Teams4U report on Sexual Health Education Training delivered in Kumi, Uganda,

In collaboration with Mission Direct

Seminars conducted: 11-12th March 2021
Members present: represented local primary schools, Community Development Centres (CDCs), local churches, Mothers Union, and Seeds of Hope (a child sponsorship organisation).

Purpose of Training:
To equip community leaders with knowledge and tools to openly discuss issues of sexual health in the community, particularly with those under 25 years of age.

Structure of Training:
Training was structured to be as interactive as possible with plenty of opportunity for participants to engage with the trainers, ask questions, produce their own lessons, and give presentations to each other on material learnt. Each topic included an opportunity to discuss any myths or misconceptions in the community concerning that topic.

Topics Covered:
- Why Sex Education is beneficial
- Puberty
- Menstruation & Menstrual Hygiene
- Discussing periods with boys
- STIs
- Sexual Health Risks & Contraception
- Teenage Pregnancy & Family Planning

Pre-Evaluation:
Attendees were asked to fill in a self-questionnaire to assess knowledge prior to the training.

Menstruation:
63% understood that menarche occurs over a range of years dependent on the individual with 15% believing menarche occurred when a girl reached 8-9years of age.

33% were able to accurately respond that menstrual blood came from the uterus with a further 26% able to identify that the blood came from some aspect of the Female Reproductive System, but named incorrectly: e.g., vagina, ovaries, cervix.

Purpose of Menstrual Cycle				
Reproduction	Clean Uterus	Remove unfertilized egg	Sign of Maturity	Other
26%	11%	19%	11%*	33%

* “sign of maturity” is a common response from the community, and interestingly came from male attendees.

What is clear from the responses gleaned above, is that though there was an understanding of the menstrual cycle, there was a lack of clarity in the responses and no standardised terminology to describe it. Some responses were completely vague: “female is healthy”, “natural clean up”, “fulfilment of hormonal balance”, “pass out blood the body no longer

needs" etc. This ambiguity is important to address as our attendees are well respected community influencers whose authority in these matters would not be questioned within their communities.

Some cultural beliefs crept in, with 19% using language such as "clean, wash out, remove impurities" in their description, which negatively associates a normal biological process with something 'dirty'.

93% said menstruation caused girls to be absent from school. If reasons were provided, they generally referred to lack of pads and lack of suitable provision in schools (such as changing rooms). There was unanimous agreement that boys should be in receipt of menstrual health education as well as girls.

Sexual Health:

When asked their opinion on the average age for sexual debut in their communities we received a range of answers from the age of 5-25. The most consistent age provided was 12years old, which may reflect on the global average age for Menarche also being 12years. According to the National Adolescent Health Policy published by the Ministry of Health in Uganda in October 2004, the median age for first intercourse is 16.8. This of course, is difficult to accurately ascertain as is solely dependent on an honest response from young people themselves.

We asked each attendee the number of teenage pregnancies in their project and collected a span of answers from 0-12 per project. Overall, 50 teenage pregnancies were reported across the 19 projects and schools represented.

11% felt that schools should not provide students with education on contraception and 63% responded with the opinion that contraception is harmful. When asked at what age should education on contraception be taught, there were conflicting opinions with the range being 7-19yrs, mode being 10yrs, closely followed by 18yrs, and the median age 12.

Myths & Misconceptions:

Each attendee was asked these questions prior to training and as part of the post-evaluation.

*Note: % Belief Change is the % of those who changed their mind from initial response to that provided in the post evaluation. T/F short for whether the statement is True or False.

	% True Prior to Training	% Belief Change*	T/F*
Sex education will encourage children to play sex	15%	75%	**F**
Menstrual blood is impure	37%	60%	**F**
Contraception causes cancer	30%	100%	**F**
Contraception causes infertility	26%	70%	**F**
Girls can attend church on period	89%	0%	**T**
Sex does not cure period pain	70%	7%	**T**
Counting days is a good method of contraception	70%	21%	**F**
Candida is an STI	67%	72%	**F**
Cervical Cancer is an STI	26%	48%	**F**
STIs can be transmitted through sharing personal items	11%	33%	**F**
Girls can menstruate through hands	4%	100%	**F**
Men need no education on periods	4%	100%	**F**
Teaching contraception will encourage sex	19%	80%	**F**

The table above shows some healthy behavioural change because of the seminar, nevertheless we have noted that there was 0% conversion regarding those who believed girls should not attend church on their periods and there was an inclination post training to believe Cervical Cancer is an STI, rather than primarily caused by the sexually transmitted HPV virus. This is perhaps a difficult distinction to make as the trainers were attempting to make delegates aware that consistent and correct condom use has been proven to reduce certain cancers instead of the cultural belief that the use of contraception causes cancer. And conversely, it is positive to note there was a 100% change on the belief that contraception causes cancer.

Feedback:

Feedback was conducted through post-evaluations completed by the delegates and through recorded audio interviews with four individuals.

Generally what attendees found most interesting through the seminars were the presentations and demonstrations on the various Family Planning methods, conducted by our nurse. It was the first time some of them had seen a female condom and been able to find out about the benefits and concerns of the different options. We have learnt that many in the community have misconceptions about contraception because they had not been informed that it is important to line up the right method according to the needs and health of the individual, and that not all methods are appropriate for everyone. When they discovered that a health provider should do a proper investigation of the history of the person before recommending a contraceptive method, they learnt that contraception itself is not harmful, but problems arise if the individual is not honest, or the health provider is not thorough.

Several commented on the facilitation of our trainers and highlighted how clear, passionate, and friendly they were.

In going through the evaluations, we extracted some comments we felt required further explanation, see Annex A. We then referred these comments back to our trainers for their thoughts and then past our Special Advisors Health Panel in the UK for clarity and feedback. This is then sent back to our trainers for their learning and development, and any misconceptions caused will be addressed with the delegates in the recommended peer-to-peer mentoring process.

Recommendations:

Our main recommendation from the seminar is to pursue the follow-up mentoring process where our trainers meet the delegates in-situ and support them in delivering this information within their projects.

A number of delegates asked for further support in addressing Gender Based Violence and supporting their communities in making reusable sanitary pads. Dependent on the needs of Mission Direct, this is training Teams4U Uganda can offer at a later stage if required.