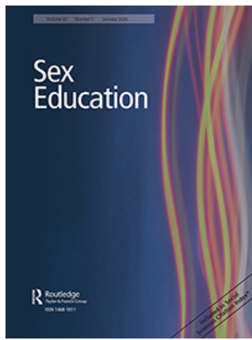

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Institutional and contextual obstacles to sexuality education policy implementation in Uganda

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ABSTRACT

The successful implementation of sexuality education policy for young people has been shown to depend on a sound legislative and institutional framework. This article shows that both institutional factors and contextual obstacles have impeded the implementation of sexuality education policy in Uganda. Qualitative research techniques were employed in the form of systematic document reviews and extensive field-work with 64 participants, of which 32 were in-depth interviews with policymakers and key stakeholders in Kampala and Mbarara districts. In addition, four focus group discussions (n = 32) were conducted with teachers. The analysis was carried out thematically and manually, using open and axial coding. It was found that policy success was primarily limited by two broad factors: firstly, by institutional weaknesses such as a lack of capacity, inadequate financial commitment, poor coordination between relevant ministries and ineffective monitoring, and regulatory frameworks; secondly, by social, cultural and religious norms that give informal power to religious and cultural leaders. Two strategies are suggested as potential ways forward: (i) a commitment to both the human and financial resources needed to monitor adolescent sexual, and reproductive health programmes, but more importantly (ii) the initiation of negotiations with cultural and religious leaders to yield more positive outcomes.

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Introduction

Young people in developing countries are confronted with major health risks related to unwanted pregnancies, sexually transmitted diseases, and HIV. With up to 187 pregnancies registered per 1000 young people aged 15–19 (Sedgh et al. 2015) and 34% of young people (15–24) living with HIV in Sub-Saharan Africa, the general picture is disturbing (Mavegam et al. 2017). In Uganda, 73% of the population are under 30 years of age, with 55% being under 18 (Uganda Bureau of Statistics (UBOS) 2016a); statistics show that 53.9% of Ugandan girls have begun child-bearing by age 19 (UBOS 2016b). Collectively

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they account for 20% of maternal deaths and lasting complications like fistula and disability (Bantebya, Muhanguzi, and Watson 2014; Woog et al. 2015).

It has been argued that Comprehensive Sexuality Education (CSE) provides an opportunity for young people to receive the necessary information about their sexual health, to reduce misinformation, and improve their ability to make safe and informed choices. (UNFPA 2014; UNESCO 2018). CSE has been shown to contribute to the delayed initiation of sexual intercourse, a decrease in the number of sexual partners, an increased use of condoms and contraception (UNESCO 2018), and the promotion of gender equality and rights (Vanwesenbeeck et al. 2016).

The benefits then, of sexuality education are demonstrable. However, debate persists about the efficacy of distinct types of sexuality education offered in different contexts. An 'abstinence-only' approach focuses on delaying sexual intercourse until marriage, while CSE takes a more realistic and positive approach to sexuality, equipping young people with the knowledge, skills, and attitudes they need to enjoy their sexuality (UNESCO 2018), by including topics on sexual pleasure, condom use, and open communication on sexual diversity (Peter, Tasker, and Horn 2015; Ketting, Friele, and Michielsen 2016). In Uganda, CSE has been largely rejected on the assumption that CSE promotes promiscuity and immorality among adolescents in a 'morally upright' society (De Haas 2017). Following a newspaper article of 7 May 2016 which stated that 100 schools in Uganda were being tricked into teaching homosexuality (Ahimbisibwe 2016), religious leaders mobilised communities, and ministries to ban every component of school-based sexuality education (except that taught within science as a subject). This incident set in motion the formulation of the sexuality education framework, developed in consultation with religious leaders, and prescribing an abstinence-only approach to sexual health which included information about body changes, hygiene, drugs and substance use, gender-based violence, and self-esteem, but notably, discouraged the use of condoms, other contraceptives, and predictably said nothing about sexual pleasure, abortion or gender, and sexual diversity.

It has been established that a key prerequisite to the implementation of sexuality education (whether comprehensive or abstinence) is the existence of sound policy and legislative framework that is often lacking in developing countries (Panchaud et al. 2018). In Uganda, the first relevant policy on sexuality education was the 2004 National Adolescent Health Policy (NAHP). Subsequently, the National Adolescent Health Strategy 2011–2015 was formulated together with the Adolescent Health Policy Guidelines and Service Standards 2012. These were not sexuality education policies, although sexuality education is part of the strategy to mainstream adolescent health concerns within the national development process.

Within the NAHP 2004 and the National Adolescent Health strategy 2011, behaviour change communication was identified as one of the strategies to implement the policies. Integrating these themes into formal education and informal training programmes for young people, and the training of teachers and health workers to provide services to adolescents, was an additional approach that the NAHP and Strategy 2011 sought to adopt. The 2012 Adolescent Health Policy Guidelines and Service Standards include reference to school health and sexuality education, specifying that teachers and health workers should be trained in human sexuality, sexual and reproductive health rights, STI,

HIV/AIDS, ABC (abstinence, be faithful and condom use), male circumcision, nutrition and hygiene, life skills, and sexual gender-based violence.

In 2013, Uganda signed the Eastern and Southern African Commitment to Comprehensive Sexuality Education (Government of Uganda 2013). However, policies related to it were not operationalised at the national level until 2018, when the Ugandan government launched a new sexuality education framework (Ministry of Education and Sports Uganda 2018), which came out after this study had been completed. The role of spearheading and coordinating each of these policies was devolved to the Ministry of Health, while the Ministry of Education was mandated to integrate sexuality education into the school curriculum or programmes. At the ministry level, a multi-sectoral committee called the National Steering Committee on Adolescent Health, and a technical and advisory committee to reinforce the technical base required for decision-making was also to be established. The policy also prescribes a district committee on adolescent health to coordinate health activities at the district level.

This study assesses the institutional and contextual obstacles to the implementation of the above sexuality education programmes in Uganda. Prior studies have highlighted some contextual constraints, in particular, socio-cultural barriers (Iyer and Aggleton 2013; De Haas 2017). In addition, comparative studies by Panchaud et al. (2018) have drawn attention to some of the institutional barriers to comprehensive sexuality education in Ghana, Peru, Kenya and Guatemala. She cites lack of coordination between the education and health ministries, lack of political will, and inconsistent funding that in combination, result in disorganised implementation and undermining the quality and effectiveness of the policy goals. Suffice it to say institutional blockages to the implementation of sexuality education have seldom been examined in Uganda, and this article explores the Ugandan experience to develop a better understanding of how these barriers manifest themselves and speak to those wishing to devise strategies that improve the implementation of sexuality education. It expands on the literature which shows that institutions matter for political life in general, and policy implementation in particular (Hill and Hupe 2014) but further emphasises that institutions operate within particular socio-cultural contexts.

It is often argued that information and skills alone are not enough to deal with adolescents' sexual and reproductive health challenges. Policies and programmes must address the socio-economic, cultural and structural dynamics which affect individual risks (Wamoyi et al. 2014; Ninsiima et al. 2018), or what Svanemyr et al. (2015) and Vanwesenbeeck et al. (2018) have called a multicomponent approach, calling for an ecological model of analysis. Burns (2002) has indicated that even if girls have the information and skills necessary to have healthy sexual relationships, power imbalances in gender relationships limit their agency to achieve desired goals. Thus, in order to obtain better sexual and reproductive health results, strong institutions are needed to address the structural causes of gender inequality while enhancing the legal framework (Ninsiima et al. 2018) and creating an enabling environment (Keogh et al. 2018) for sexuality education to be available.

Important to note also is that sexuality education cannot flourish within the weak institutional infrastructure for education and health service delivery prevailing in most developing countries (World Bank Group 2018). For example, a study evaluating learning assessment in Uganda found that children are often in school but not learning because learning environments are constrained (Twaweza 2018). This reflects wider systemic problems in education including insufficient and inadequate teacher training, teacher

shortages, overcrowded classrooms and unreliable financial support (Panchaud et al. 2018; Twaweza 2018).

This article employs the transactional model of implementation developed by Warwick (1982) to understand the implementation of policies related to sexuality education. This model was utilised because it seeks to explain policy implementation in the context of developing countries and the implementation of controversial topics like family planning and sexuality. Warwick criticised top-down theorists for assuming that policies formulated by legitimate authorities have the essential ingredients for their own implementation. Such assumptions misunderstand the complexity of the obstacles implementers confront, and consequently fail to capture the rich variety of local responses and flexible actions that can arise during implementation. Propositions important to this analysis include the notion that:

> … policy is important, but it never determines the exact course of implementation […] the program's environment is a critical locus for transactions affecting implementation […] implementer discretion is universal and inevitable […] clients have an important influence on the outcome [and] implementation is inherently dynamic. (Warwick 1982, 181)

The model allows for the fact that implementation is often marked by complexity, and that context and environment are critical elements to success (Warwick 1982; Brynard 2005). This is significant when the policy area is controversial, such as the case of the highly contested nature of sexuality education in Uganda, where context, environment, the discretion of teachers, and clients' influence all play a meaningful role.

Methods

This study was carried out in Mbarara and Kampala districts. The latter is host to many policymakers and other stakeholders while the former was chosen because this study forms part of the 'Who am I' project, conducting both quantitative and qualitative studies on sexuality education in Southwest Uganda. Qualitative research methods were used, in particular, document analysis, in-depth interview (IDIs), focus group discussions (FGDs) and observation.

Document reviews were conducted on relevant material from the National Adolescent Health Policy, the Adolescent Health Strategy 2011–2015, the Adolescent Health Policy Guidelines, Standards 2012, the Eastern and Southern Africa Ministerial Commitment on Comprehensive Sexuality Education (Uganda 2013) and other relevant programme documents such as the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY). The document review investigated whether these documents revealed any activities committed to sexuality education in terms of finance for policy implementation, principal stakeholders and responsible agencies.

Field-work was carried out between May and August 2016 with 64 participants. It consisted of in-depth interviews (n = 32) and four focus group discussions (n = 32) to assess how far activities associated with the policy (such as training teachers and providing materials) were, in fact, being implemented. In Kampala, eight in-depth interviews were conducted with Ministry Officials (see Table 1), two with international organisations, three NGOs which were directly involved in sexuality education, and four religious leaders.

Table 1. Study sample.

Category	No. of informants	Sex and age	Description
Ministry of Health	3	1 male 2 females (age: 33; 48)	Reproductive Health Department
Ministry of Education	4	3 males and 1 female (age: 38–53)	Director; Commissioner, Gender Division, HIV Division
Ministry of Gender, Labour & Social Development	1	Male (age: 50–55)	Anonymous
Local Government Mbarara	4	Male (age: 42–51)	Health, education, and administrative offices
Religious leaders	4	1 female, 3 males (age: 40–58)	Muslim, Protestant, Inter-Religious Council and Family Life Network
NGOs	4	Working in adolescent sexual and reproductive health males (age: 28–40)	Straight talk, Reach a Hand and Reproductive Health Uganda (2)
International organisations	2	1 male and 1 female (age: 38–45)	WHO, UNFPA
Teachers	10 IDIs	6 females and 4 males from each school +2 head teachers	6 females from each school and 4 men from 4 schools
Teachers	4 FGDs	Mixed males and females (age: 23–46)	Groups of 8 = 15 males and 17 females

In Mbarara district, four in-depth interviews were conducted with district officials and one with the representative of a reproductive health NGO. Stratified purposive sampling was used to select six schools from a larger sample in a parallel quantitative study which this project was linked to. Three sub-counties were chosen from rural districts based on accessibility (one school from each), one semi-urban (one school) and two schools from the municipality. From the sub-counties, schools that were receptive and willing to participate were selected. In-depth interviews with 10 teachers aged 29–50 and four mixed focus group discussions with teachers (n = 32) aged 23–46 were carried out. Teachers were selected on the basis of their expertise or involvement in sexuality education. They included senior women, senior men (individuals selected by schools to specifically take on counselling role to girls and boys, respectively), science and religious education teachers and head teachers. The rural-urban divide was deliberate to account for any differences in the quality and quantity of teaching sexuality education.

For data-collection, an open interview guide was used. The interview guide for policymakers focused on their attitudes toward sexuality education, their knowledge of the policies, and successes and challenges to successful implementation. The guide for teachers and health workers mainly focused on their knowledge of and attitudes towards sexuality education and what they were currently teaching.

Interviews lasted between 45 min and 2 h. Interviews and FGDs were recorded and transcribed verbatim. Data were read and re-read and then open coded. Concepts were based on words or phrases that were used in open coding. Open codes were arranged using phrases like knowledge of the policy, knowledge of sexuality education, attitudes towards sexuality education and barriers regarding policy implementation. In open coding, data were examined for differences and similarities (Strauss and Corbin 1990). Concepts such as commitment, resource allocation, institutional capacity and monitoring were deductively derived from the theoretical literature. Religiosity and politics in policy implementation and the design of the curriculum were not anticipated based on the literature review but were inductively derived from the data. Concepts and phrases together formed the themes, categories, and sub-categories from which sections in this paper were constructed.

Ethical clearance

The study received approval from the Institutional Research Ethics Committee of Mbarara University (reference MUIRC 1/7), the Uganda National Council of Science and Technology (reference SS 4045), and the Ghent University Hospital Ethical Committee. Written or verbal informed consent was sought and gained from all participants.

Findings

Institutional barriers to the implementation of sexuality education

This section assesses evidence for the presence or absence of policy implementation in Mbarara district. Findings reveal whether the administrative mechanisms provided for by the policies exist, whether SE is being offered at schools and whether teachers are

trained and provided with suitable materials. In formal terms, the policies stipulated a range of measures including integrating sexuality education into formal education as one of a number of strategies to improve young people's health.

Field results indicate that efforts have been made to introduce sexuality education in all primary and secondary Ugandan schools. For example, the biological components (e.g. body changes, fertility, and pregnancy) have been incorporated in the mainstream subjects like science or religious studies and are taught and examined. In addition, the PIASCY (Presidential Initiative on AIDS Strategy for Communication to Youth) school programme contains messages about HIV awareness, body changes, gender equality, hygiene and life skills. This programme was rolled out in 2003 and was designed to be implemented as extra-curricular activity (not part of the formal school timetable). However, teachers and district officials in this study stated that PIASCY had 'died' and was no longer being implemented:

> [The] Government starts programmes like PIASCY but they never follow them up. I think they start such things and after achieving what they want, they pull out. (FGD teachers semi-urban)

> PIASCY is no longer active. It was vigorous when the district officials were still active and monitoring what we were teaching. They also used to invite senior woman/man for training. When they stopped, we also relaxed. (FGD teachers rural)

> PIASCY is no longer active. It was funded by [the] American government for 5 years, but when the funding stopped, the programme also stopped. (district education official (male), Mbarara)

The above quotations point to institutional weaknesses in terms of monitoring and follow-up. It is also true that the PIASCY programme was project-based and was not financially sustained once the project ended.

Teachers and Ministry Officials indicated that sexuality education was not programmed as a separate lesson but was incorporated in other activities like drama:

> We do not have sexuality education on the timetable but we encourage schools in their music dance and drama to focus on thematic areas e.g. a play on HIV, a dance depicting the situation that would cause early pregnancy. Whichever teacher is going to teach can always teach some aspects of sexuality education. (Male, Ministry of Education and Sports)

According to participants, pressure on the teachers and school administration to achieve good exam results in core subjects was more pressing than delivering sexuality education, which was optional and co-curricular, being delivered alongside the formal school curriculum. A member of an FGD with teachers (mixed) in a rural school said;

> Children no longer get the co-curricular activities they are supposed to get mainly because they are not examinable. We care about what will be examined because we are in a competitive world.

> The Ministry sometimes requires us to do everything but we have congested programmes. Different projects bring different activities that we take on. At the end [of the day], the ministry and the community need grades, not those other activities. (FGD mixed teachers)

Sexuality education was not seen as core business by teachers and neither were they mandated to teach it. While some senior women teachers volunteered to offer sexuality

education, a male official in the Ministry of Education said; '…senior women are there but of course, they have their core activity of teaching. They are not employed to do the job of being a senior woman only'. In most schools visited, senior women met girls 1–3 times in a school term, on other occasions different teachers offered counselling to pupils during a school assembly. In four out of six schools visited, the boys were not counselled by the male senior teachers who argued that girls needed sexuality education more than boys. Thus, schools emphasised sexuality education for girls, who they assumed to be more vulnerable, while provision for boys was seen as less important. Following this line of reasoning, one senior woman reported 'Girls have more challenges, they need to be locked up', while a senior man reported 'girls need sexuality education [more] than boys because girls mature faster and have a risk of getting pregnant.'

Coordination between different ministries and local governments

The three adolescent health policies of 2004, 2011, and 2012 all suggest that there should be a steering committee to coordinate adolescent reproductive health activities. But on enquiring about this committee, officials at the responsible ministries said:

> That would be best answered by the Ministry of Health because the Policy provides for that steering committee; it could have been functional but I don't know. It is possible I have not been following. (Ministry of Education and Sports official, male)

> If you want to know issues of in-school activities, go to the Ministry of Education. They are mandated to oversee what happens in school. (Ministry of Health official, female)

Policy-makers had no knowledge whether or not the activities demanded by the policies were actively followed up to ensure implementation. Nor did an official from the Ministry of Education who was meant to be part of the steering committee know if in fact, it existed. A male official from the Ministry of Gender, Labour and Social Development said

> But you know in this country after the policy is in place it is like an end in itself … the inter-ministerial committee is normally active [only] at the time when the policies are being formulated.

Further evidence of limited coordination could be witnessed at the district-level. District level officials, who were delegated by the policy to form a district committee on adolescent sexual reproductive health headed by a chief administrative officer, were not aware of the existence of the District Adolescent Health Committee prescribed by the policies. A male district official said

> If that committee of reproductive health exists, it might not be active. If it was active then I would have at least attended one of the meetings. Do you know the difference between what ought to be and what is? We have wishful thinking in form of policies. Go to the ground at health centres, schools and observe yourself.

Government officials then did not have much trust in the policies themselves, nor did they perceive them to have much impact on the ground. Some participants claimed that the central government had developed these ideas in isolation and implementation was consequently not as effective as it ought to have been. The inspectors of schools and health workers interviewed were oblivious to the existence of the policies. Circulation of

the policies to policymakers at the local government or district level was more than problematic.

> I think some of those policies stay in the Ministry's shelves. They don't reach health centres because if the policy is in place, it should be available even online for easy access. (medical officer, male, Urban)

A policymaker explained why the policies were not implemented as follows:

> I think we didn't come out with an action plan to operationalise the policies and the issues of reproductive health are scattered in the different sectors. You find one ministry addressing an issue and wants to appear successful alone, as if the issues don't have relationships [between them]. (Ministry of Gender, male)

Such a response suggests both a lack of leadership and a dearth of cooperation between ministries responsible for implementing policies on the ground and, more importantly, supposedly consolidating sexual and reproductive health activities for adolescents. Two of the NGOs working on sexual and reproductive health suggested that internal conflict within government institutions/ministries (about who does what) was responsible for the consequent scattergun approach to sexual and reproductive health issues whereby different units/ministries aim to attract funding for their particular units rather than work together for better results.

Limited funding

In addition to the organisation and institutional factors highlighted above, an additional constraint on the effective implementation of the adolescent health policies highlighted by ministry officials was limited funding. None of the three policies was clear about the source of funding. Training teachers and health workers are central to the successful implementation of sexuality education, yet in the six schools visited teachers received no training except for the counselling lessons they received during their initial teacher training. The senior women/men teachers indicated they had received some training for PIASCY approximately five years before this fieldwork was undertaken, but since then had received only very 'scattered' training from different projects supported by UNICEF or NGOs.

> About sex, we talk about the outcomes of early sex lightly and we don't go deep into the details. (senior woman teacher, semi-urban)

> Sexuality education is not on our timetable, but we only teach a few things so that children can know. Some teachers skip 'reproduction' as a topic to avoid questions from young children which will be hard to answer. (FGD teachers, rural)

It was reported by Ministry officials that limited funding constrained activities linked to sexuality education. The health sector is underfunded and is reliant upon funding from donor agencies and development partners to fill some of the gaps.

> When the government is boasting of SRH programmes, I wonder which programmes. NGOs do all the work on adolescent sexual reproductive health. They should then leave us to do what we want. (NGO director, male)

Many SRH activities are carried out by NGOs although central government and some NGOs were reported to disagree about the content. It was suggested that this had

caused some clashes particularly when the government alleged that NGOs were teaching sexuality education in ways not approved by the government. Importantly, however, adolescent sexual and reproductive health projects provided either by government or through NGOs were uncoordinated across different parts of the country, often with distinct goals, and with limited guidance from institutions or ministries. Moreover, most projects had a short time frame.

> All the work on adolescents' sexual and reproductive health is done by partners and NGOs but they need support from the government. The government should come in terms of monitoring and helping us plan but also in terms of how to make sure these activities are sustainable. The government takes the key responsibility. You cannot rely on NGOs, they are here today, but tomorrow they are going away. (NGO programme manager, male)

Contextual barriers

A variety of contextual barriers existed with respect to the implementation of sexuality education. Socio-cultural, religious and political factors were particularly influential in hindering the effective implementation of sexuality education-related policies.

Findings suggest that the value of sexuality education was appreciated even by religious leaders, but comprehensive sexuality education (CSE) which was equated with encouraging homosexuality, abortion and masturbation (regarded as foreign practices), was resisted. According to a commissioner from the Ministry of Gender, Labour and Social and Development, the content within the curriculum is good enough; 'we have never stopped sexuality education, because it is in our curriculum. What we do not want is CSE promoted by our partners. We have said no to CSE'. Another leader from the inter-religious council stated:

> Comprehensive sexuality education is detested and some topics in CSE are offensive, for example teaching 10 year-olds that there are some people [are] naturally attracted to the same sex and that this is natural and normal!

Another informant believed that comprehensive sexuality education was being imposed by outsiders:

> Donors are promoting comprehensive sexuality education and in the Ugandan setting the 'C' is inconsistent with our African values. As a country, we are opposed to comprehensive sexuality education … even the President said Uganda will implement the resolutions within our beliefs, and that is abstinence-only. (National Population Council representative, male)

Resistance by religious organisations was widely supported by the community including bureaucrats and politicians. Voters' morally conservative views about sexuality may have influenced politicians' minds when taking decisions. This was hinted at by a respondent from the Ministry of Education:

> The government is very careful not to offend cultural and religious institutions and in whatever we do, we make a deliberate effort to consult them.

An interview with an NGO director analysed the scenario from a political perspective,

> Some policy makers act as if they do not know issues of adolescent sexual health. Comprehensive sexuality education was passed by the government when they signed the ESA 2103, but they just play politics. They worry about the next vote.

The central government then, understands the importance of CSE, because ESA 2013 implies a commitment to comprehensive sexuality education, but the fear of electoral backlash from voters who reject CSE plays a role in determining their everyday position. The power of religion was also highlighted by an official from the Ministry of Education and Sports. He reported that the National Curriculum Development Centre engages with the Inter-Religious Council of Uganda in designing religious education and life skills based sexuality education and the contents of the curriculum have to be reviewed by the Inter-Religious Council. A respondent from the Inter-religious Council of Uganda revealed that: 'We are custodians of morality. We must be consulted when anyone wants to teach issues of morality'. Such consultations delay the process or at the very least create disagreements regarding the content of sexuality education.

Discussion

Obstacles to the successful implementation of sexuality education in Uganda are both institutional and contextual in character. Using the transactional model, we have identified key contextual, environmental and institutional factors affecting policy implementation (Warwick 1982). Knowing about these is essential to understanding sexuality education in the Ugandan context, where policy success demands attention to the formal and informal negotiations between, and within, both the state and a range of different stakeholders including religious leaders. Findings show that cultural values resulted in a limited commitment to sexuality education in general and the provision of comprehensive sexuality education in particular. In many ways, unwillingness to commit to sexuality education in Uganda is less about policy efficacy and more about political calculation.

Vorhölter (2017) suggests that in a political environment where majority voters come from within strong religious communities, politicians' potential to implement controversial issues like sexuality education is constrained. According to Vorhölter (2017), restrictive laws and policies concerning sexuality result from a strategic political power play in which the government allies itself with influential societal groups in order to gain political support.

It is clear from this study and other studies (Obare, Birungi, and Kavuma 2011), that limited funding has hindered policy success. However, the allocation of funds and implementation are not simply administrative problems they are also political processes (Grindle 1980; Hill and Hupe 2014). Implementation studies show that multiple actors are involved in determining who gets what, when, how, where and from whom (Hill and Hupe 2014). As Warwick maintains, 'the program's environment is a critical locus for transactions affecting implementation'.

According to Cornwall, Corrêa, and Jolly (2008, 5–13), indicates that many power relations play out where powerful political figures may view sexuality as a 'private affair' and a distraction from important issues. This makes implementation avery dynamic process. The power relations and transactions have clearly been a part of the process of allocating responsibilities to different ministries and agencies in Uganda. Different departments have competed against one another as opposed to working together (Kall 2015), and this has led to lack of coordination of sexual and reproductive health activities, with the consequence that little impact has been felt.

Whilst Warwick's (1982) transactional model is useful, we found that some variables the model underplays were important in explaining the lack of effective implementation. Similar to Panchaud et al. (2018), we suggest that aspects such as the content of the policy, commitment from the top through to the bottom, human and financial resources, coordination between different actors, monitoring and evaluation – all of which demand greater input from the top (Hill and Hupe 2014) – have significant explanatory value. As Brynard (2005) argues, content is important for setting goals and outlining the actions necessary to achieve them. It is also a yardstick by which to understand the level of commitment. The contents of various sexuality education policies were not clear enough. The financing too was unspecific and led to confusion and inertia. The government did not commit itself to fund the activities implied by the policies with the result that implementation was seriously affected.

A further significant element affecting policy implementation is institutional capacity. Institutional constraints are reflected in the weak dissemination of information and the poor coordination between the different ministries and local governments. The Ministry of Education and Sports and the Ministry of Health, while both being core ministries with responsibility for adolescent sexual and reproductive health have not worked together closely. Many of the local government officials, teachers and health workers interviewed were unaware of sexuality education policies. Hill and Hupe show that 'if policy action depends upon a number of links in an implementation chain, then the degree of cooperation between those agencies required to make those links has to be very close' (Hill and Hupe 2014, 47). While Warwick claims that 'formal organisational structures are not deterministic' (Warwick 1982, 181), an inability to coordinate and strengthen the implementation chain through the linkage between different departments from the top to the local level, has clearly hampered the successful pursuance of sexuality education programmes in Uganda.

It should be noted, however, that institutional weakness is not unique to sexuality education. The World Development Report 2018 reveals that fully half of the low- and middle-income countries assessed since 2010 did not have systems in place to ensure that resources intended for schools, health clinics and other service delivery units reached the front lines (World Bank Group 2018). The study reveals weaknesses in implementation capacity, ineffective leadership, coordination between education agencies, and implementation teams that at most times are less motivated (World Bank Group 2018). Sexuality education cannot flourish or become a 'successful island' within such weak overall institutional infrastructure for education and health.

Strong institutions are important for monitoring and the quality assurance of programmes. However, these institutions were found to be weak. The PIASCY sexuality education programme which had already been rolled out in the whole country was not sustained. Teachers expected follow-up training and on the spot support (Rijsdijk et al. 2014) to maintain quality and sustainability. Success stories in Estonia and Colombia show that the monitoring and evaluation of programmes is key to the successful implementation of sexuality education (Huaynoca et al. 2015; Kempers et al. 2015). In this case, however, it was absent.

Teachers in Uganda were ill-equipped to teach sexuality education. This finding is similar to what Mkumbo (2012) found in Tanzania, where teachers expressed discomfort in teaching most of the key aspects of sexuality education. For sexuality education to be effective, training teachers and providing the tools they need is particularly important

because the participatory pedagogic methods used are often new to the educational system (UNFPA 2014). Moreover, so long as sexuality education in Uganda remains a co-curricular activity it is unlikely to be taken seriously by both teachers and students.

Limitations

Like all studies, this one has its limitations. The evidence of policy implementation on the ground was collected from six schools in just one district. While the schools involved share characteristics typical of other rural districts in the country, we cannot legitimately generalise too widely beyond the setting in which data collection took place. While data were collected from a range of national and district officials, numbers were small and it is possible that a larger scale study would reveal factors not highlighted in the present investigation.

Conclusion

Study findings reveal that when it comes to developing sexuality education, good policy is not enough. Policy frameworks need to be coherently and systematically implemented, which demands commitment, resources and an understanding of the wider social, political, and in this case, religious context. While the policies described here were intended to lay the foundations for sexuality education – including the provision of youth corners in schools, training teachers and health workers, and developing and providing appropriate materials – implementation was weak.

Ineffectiveness in implementation can be explained by lack of institutional capacity and commitment in terms of finance, poor coordination, competition between ministries, and weak regulatory frameworks. Crucially, institutions are shaped by the larger context of social, economic, political and religious value systems which facilitate or hinder effective implementation. Institutionalising the provision of standardised sexuality education on a sustained basis, and monitoring the quality offered, is a key to social change and healthy youth development. However, institutionalising provision can only be effective if the government works to strengthen health and education systems, enhance the quality of service delivery in general, and motivate staff to develop positive attitudes. This will require strong political leadership, a commitment to mobilise resources, and work towards increasing access to quality education and health in general, and sexual reproductive health services in particular.

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