack of decision-making power, even with regard to their own health, hinders their ability to practise family planning. Though the fertility rate is dropping slowly in Uganda, it remains higher in the rural areas than the national average of 6.2; on average men have one more child, and women nearly two more, than they consider desirable.

There are many barriers to the use of family planning amongst men, some of them cultural, others more practical. Services may not reach men if they occur away from their places of work or rest and there is a need for more community engagement. However, it is also recognised that even in health centres the service may not be offered effectively or consistently.

Consequently, as part of its multi-faceted approach, USHAPE decided to engage directly with these issues. To start this work, men from the local community around Bwindi were invited to take part in discussions about male involvement in family planning. Three focus groups brainstormed two major questions: first, what are male attitudes towards family planning? And second, what can be done to increase male involvement in family planning? Participants were encouraged to give any views they had come across, not simply views that they personally held.

Twenty men aged 21 to 59 took part in the first discussion group. The group was a rich mix comprising community members and healthcare workers, village health promoters, a tourist lodge manager, a driver and two community development workers as well as the District Health Officer, the Executive Director of the Hospital, doctors, clinical officers, nurses and students associated with Bwindi Community Hospital. Further workshops have since taken place mainly at Kisiizi Hospital, and more than 150 men have now participated.

Several clear themes emerged from the events regarding barriers to the use of contraception. There are:

⇒ Cultural beliefs
Expectation to produce children in a marriage; prestige lies in numbers; both sexes needed to provide labour and security.

⇒ Misconceptions
Belief that family planning causes future infertility, disabled children, cervical or penile cancer, weight gain (female hormonal methods) or impotence (vasectomy); belief that family planning may allow infidelity or reduce sexual pleasure.

⇒ Suspicions
Fear that family planning is a strategy for elimination; conflicting messages from religious leaders, health workers and politicians.

⇒ Practical
Men are busy at work or perhaps in the bar; current services are inconvenient; they also have few personal options for family planning.
5. Village Health Teams (VHT)

Whilst other strands of USHAPE activity take place in health centres, schools, or churches, there are still people who will not be reached through these venues. Having authoritative people within communities also offers the opportunity to reach young people without them having to ‘go’ anywhere else.

For the past three years, members of USHAPE have provided training for Village Health Team workers to help them disseminate sexual health messages. This is a cadre of unpaid, elected members of village communities; this group are recognised throughout Uganda as ‘Health Centre 1s’ – that is the first rung on the ladder of health care provision taking place in local communities. The role of these village health teams and, in particular, training them to talk about contraception, is seen as key to ensuring that messages about sexual health spread throughout whole communities.

The first workshop aimed to help VHTs develop strategies for raising family planning issues in their communities. It introduced ideas about how to assess where women were in the ‘behaviour change’ process (awareness, interest, trial, adoption, advocacy and then champions) and relevance to family planning. It also addressed any prevalent misconceptions and myths around family planning and ways of dealing with these. Over 60 people attended the first workshop.

A good deal of time was spent disentangling truth from fiction. Common myths were that:

- OCP causes fibroids, loss of libido and vaginal dryness;
- Condoms can reduce male sexual prowess, cause cervical cancer
- People break them intentionally in order to spread HIV
- Implants can move around the body and cause weakness in the arm
- IUDs can disappear in the body, cause severe abdominal pain, hurt the man during intercourse and that people commonly still become pregnant.

Time was also spent on the nature of cervical cancer as well as risk factors and prevention. A further series of four training sessions was delivered in the summer of 2015, with a specific focus on adolescent sexual needs; almost 180 participants took part.

These training days focused on those characteristics of adolescents that make them a ‘special’ group in relation to family planning. Participants were invited to discuss:

1. What are some common problems for adolescents?
2. How to gain the trust of adolescents so that they feel able to speak to and confide in you
3. Ways to communicate with adolescents that will encourage them to talk to you
4. Issues it might be important to be aware of when working with adolescents and how to approach them.

The aim was to give participants the skills not only to promote abstinence but also explain family planning options. It was also important to empower adolescents to leave violent relationships and be able to say no to sexual intercourse.

Topics covered in the VHT workshop

- Qualities and responsibilities of a good VHT
- Ways of introducing ideas and approaches to teaching
- Effective communication and counselling skills
- Behavior change assessment
- Family planning methods
Throughout the training programmes, VHTs have been encouraged to think creatively about meeting the expressed needs and concerns of their communities. Some members of the target population, for example, (and in particular teenagers), may find it difficult to attend family clinics; there can also be difficulties as regards location and access, as well as anxieties arising from family pressure or fear of visiting health care professionals. The fact that VHTs are recognised and trusted people within and from the community itself increases the likelihood of disseminating accurate information to help inform choices.

Training sessions have been well attended, with participants interacting and remaining interested throughout the day. Using a variety of methods to discuss a range of family planning issues helped in building understanding of how a variety of approaches can be used in working with young people. Taking time to debunk myths and replace the misconceptions with facts about contraception also helps whole communities to consider safe and effective approaches to family planning.

At the same time this support for VHTs helps them to address each community’s specific needs in the most sensitive ways. USHAPE would like to reach all 500 VHTs who are active in the Kanungu District with similar training annually. This aspiration will inevitably be dependent on securing funding to reach these far-flung community leaders.
Taking Stock and Moving Forward

1. Learning From This Work

Negotiating adolescence and working out the place of sexuality in our lives is something we all face. USHAPE Community endeavours to help everyone, especially young people, to protect themselves – by making them aware of the risks of intergenerational sex and giving the information they need to protect themselves if they become sexually active.

Delivering this work through schools, churches and communities has enabled USHAPE to reach many more people, and be effective in working with them, than would than would have been possible without this initiative. It has also ensured that the approach is tested in discussion with community leaders, and delivered “Ugandan to Ugandan”, in the local language. It will be important to avoid the sessions reverting to the more familiar didactic style of teaching, and to keep the sense of fun and energy through games and drama. This can draw on the more interactive approach adopted by Volunteer Uganda in their HIV awareness days.

Through this process, the case for focusing on protecting sexual health and avoiding unplanned pregnancy, rather than just promoting abstinence has come to the fore on numerous occasions. The prevailing messages in church have hitherto been largely about abstinence and unfaithfulness. But many religious leaders are also aware of problems resulting from teenage pregnancy and infidelity, and we have found that most support USHAPE teaching. Parents worry about their children becoming sexually active if they are given information, and these concerns need to be listened to. After discussion, however, most accept that schools and VHTs should have a role in this education. Men play such a central role in decision-making that it has been important to engage with them. They can be a strong support to their families but there is cultural pressure on men to have large families. Whereas women have more contact with health services, men are more likely to be influenced by myths about potential harms from modern contraception. More sensitisation is needed through male engagement events, community meetings, and on the radio.

Our pilot to establish a network of Pastoral Lead Teachers has played an important role in the success of USHAPE in Kanungu. The training days and recent conference, as well as the Sugar Daddy Awareness lessons, have kept children and young people’s welfare high on the agenda in schools. Having both a male and female teacher designated at each school has been a key decision in ensuring the Pastoral Lead Teachers can support both boys and girls appropriately. It will also be important for the future to ensure women are able to take on leadership roles as Ugandans develop and extend this initiative. Too often health services and schools operate in isolation; USHAPE Community has been developed with input from volunteer doctors and teachers, and we believe that bringing Ugandan teachers and health workers together to discuss the initiative has been invaluable. As a result, schools and churches across the area are helping young people negotiate the challenges of adolescence, with up-to-date information and culturally-appropriate support. Nevertheless, there remains a huge gap in provision of adolescent friendly sexual health services which needs to be addressed. Further work is required to develop the most appropriate approaches to reach young people.
2. Making Progress on Sustainability

USHAPE’s cascade model appears to work, with UK volunteers playing a role in training and mentorship, but with most of the delivery at a community level being in the hands of Ugandans.

USHAPE has been established through a partnership between the UK Royal College of General Practitioners and Bwindi Community Hospital, a forward-looking health facility in south-west Uganda. Work with local schools is facilitated by linking with Limited Resource Teacher Training (www.LRTT.org), which runs skills-exchange workshops for local teachers, facilitated by newly qualified teachers from the UK. Whereas this approach to skills exchange is effective for mentorship, sharing knowledge and inspiration, it isn’t so well suited to delivering services at a community level – that needs to be done through Ugandan institutions and led by Ugandans.

This is already happening. The training of Village Health Teams is coordinated by Bwindi Community Hospital and delivered in the local language by the health promotion officer and USHAPE trained staff. Youth Outreach, which runs during school holidays, is organised by a USHAPE trainer and is delivered by nurses who have completed the USHAPE family planning certificate.

The Pastoral Lead Network has enriched the work of local schools, providing training and development opportunities for Ugandan teachers, who in turn act as change agents within their schools. The PLN has now established a committee and plan to register as a community organisation, so that they can secure funding and extend the work to other schools beyond Kanungu town.

Building community networks takes time. While it is hoped that teenage pregnancies become less common, sexually transmitted disease reduces, and more women can access contraception, we know that we will have to wait before we can demonstrate these benefits. This descriptive report pulls together our experiences in community outreach, but we recognise that ultimately funders need to know that the approach makes a long-term difference.

Throughout our work, USHAPE has sought to evaluate and learn from what has been done, and we will build on this to evaluate the projects in the longer term.

The structure of a skills-exchange partnership has enabled USHAPE to grow fast. There remains a need to secure more resources to deliver the community-based work. This would provide resources for teachers to use in school, coordination for the Pastoral Lead Network, support for youth-friendly corners at health facilities, and funding for health workers to contribute to this work. This implies developing some more formal structure to provide the management and governance needed to deliver this programme. Rather than seeking to create another competing NGO, we are exploring options to channel this work through a larger organisation working in the same field that would complement the roles of the RCGP and Bwindi Community Hospital.

Currently the training of Ugandan health workers at the top of the USHAPE cascade relies on the efforts of long term UK volunteers based at Bwindi and Kisiiizi Hospitals for the organisational aspects of courses and the bulk of the teaching. We are planning ‘Train the Trainer’ courses in the hopes of passing on this responsibility, but recognise there will be a need for ongoing support and mentoring. If the community cascade is to continue and expand, more funding will be required for Ugandan staff time and the transport costs of moving people around in this remote area. There is a need for USHAPE to develop some more formal structure to provide the management and governance needed, and rather than seeking to create a new NGO, we are actively discussing a further partnership that would complement the roles of RCGP and Bwindi Community Hospital.

USHAPE has shown how a skills-exchange partnership can unlock the potential of health services, schools and community groups to work together to promote sexual health and pastoral support within a rural Ugandan community.

“**My favourite experience with U-SHAPE has been going out to the villages to meet the Village Health Workers. I was confident enough to teach them about the benefits of family planning. We also spoke with them about how to approach the adolescents in the village and offer advice, as youths are easily taken by many worldly desires and they end up being destroyed. I would love to do more U-SHAPE training, especially becoming a trainer myself!”**

- Barbara, Midwife, September 22 2015
3. Lessons and Challenges

Partnership works well when:

⇒ Family planning-trained health workers develop confidence by teaching others
⇒ Teachers and health workers plan programmes together.
⇒ Churches and secondary schools facilitate youth outreach.
⇒ Western volunteers offer support, information and mentoring.

Continuing challenges include:

⇒ Cultural barriers and myths which are still prevalent.
⇒ The provision of adolescent-friendly contraception.
⇒ The creation of effective community networks that endure.

Looking to the future:

⇒ USHAPE Community’s initiatives should aspire to be ‘Ugandan to Ugandan’.
⇒ More women need to be encouraged to take leadership roles.
**USHAPE Contributors**

**In-country leads**
- Dr Sarah Capewell 2012/3
- Dr Rowena Neville 2013/4
- Dr Emma King 2014/5
- Dr Claire Thomas 2015/6
- Dr Ceri Gallivan 2015/6/7
- Dr Emily Clark 2015 (Kisiizi)

**On-going volunteers**
- Dr Clare Goodhart - Clinical Lead
- Dr Merlin Wilcox - Research Lead
- Dr Jonathan Graffy - M&E Lead
- Dr Emma Fall - M&E and research

**Royal College of General Practitioners**
- Tom Owen - International Project Development Manager (THET Grant)
- Cynthia Frimpong Asiamah - USHAPE International Administrator
- Professor Val Wass - Chair of Steering Group
- Dr Sandy Mather - Head of International

**Limited Resource Teacher Training**
- Sam Nightingale - In-country Manager
- Simon Graffy - LRTT Founder
- Stella Knowles - Pastoral Lead Liaison 2014
- George Kynaston - Pastoral Lead Liaison 2014
- Sam Fairclough - Pastoral Lead Liaison 2015
- Mike Roberts - Pastoral Lead Liaison 2015

**Advisors**
- Professor John Guillebaud - Margaret Pyke Trust
- David Johnson - Population & Sustainability Network
- Vincent Mubangizi - Head of Family Medicine, Mbarara University
- Stephen Sebudde - District Health Officer Kanungu

**Bwindi Community Hospital**
- Sarah Uwimbabazi - Lead Family Planning Nurse
- Haeven Nahabwe - Senior Health Promotion Officer
- Geshom Babazi - Family Planning Healthcare Assistant
- Dr Birungi Mutahunga - Executive Director of Bwindi Community Hospital
- Dr Julius Nkalubo – Sexual and Reproductive Health Program Head

**Uganda Nursing School Bwindi**
- Anyango Jane Frances - Principal
- Febronina Kemigisa - Nurse Tutor

**Kisiizi Hospital**
- Kagaaza Damari - Kisiizi Hospital USHAPE Trainer

**Pastoral Lead Network, Kanungu**
- Ampumuza Rogers - Pastoral Lead Network Accountable Officer
- Frank Mant - USHAPE and Sugar Daddy Awareness Coordinator
- John Bosco - Chairman of Pastoral Lead Network Committee
- Orikushaba Alex - 'Mend the Broken Hearts'

**USHAPE Graduates Providing Outreach**
- Kyalisima Moses
- Kangabi Barbara
- Akankwasa Fortunate
- Kunihira Ephraim
- Kemigisha Racheal
- Nakayonda Shamirah