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Self-managing Reproductive Health for Adolescent Refugees in Kampala

George Palattiyil, Ann-Christin Zuntz, Harish Nair, Paul Bukuluki, and Kalyango Ronald Sebba

ABSTRACT: This article provides an ethnographically informed critique of the humanitarian self-management model that informs reproductive health trainings for young urban refugees in Kampala, Uganda. It draws on interviews with 16 adolescent refugees, as well as policymakers, aid workers and health care professionals in Kampala in April 2019. We found that reproductive health education training sessions are a site of gendered learning where displaced boys and girls gain an understanding of what it means "how to live a good life" and how to become marriage material. Their focus on self-control also reflects a wider shift in humanitarianism toward female empowerment as a tool of neoliberal governance. In a low-resource context, however, "self-managing" one's reproductive health takes on a different meaning, as displaced adolescents weigh up opportunities for short-term income from transactional sex with imagined reproductive futures elsewhere.

KEYWORDS: adolescent refugees, Kampala, refugee self-reliance, reproductive health, self-management, urban displacement

Adolescent girls in the Global South are disproportionately affected by HIV and AIDS. In Uganda, the HIV prevalence in the general population (15–49 years) declined from 7 percent in 2011 to 6 percent in 2016 (UNICEF 2020). However, it is four times higher among teenage girls than boys; two in three new HIV infections are found in female adolescents (UNAIDS 2021). Among Ugandans between the ages of 18 and 24, one in three women have suffered sexual abuse at the hands of not only strangers and neighbors, but also loved ones. Survivors are more likely to experience mental distress, early pregnancy and sexual risk-taking behavior. In addition, sexual violence often goes hand in hand with poverty: in the same age group, one in six young women who had sex before the age of 18 had engaged in transactional sex (MGLSD 2015). In Kampala, displaced girls are particularly at risk of HIV infections because precarious livelihoods push them to exchange sex against material support and expose them to gender-based violence (WRC 2016).

Hope Uganda,[1] a national NGO that provides services to urban refugees, has attempted to reverse this trend through reproductive health trainings for displaced adolescents. The walls of its community center in Kabusu, central Kampala, are adorned with colorful paintings of African women of all ages: a girl on a slide; women picking fruits from a tree, carrying a load,

or displaying fashion. Next to a portrait of a young woman with a pensive, determined look in her eyes, a slogan reads: "Women in a changing world of work." How does one become a strong African woman? Hope Uganda provides answers to young refugees: through self-managing their reproductive health, adolescents can learn "how to live a good life," as 17-year-old Rwandese Alice sums up the message. Alice and her female peers receive information on "how to control *ourselves* and how we can abstain from boys," so they can continue their education without the pressures of teenage pregnancies and HIV infections. Many of Hope Uganda's beneficiaries also receive or have previously obtained scholarships sponsored by the Jesuit Refugee Service, which has led them to develop high-flying career ambitions. In the future, they imagine themselves in white-collar jobs, as doctors, lawyers and journalists. But safeguarding one's reproductive health also fulfils another purpose: to become "good girls" in the eyes of their communities, and thus marriage material. As 14-year-old Congolese Agnès puts it, this will allow her to avoid following her mother's example who "was a filthy woman for my father. Me, it was my desire to say no, because I don't want to repeat the story of my parents."

This article provides an ethnographically informed critique of the humanitarian self-management model that informs Hope Uganda's reproductive health trainings for young urban refugees in Kampala. Our study captures adolescent refugees' perspectives at a crossroads: most of our interlocutors recently started secondary school but had to drop out for financial reasons. While they are not sexually active yet, they have already received reproductive health trainings at Hope Uganda and at school. We provide insights into how young refugees weigh up short-term income from transactional sex with imagined reproductive futures elsewhere. After an overview of our research methods, we situate Hope Uganda's trainings in the context of Uganda's self-sufficiency policy for urban refugees.

Next, we interrogate the gendered expectations that reproductive health trainings create. Recent studies on gender and forced migration highlight that displaced women (and men) may occupy "multiple positions within conflict and displacement situations" (Fiddian-Qasmiyeh 2014: 395; cf. Chinkin et al. 2020; Hajdukowski-Ahmed et al. 2008). Scholars have called out victimizing representations of refugee women and girls, asking instead how their agency unfolds under difficult circumstances (Olivius 2014, 2016). By contrast, Hope Uganda's reproductive health trainings entrap adolescent refugees, especially girls, in binary positions as either "filthy" or "champions" of reproductive health. Trainings combine messages of female empowerment and conservative gender norms. These contradictions, we argue, are typical of Uganda's cultural and religious approach to AIDS prevention policies but also reflect a wider shift in humanitarian governance toward female empowerment as a tool of neoliberal governance. Finally, we contrast the humanitarian rhetoric of reproductive health management with adolescent refugees' lived experiences of "social abandonment" (cf. Biehl [2005] 2013) and institutional neglect at the hands of local authorities, the international community and aid providers.

Research Methods

In this article, we present findings from a comparative pilot study on adolescent refugees' reproductive health in Jordan and Uganda (for results on Jordan, see Zuntz et al. 2021). In April 2019, Ann-Christin Zuntz interviewed 16 adolescents between the ages of 13 and 18, with an equal gender split between boys and girls. Except for two girls from Rwanda, all interviewees were originally from the Democratic Republic of the Congo (DRC); 14 had spent more than five years in Uganda. All were past or present beneficiaries of Hope Uganda and recruited with the help of volunteers from their respective communities. Interviews were conducted in either English

or French. Younger adolescents, who had done their entire schooling in Uganda, were fluent in English. Older interlocutors, especially boys, preferred to speak French. Together with a refugee volunteer, Zuntz made follow-up visits to two Congolese families in their homes in Katwe, a low-income neighborhood in Kampala. In addition, George Palattiyil and Zuntz conducted key stakeholder interviews with national and international aid workers, academics, policymakers and health care professionals in Kampala.

Our study was underpinned by strong ethical considerations. In advance of the research, the project obtained ethical approval from the School of Social and Political Science, University of Edinburgh, at Level 3 (for studies involving vulnerable populations and multiple and complex risks), as well as in-house approval from Makerere University. Our research design sought to address the risk of retraumatizing young interviewees, the need for reciprocity and issues of representation. First, because of the sensitive nature of our study topic, we asked indirect and open-ended questions, and avoided singling out traumatic events and memories (Guha 2019). Instead, we invited interviewees to narrate their learning experience with Hope Uganda and to describe an ordinary day in their lives. Interview techniques also drew on Zuntz's long-term experience of conducting fieldwork with refugee women in Jordan, and Hope Uganda's ties of trust with many of our interlocutors. Consent was obtained verbally, first by members of Hope Uganda, then by Zuntz. As many adolescents were already economically active, we deemed that they were able to give consent themselves. All interviews took place on the premises of the Hope Uganda community center in Kabusu, a sheltered location where adolescents could speak freely and in private.[2]

Second, as the relationship between UK-based researchers and interviewees in Kampala was shaped by extreme power and wealth inequalities, we chose to compensate all refugee interlocutors: each adolescent received 40,000 Ugandan shillings (about $11) for the interview. Most interlocutors planned to hand over the money to their parents or carers instead of spending it on themselves. Therefore, we asked adolescent refugees what reproductive health products they would find useful but usually did not have enough money to buy. Based on these conversations, we also provided sanitary pads (for girls) and plastic razors (for boys). Finally, we aimed to avoid cliché representations of the passive suffering of "womenandchildren" during conflict (Enloe 1990), and the tokenistic use of young women's empowerment stories (Bessa 2019). In this article, we thus seek to highlight moments when girls go off humanitarian scripts, and to make sense of adolescents' reproductive health strategies in the broader context of refugee families' livelihoods.

Refugee self-reliance in Kampala

This section looks at the livelihood struggles of adolescent refugees in Kampala deemed "self-reliant" by the host country and the international community. We start by presenting the life stories of Francois, Alice and Marie, before situating the findings in the wider context of the refugee response in Uganda. Francois, age 15, comes from North Kivu in eastern DRC. Five years ago, his parents were killed in the conflict, and he and his younger brother, Johnny, were separated from their other siblings. With only $16 in their pockets, the boys boarded a bus to Kampala, in their hands the picture of a paternal aunt they had never met. When the brothers arrived in Kampala, they could not communicate with locals; at the time, they spoke only French and some Swahili. For four months, they survived by collecting scrap metal and sleeping rough. One day, a Congolese woman intervened when the boys were beaten up by other street kids. She took them to the Office of the Prime Minister, where refugees can register upon their

arrival, and Francois was able to track down his aunt and a sister. Today, the brothers share a two-room apartment with their aunt, her husband and their three children. Seventeen-year-old Alice, by contrast, has never visited her family's country of origin. She was born to Rwandese parents in Kyaka II Settlement, a refugee camp in western Uganda. Ten years later, Alice's family decided to relocate to Kampala, where parents and children now share a one-room flat. Alice does not know much about the circumstances of her parents' flight because they refuse to talk about it. However, she believes that one reason why her mother has so many children—nine at present—is that she lost her entire family in the genocide.

A medical technologist working with Hope Uganda explains humanitarian assumptions about refugee livelihoods in Kampala: "Refugees in Kampala, they are supposed to support themselves. But when they get a shock in life, that's when [Hope Uganda] is supposed to come in, like when they have a sick person [Hope Uganda] will come in to facilitate medication, if the caretaker or the breadwinner is the one who is hospitalized, [Hope Uganda] will come in to pay the house rent for three months. That is the one-time support, although even that one is not enough. You find that 20 will come, but 5 will be assisted" (key stakeholder interview). When asking for assistance, several of our young interlocutors were told by NGO representatives to go back to the camps in rural Uganda, and this was confirmed to us in formal and informal conversations with interpreters, legal counselors and medical staff based in Kampala: "If they are not self-reliant, they should go back to the camps." In reality, while some of our interlocutors, like Francois, came to Kampala directly, the families of most young people had spent at least some time in the camps. Reasons for leaving were diverse; some families were afraid of the presence of warring Congolese parties in the camps (cf. Lyytinen 2015). Others feared that there was a higher risk of getting HIV inside the rural settlements. As one young man in our sample was told by his father: "I brought you to Uganda healthy. I don't want you to get sick here!"

To Alice and Francois, "self-reliance" means economic precarity, petty jobs and a halt to their educational dreams. Both had to drop out of school because their parents could not afford to pay the fees. In Kampala, more than half of displaced children and adolescents are not in the educational system (Kashaija 2009).[3] Francois studied for only two years, as long as Hope Uganda paid for his schooling. He then started selling fried fish in the street and recently switched to trading necklaces. He estimates that on a good day, he earns up to 20,000 shillings ($5). He gives the money to his aunt, the family's main breadwinner, who sells fruit in the streets to pay for their monthly rent. Alice's father works as a volunteer with Hope Uganda, but his monthly income of 200,000 shillings ($55) hardly pays the rent of 70,000 ($19), let alone tuition fees for his children. Recently, Alice's mother was attacked on her way back from the market and had her spine broken. Now the family struggles to scrape together the substantial treatment fees, 2 million shillings ($550). Alice and her 15-year-old brother collect scrap metal in the streets, an exhausting and dangerous type of work. Often, their finds are confiscated by the Kampala Capital City Authority, and one kilogram of discarded magnets sells for only 1,000 shillings ($0.30). Despite Uganda's pro-refugee discourse, there is ample evidence that local authorities frequently round up street children, and sometimes extort money from them (Fallon 2014; Nyeko 2019). Alice's family eats once a day: "We pray that there is something to eat . . . and then we go to sleep."

In this situation of dire hardship, our interlocutors graphically describe that transactional sex is a mundane reality for girls, and the only chance to make a decent living. Alice and most other female interviewees recount being propositioned by older men: "These *boda boda* men [drivers of motorcycle taxis] buy you anything, they tell you: what do you need?" These transactional encounters are widely condemned by Hope Uganda and in schools (cf. Porter 2015) as dangerous and immoral. However, in some poor families, parents may indirectly encourage

their daughters to engage in sex work. As a 14-year-old girl tells us, "Some parents are dangerous. Once they see you with money, they appreciate you." In a similar vein, a member of the Infectious Disease Institute, Makerere University, complains: "In those families, the mother is normally the caretaker, she has to look for food. So the young girls are sometimes tasked to support, to also contribute. The mother may not come out directly to tell you to go and do sex work, but it is implied because the mum is saying you can also contribute" (key stakeholder interview).

Hardship forces some of our interlocutors to consider sex work. Marie, 15 years old, asked her parents' permission to frequent a nightclub. Marie's family is very poor, even to Kampala standards. Six children and the parents all live in one room. Her mother, the family's main breadwinner, sells necklaces in the street for 2,000 to 3,000 shillings ($0.55–0.88) a piece. "We drink porridge without any sugar" is how Marie describes their living conditions. She had to drop out of school several months before the interview, and her attempts at securing a "normal" job had failed: a local hairdresser demanded 300,000 shillings ($82) to take her on as an apprentice, and the owner of an office offered to employ her as a cleaner only if she had sex with him first. In the neighborhood where Marie lives, transactional sex is not an abstract possibility but a reality at her doorstep. Her Ugandan neighbors, 16 and 17 years old, make good money from dancing and transactional sex in nightclubs. "In the morning, they buy clothes. They come back at home and they buy food." Not only do they earn up to 100,000 shillings ($27) a night, they also seem to have fun: "They say, I enjoyed yesterday, I got the money." Marie is aware of the health risks of her neighbors' lifestyle: "[When they get pregnant], they drink some medicine." Marie is losing patience with her own situation and the lack of alternatives: "I saw my friends in the morning when they go to school with their uniforms; for me I stay at home, I am bored."

In Uganda, where most displaced people reside in settlements in rural locations, urban refugees like Francois, Alice and Marie are in the minority. With approximately 1.4 million forced migrants, mostly from South Sudan (62 percent) and DRC (29 percent), Uganda is the largest refugee hosting country in Africa (UNHCR 2022); in addition to more established refugee communities, almost one million people have sought refuge in the country since 2015 (UNHCR 2022). Uganda has received much praise from the international community for its open-door policy. It is a signatory to the 1951 UN Refugee Convention and its 1967 Protocol, as well as the 1969 Organisation of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa. For decades, incoming refugees were required to live in rural settlements, as per the 1960 Control of Alien Refugees Act. In 1998, Uganda launched its self-reliance strategy, allocating refugees small plots of land. In 2006, the Refugee Act (implemented in 2008) gave refugees the right to work and live *outside* camps. In 2017, the UN Secretary-General António Guterres called the country "a symbol of the integrity of the refugee protection regime" (Momodou 2018).

However, unlike those in rural settlements, refugees in Kampala are deemed to be already self-reliant. In Uganda's capital, home to 1.7 million people, only 4 percent of the population are registered as refugees (UNHCR 2022); their presence is overshadowed by Uganda's and the aid sector's focus on forced migrants in rural settlements. In the capital, the UN High Commissioner for Refugees (UNHCR) and its implementing partners provide only a minimal amount of livelihoods support, as well as legal and medical aid (WRC 2016). De facto, the Ugandan government pursues a "policy of self-sufficiency" (Stark et al. 2015: 174) toward urban refugees. Studies with urban refugees in Kampala confirm Francois, Alice and Marie's livelihood struggles, painting a picture of ongoing economic hardship, feelings of alienation and dreams of onward mobility (e.g., Bernstein and Okello 2007; Clark-Kazak 2014; Den Boer 2015; Lyytinen 2015; RLP 2005; Russell 2011; Sandvik 2012; Stark et al. 2015; WRC 2016). While refugees' access to chronically underfunded public health care seems to be no different from the struggles

of locals, they experience discrimination in schools and the labor market. Existing research notes refugees' frustrating interactions with the UNHCR and NGOs, including the pressure to relocate to rural settlements.

Finally, some refugee girls resort to transactional sex in a local and regional context in which the latter is a common livelihoods strategy, not only for the displaced and the poor but also for middle-class women. In Uganda, transactional sex is found across all social classes and can involve partners of similar age or with huge age gaps (Bocast 2017). Economic and affective considerations are often intertwined, and there is a wide spectrum between transactional encounters as part of normal courtship (Nyanzi et al. 2001; cf. Chant and Evans 2016) and survival sex that exposes marginalized girls like our interlocutors to mental and physical health risks. As the subsequent sections demonstrate, living with violence and poverty has important implications for adolescent refugees' ability to self-manage their reproductive health, both as a moral project and as poster children of the international humanitarian community.

Reproductive Health as a Moral Project

We now turn to adolescent refugees' understanding of reproductive health and how this is informed by Uganda's conservative approach to combating AIDS and turning reproductive health into a moral project. During the interviews, we asked all interviewees what they understood by "reproductive health." Adolescents' answers reveal a mixture of textbook knowledge and practical advice such as "not sharing sharp objects" with HIV-infected people and "providing separate cutlery and plates." Most adolescent refugees referred to menstruation management, body changes during puberty and how to prevent HIV infections. Francois, for example, at first struggled with the term. Then he remembered his classes in primary school where he had learned "about HIV, about getting pregnant, about body changes." While Francois had never attended NGO-led information campaigns, Alice had received information in primary school and during several trainings organized by Hope Uganda. To her, reproductive health means "how a girl can keep herself from getting pregnant." Most interviewees knew that antiretroviral medication and HIV testing were freely available at Kampala's public health centers. Many had attended a one-day Hope Uganda course that focused on menstruation hygiene, abstinence and preventing teenage pregnancy and STI infections. On the day of the training, Hope Uganda also offered free HIV screening, but none of our interlocutors admitted to taking part. Sometimes, these program included a practical demonstration. A 17-year-old Congolese girl recalled that the organization had taken adolescent refugees to a camp where they were introduced to a man with HIV, whose wife and children had not been infected. Although almost all our interviewees had dropped out of secondary school, they had thus learned about HIV and body changes during puberty during the final years of (tuition-free) primary school, and during NGO-led workshops. Perhaps surprisingly, those in their early teens seemed better informed about reproductive health issues. This can be explained by the fact that they had spent most of their schooling in Uganda, while older teenagers had often missed out on several years of education during displacement.

On the other hand, reproductive health trainings were not only factual but also charged with moral messages about how to become marriage material and how to achieve one's dreams. "Family values" certainly inform how our interlocutors envision their grown-up lives. Like many, Alice and Francois dream of getting married in their twenties and having several children. Having grown up with eight siblings, Alice would like to have only two children. What matters to Francois is training as a doctor, before finding a spouse in his late twenties and hav-

ing four children. During reproductive health trainings, young refugees are framed as not yet ready to exhibit sexual agency. Like many of her peers, Alice observes that while Hope Uganda provides information on the use of contraceptives, it strongly encourages its young audience to abstain from sexual activities all together. "[Hope Uganda] doesn't give condoms to children!" During reproductive health trainings, our interviewees are familiarized with an antagonistic gender model where women are portrayed as more responsible and men as perpetrators, and which emphasizes female but not male virginity: "It's the girl's problem; boys are just tempting girls." For Alice, becoming marriage material means saving herself until her wedding day. She looks down on teenage girls who have sex: "Some teenagers now, they think they are strong, they can manage themselves." In the present, what Alice is most afraid of is getting pregnant, as this would interfere with her dreams of continuing her education. As another 14-year-old Congolese girl remarks about a friend who had to drop out of school when she had her first child: "She had a dream before." For boys like Francois, becoming a suitable spouse means building a career and accruing material resources that will allow him to sustain a family (cf. Porter 2015). During Hope Uganda's courses, he learns to "be more responsible" and to refrain from seducing girls.

That female adolescents start to think of themselves as vulnerable, but also morally superior and obliged to preserve their virginity, becomes clear when we look at the precautions teenagers of both sexes take. Girls usually made a long list of behavioral advice, including not wearing revealing clothes, not going on errands on their own, not going out in the dark and staying away from men. Male adolescents, by contrast, mentioned only condom use. Clearly, they found it more acceptable to have premarital sex. Francois, for example, is more concerned about finding a girlfriend and protecting himself from HIV and other STIs than preserving his virtue: "You get this [i.e., HIV] from a woman who doesn't clean herself." Gendered expectations about how one should protect one's reproductive health have implications for how teenagers take up Hope Uganda's services. Despite its pro-abstinence rhetoric, the NGO distributes free condoms; however, girls report that only boys take advantage of the offer. Girls refrain from getting contraceptives, for fear of being perceived as promiscuous by their peers and families. While male adolescents in our sample often have less academic knowledge about reproductive health, they are more likely to have been tested for HIV.

That refugee youth in Kampala hear about reproductive health at school and during NGO trainings is a legacy of Uganda's long-standing fight with HIV/AIDS. Since the late 1980s, and much earlier than other countries in Southern Africa, Uganda began implementing AIDS prevention policies, often dubbed the ABC strategy: "Abstinence, be faithful, use a condom" (Allen 2006). In the 1990s, Uganda received much praise for its declining HIV prevalence, turning into a model country for the use of the ABC strategy in Africa and even in the US, where the approach was revived under the first Bush administration. Although doubts about estimates remain, lower HIV rates are often ascribed to increased age of first sexual activity, smaller number of partners and greater condom use (Allen 2006; Parkhurst 2011). More recently, scholars such as Stella Neema from Makerere University complain about the reduction of awareness-raising campaigns and the new generation's lack of awareness of the ABC strategy (key stakeholder interview). Still, we found our young interlocutors to be surprisingly well informed. On closer inspection, reproductive health education does not simply transmit scientific knowledge but has an important moral dimension, combining a message of female empowerment with entrenching conservative gender norms. Hope Uganda's preference for abstinence over condom use reflects wider trends in Uganda's AIDS response. In 2006, British anthropologist Tim Allen was told by a doctor at Mulago hospital in Kampala that ABC had been rephrased as "anything but condoms"—a concession to Uganda's main donor, successive conservative US governments, and nationalist governmental strategy. Uganda's long-term President Yoweri Museveni links

decreasing HIV rates to the success of the country's "family values," and the First Lady has been quoted as ascribing them to Christian faith and abstinence (Allen 2006).

As a consequence, reproductive health training sessions during NGO courses for refugees, and at school for young people more broadly, become a site of gendered learning where girls and boys absorb patriarchal gender roles. In a similar vein, signs in the courtyards of girls' schools in northern Uganda focus on abstinence and purity; in boys' schools, signs encourage the students to focus on their educational success (Porter 2015). Teachers police both male and female students' sexuality, trying to stop them from premarital sex, but to different ends: "The right time for a girl is linked here to the biological ability to carry and birth a child, for the boy it is linked to the ability to meet masculine social expectations of paternity . . . Notably absent from the masculine norms reproduced in the school setting is the important notion of the desire and consent of the boy's partner" (Porter 2015: 279).

Other studies with secondary school-aged children in various parts of Uganda also confirm that gender socialization in schools happens in a cultural context where early sexual activities and unequal power relations between boys and girls are common (Muhanguzi 2011; Nyanzi et al. 2001). Growing up, teenagers in Uganda internalize gendered expectations about how to behave toward each other: as male desire is regarded as "natural," boys are supposed to pursue girls, sometimes aggressively. Girls, by contrast, are required to refuse their advances, lest they be regarded as "cheap," HIV-infected or prostitutes. The power dynamics of courtship make it difficult for girls to negotiate condom use or refusal, increasing their risk to unwanted teenage pregnancy and HIV infections. In the case of the destitute refugees in this article, girls' bargaining power over their reproductive health is even further reduced. In a displacement context, entrenched gendered inequalities sit oddly with the discourse of responsibility directed at Ugandan and refugee girls. As we show next, female adolescents' responsibility for their reproductive health is not merely an individual affair—it can also take on national, and even international, importance.

Reproductive Health Champions and Humanitarian Discourse

During World AIDS Day 2019, which Hope Uganda commemorated together with high-ranking government officials, Ugandan Vice President Edward Ssekandi gave a speech that is now quoted on Hope Uganda's website. After praising efforts to "empower young people to champion the end of HIV infections," the vice president revisited gendered stereotypes about male and female sexuality and vulnerability to HIV. He located the reasons for Uganda's ongoing AIDS crisis in adolescents' irresponsible behavior, especially young men's lack of interest in getting tested and taking their medication. This put the onus on refugee girls: they were not simply responsible for avoiding HIV infections because conservative gender norms committed them to virginity, and later motherhood. Somewhat paradoxically, displaced girls with no access to Ugandan citizenship also had to save the nation.

This section probes the divergent humanitarian logics inherent to such official statements about adolescents' reproductive health, and their implications for young refugees. The reproductive health self-management model taught during NGO trainings and at school has an additional public health dimension that comes with great expectations about the role of adolescents, especially girls, as the vanguard of Uganda's fight against AIDS. This reflects a wider shift in humanitarianism towards female empowerment as a tool of neoliberal governance and is communicated to international audiences and to girls themselves through a contradictory discourse that paints young females as the most vulnerable *and* the most promising (e.g., Koffman and

Gill 2013; Moeller 2018; Shain 2013; Switzer 2013). On the one hand, adolescent girls are conventionally represented as disproportionately at risk of early marriage and childbearing, sexual violence and lacking access to reproductive health information and restricted freedom of movement (Croll 2007). In that vein, a representative of Uganda's National Population Council, a government agency, describes the reproductive health struggles of adolescent girls:

> I think girls are disproportionately affected compared to boys given that girls face numerous sexual and reproductive health issues. They have to deal with menstruation, they have to deal with unwanted pregnancies, they have to deal with rape . . . The society also expects girls to behave in a particular way, which also affects the way they relate to people, the way they access services, and all those things. (Key stakeholder interview)

A common recommendation is to develop programs specifically for female adolescent refugees; for example, this is the outcome of a 2016 study of refugee girls in Kampala (WRC 2016). On the other hand, Ugandan and international policymakers have pinned their hopes on young females as beacons of hope, modernity and development (Chant 2014, 2016). Various international campaigns such as the World Bank's 2008 Adolescent Girls Initiative, the UN Foundation's 2010 Girl Up Campaign and the Department for International Development's 2014 Girl Summit propose to "advance gender equality through market mechanisms" (Chant 2016: 315). This means including girls into formal labor markets through access to better and longer education; female empowerment campaigns put the responsibility for fighting poverty on girls' shoulders, while obscuring the structural root causes of underdevelopment (Hickel 2014). Displaced women are co-opted into aid programs because they are considered "more hardworking, more caring, more responsible and more mindful of the environment than men" (Cornwall and Rivas 2015: 399). Harvesting girls' economic potential goes hand in hand with encouraging them to make "smart" reproductive choice—hence a focus on programs that prevent early and multiple motherhood (Chant 2016).

International humanitarian discourse on promising young women is reflected in Uganda's female empowerment campaigns. Since the 1980s, Uganda has become the international community's posterchild for women's and girls' rights (Cheney 2007; Tamale 1999). Makerere University's School of Women and Gender Studies, founded in 1991 by women's rights activists, was the first of its kind in Africa (Moore 2016). National legislation, including the 1990 Penal Code Act, which sets the minimal age for consensual sex with a person under the age of 18, and the introduction of Universal Primary Education in 1997, have sought to increase girls' access to education and protect them from early motherhood. Critics point out that the government's promotion of women's rights has increased their participation in politics but failed to address more systemic issues of gender inequality, especially in the economic and social sphere. While Ugandan women's lived experiences of gender relations greatly vary, many struggle with gaining control over their reproductive choices, as well as household resources and the right to work (Wyrod 2016). But adolescent girls' bodies have also turned into "a battlefield on which various players struggle to redefine morality and regulate adolescent sexuality" (Parikh 2004: 87).

On the ground, globalized female empowerment discourse traps adolescent girls in endless contradictions, through trainings that come in different shapes and forms. Taken together with studies on empowerment trainings for upwardly mobile Ugandan girls (Bocast 2019; Moore 2016), our findings highlight the clash between ideals of empowered girls, and the lack of real-life opportunities for education and future employment. At first glance, Erin Moore's research with a transnational feminist NGO looks at a very different demographic of girls and NGO workers: unlike the destitute refugees in this article, Moore's protagonists are middle-class Ugandan girls, to whom upper-middle-class NGO workers flash their private cars and cosmo-

politan lifestyle. (To be clear, while Hope Uganda's Ugandan employees are certainly better off than their refugee beneficiaries, most have had no opportunities for travel and higher education in the Global North.) NGO workers in Moore's study freely discuss abortion and gay rights, issues considered taboo in Uganda's cultural climate; they convey a form of "transnational, liberal feminism" (2016: 380) at odds with the conservative messages that young refugees in our study receive from NGOs and schools.

Underneath the surface, however, there are striking parallels between different female empowerment programs in Uganda: they use similar discursive tactics that brand girls as powerless and vulnerable, to make a case for female empowerment, but there is a mismatch between imagined and real-life girls. While Moore's young protagonists refuse to be represented as weak, confidently asserting themselves during NGO trainings, the adolescent girls in our study pay lip service to Hope Uganda's messages of abstinence and gendered responsibility, while at least some of them already explore opportunities for transactional sex. Finally, what all these girls have in common is that imagined white-collar jobs are not within reach; even for Moore's middle-class subjects, finding employment with the NGO that trains them remains their only career option. In a similar vein, Ugandan beneficiaries of scholarships struggle to reconcile personal career ambitions with local NGOs' expectations that successful girls should return to their rural communities of origin and submit to patriarchal norms (Bocast 2019). In the final section, we turn to adolescent refugees' experiences of "social abandonment," arguing that our interlocutors' reproductive agency is curtailed by the lack of material support and educational opportunities.

"Not on the Map": Social Abandonment and Reproductive Agency

Youth, and girls in particular, are singled out in policy discourse as Uganda's vanguard in the fight against HIV and poverty. At the same time, locals and refugees alike are not given adequate resources to take care of their reproductive health: even though antiretroviral drugs are available for free, drug shortages at public hospitals, social stigma, high transport costs and overall food insecurity prevent many patients from accessing them in time (McGrath et al. 2014). A member of staff in a public health center in Kampala pointed out to us: "If someone is HIV-infected and taking drugs, they need to have good feeding. But the refugees—if you do not have any kind of income, how are they going to survive? . . . Medication can't be taken on an empty stomach" (key stakeholder interview).

To highlight the contrast between humanitarians' self-management rhetoric and our interviewees' lived reality, the final section attends to the specifics of the refugee experience in Kampala. We use the anthropological concept of "social abandonment" to think through the effects of neoliberal governance and institutional neglect on the urban poor (Biehl [2005] 2013). We aim to show that marginalized refugees have not simply "fallen through the cracks" of underfunded welfare systems; rather, their lives are determined by systematic patterns of indifference. Our discussion is structured around three themes that shape adolescent refugees' reproductive health struggles in Kampala: invisibility, ongoing violence and spatiotemporal containment.

Invisibility

Refugees are denied access to the host nation, as they cannot obtain Ugandan citizenship. On a more mundane level, displaced youth are also made invisible by the international community and the host state inside Kampala, through Uganda's "self-sufficiency policy" for urban refugees. As one of our male interlocutors poignantly remarks about the slum that he inhabits with his

family: "I live in a neighborhood that has no name on the map." While some of our interlocutors enjoyed a closer relationship with Hope Uganda, most had been supported by the NGO only once or twice in their lives (cf. Sandvik 2012). With invisibility comes a sense of being locked in, in Uganda and in one's own home; some teenagers literally withdrew from everyday life. Having to drop out of school hits adolescent refugees particularly hard, as a 14-year-old girl explains: "When I stopped schooling, I thought the world was just ending for me. I woke in the morning, I'm at home, in the evening, I'm at home, I sleep, the next day like that. I was thinking negatively about my life." Not surprisingly, discrimination at school and in the neighborhoods where adolescents live, rape and lack of parental support manifest themselves in high rates of depression and low self-worth (Stark et al. 2015). As for exerting reproductive agency, adolescents feel helpless. As a 14-year-old girl says, "Boys try to catch girls on the street. If you refuse, they beat you, because they know no one will come and help you."

Ongoing Violence

In the streets of Kampala, (sexual) violence is not a one-time event but rather an ongoing reality. In poor families in Kampala, violence against women and parental violence against children often go hand in hand. Through witnessing and experiencing violence firsthand, children are socialized into distinct gender roles: aggressive masculinities for boys, and subservient femininities for girls (Namy et al. 2017). This invalidates attempts at understanding adolescents' experience as post-traumatic stress disorder—there simply is no aftermath to their trauma (cf. Das 2007; Segal 2016). When asked about their memories of DRC, several of our interlocutors spontaneously brought up that as young children, they had witnessed the rape of their mothers and other female relatives. In Kampala, many teenagers live alongside older sisters who have returned to the family with their own children, often the result of a rape or forced prostitution, or who have been infected with HIV by their husbands.

For example, Michel, 18, originally from Goma, does not recognize the term reproductive health during the interview, but then recalls testing at an NGO center: "You get there, they prick you, draw your blood . . . If they find wrong results, they treat you . . . But AIDS cannot be healed." AIDS, however, is not an abstract threat to Michel, who has intimate knowledge of what it means to *live* with the disease. Having suffered several miscarriages, his older sister was diagnosed with HIV some years ago. Without her knowing, her husband had passed the disease on to her. Michel's sister gave birth to a child, herself HIV-infected, that she cannot breastfeed. Since she left her husband, she has made a living through work in restaurants but struggles to find enough food for herself and her baby. "People with AIDS are always hungry," Michel explains. Michel's experience of how HIV affects his family cannot be reduced to textbook lessons or practical precautions: it is intimate, everyday life knowledge that involves witnessing the suffering of loved ones, and his own inability to support them. The violence that Michel's sister has experienced has not simply disrupted ordinary life; rather, it continues to affect her and her loved ones through reordering kinship ties and obligations (cf. Das 2007).

Trauma continues when adolescent refugees themselves become the target of sexual violence. Alice aspires to become a lawyer "because they [i.e., people in her neighborhood] also raped me." She was abused by an acquaintance who threatened to kill her if she talked to anyone. Still, Alice told her father, who reported the rapist to the police. A week later, the young man was released. As a Ugandan, he had personal connections in the police force, and his parents paid a bribe. Farah's experience is similar. In 2014, when she was only 13, her parents moved to an informal neighborhood far away from the nearest school. Her parents paid a boda boda driver to take the children to school. One day, he followed Farah home and raped her in her

living room. Farah's family turned to Hope Uganda and to the police for help. Although police officers filed a complaint, "they are still looking for him." Farah's case illustrates that insufficient public infrastructure (e.g., the lack of nearby schools and public transport) and legal impunity for crimes against refugees work together to increase adolescent girls' risk to sexual violence and their overall sense of not being safe.

Containment

Finally, young refugees' "social abandonment" at the hands of local and international actors is felt through experiences of spatial and temporal containment. Earlier, we met Marie, a 15-year-old girl who considers becoming a sex worker. Instead of material support, her parents can only offer prayers: "I told my mum, you go to church and you pray for our studies. My mom said: You will study when we go to America. I asked her: When will we go there?" Like many teenagers in this study, Marie still nurtures hopes of resettlement to the Global North. Tellingly, most of our interlocutors described their imagined spouses and children as "white" or "métisse," testimony to the persistence of racialized ideas of beauty in postcolonial contexts (Blay 2011), but also to their dreams of better lives elsewhere. In 2018, however, only 3,700 Congolese refugees were resettled from Uganda, mostly to the US (UNHCR 2019). Marie and her peers are let down not only by the host country but also by the international community and its promises of upward social and spatial mobility. Still, resettlement remains a powerful dream to many. Roselinde Den Boer's study with Congolese refugees in Kampala captures the tension between waiting and longing for departure and the needs of everyday survival. As an informant explains to her, "when someone like you [i.e., a foreign researcher] comes to our homes, the thing we think about is resettlement" (2015: 490).

For young refugees, spatial containment in Uganda translates into stalled life plans. A growing body of research describes the predicament of young people in the Global South as "waithood," a portmanteau that combines "waiting" and "adulthood." As they fail to achieve markers of social adulthood, adolescents become stuck in a liminal state, somewhere between being children and grown-ups (Brown et al. 2014; Dhillion et al. 2011; Honwana 2012; Honwana and De Boeck 2005; Joseph 2011; Singerman 2007). Marie's story is a case in point: unable to continue her education, she failed to find dignified employment. At the same time, her parents cannot support her financially anymore, and the family life that she imagines for herself can be realized only in the Global North—in countries currently out of reach. For now, working in a nightclub might be the fastest, and maybe only, way for Marie to contribute to the family income.

Young men like Francois, by contrast, struggle to accrue the resources that would allow them to get married and pay the bride wealth. In the meantime, they resign themselves to potentially dangerous sexual relationships with "unclean women." These examples perhaps best illustrate the feelings of being invisible, stuck and permanently unsafe that shape our interlocutors' testimonies. Self-managing one's reproductive health takes on a different meaning, as adolescent refugees come to terms with ongoing hardship, weighing opportunities for short-term income from transactional sex and imagined reproductive futures elsewhere.

Conclusion

This article critically examined the reproductive health education that Hope Uganda, a Ugandan NGO, provides to adolescent refugees in Kampala. We found that in our small sample, adolescent girls are more knowledgeable about reproductive health issues but less likely to test for

HIV or benefit from condom distribution. This gendered focus on adolescent girls and how they manage their reproductive health through abstinence and behavioral precautions characterizes moral and public health discourses in awareness-raising campaigns and schooling. On the one hand, adolescent girls are supposed to live up to conservative gender norms of virginity and, later, motherhood. That female abstinence is encouraged also chimes with wider cultural expectations about women as passive and virtuous and men as aggressive pursuers. On the other hand, the international community's recent interest in the development potential of adolescent girls puts young female refugees on the front line of AIDS management in Uganda.

However, becoming "good mothers" and "saving the nation from HIV" are two imagined futures that seem out of reach for most of our interlocutors. Under Uganda's self-sufficiency policy for urban refugees, displaced youth are excluded from Ugandan citizenship and public services at the local level. In summary, we provided insights into how displaced adolescents experience their reproductive health struggles in the context of inclusionary national and humanitarian rhetoric and exclusionary practices. Needless to say, Ugandan academics and aid workers have no illusions about the limitations of the self-management approach to reproductive health that adolescents are taught by NGOs and schools: "So when they are many at home even getting services and food is a problem, and you find some children that join prostitution to survive. When you tell them, why don't you leave this business, they say, what can I do here in Kampala?" (Hope Uganda medical technician, key stakeholder interview). Rather, our key informants concede that humanitarian assistance for urban refugees in Kampala is "a drop in the ocean," as poignantly captured by the title of a report by the Refugee Law Project (RLP 2006).

Our findings highlight that offering more awareness-raising campaigns will not enable young refugees to protect their reproductive health. Although the demographic we interviewed had usually dropped out of secondary school, girls were surprisingly knowledgeable about how to prevent pregnancies and HIV infections. Sadly, knowledge does not translate into decision-making power in actual sexual encounters, which often take the shape of transactional sex or rape. A member of the Infectious Disease Institute, Makerere University, did the math: "A young girl will tell you I can get a client who will have sex with me and pay me maybe 20,000 shillings [$5] for sex without a condom. Then sex with a condom is 5,000 shillings [$1.40]. They might have the knowledge, but the situation is pushing them to have unprotected sex" (key stakeholder interview). This said, humanitarian actors might want to provide additional trainings targeted at boys. In the small sample we interviewed, male adolescents were remarkably less informed about sexually transmitted diseases and means of contraception. Quite tellingly, several young men understood reproductive health as "period issues," and thus girls' responsibility.

Lastly, the international community would do well to add another chapter to Uganda's refugee success story. Numbers of self-settled refugees in Kampala might be negligible compared to those residing in rural settlements in the country's provinces. Still, restoring the visibility of urban refugees requires a more nuanced understanding of the temporality of vulnerability; rather than one-time emergency assistance, displaced people in Kampala need more long-term support. It is timely that Uganda is one of the rollout countries of the Comprehensive Refugee Response Framework (CRRF), laid out in the New York Declaration for Refugees and Migrants, which was adopted by the UN General Assembly in 2016. One of the goals of the CRRF is to increase refugees' self-reliance. In September 2018, Uganda launched a three-year National Education Response Plan, aiming to increase refugee children's access to public schools. At the end of the first year, 57 percent of school-age refugee children were in education, compared to 43 percent at the beginning of the campaign. In absolute numbers, another 90,000 refugee children were now in school.

However, a closer look at Uganda's success statistics reveals that the biggest gains were made in primary education. Regarding secondary school-aged refugee children, Uganda did not meet its target of 20 percent: in late 2019, only 15 percent of adolescent refugees could continue their studies. Our research indicates that the transition from primary to secondary school is a critical moment for young urban refugees who must balance their education with work in the informal economy. Making a living in the streets of Kampala may include transactional sex; it also puts adolescents at greater risk of rape by strangers. According to its latest figures, Uganda is short of $389 million to fund its National Education Response Plan (Government of Uganda and UNHCR 2019). As the international community discovers its interest in "girl leaders" (Girl Up 2020), will the donors step up?

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NOTES

1. Throughout this article, we use pseudonyms to protect the NGO and its staff. Suffice to say that Hope Uganda is one of the bigger national NGOs in Kampala, with several years of working with displaced people outside camps, and it receives substantial international funding. We also use pseudonyms for all adolescent refugees that are included in this study.
2. For several of our interlocutors, this was the first time they visited Hope Uganda's center in Kabusu. The NGO's reproductive health trainings usually take place in community centers or churches inside the low-income neighborhoods where refugees live. On the day of the interview, Hope Uganda provided free public transport to the center in Kabusu.
3. In 1997, Uganda introduced Universal Primary Education, exempting four children per family from paying school fees. Secondary school fees are approximately $450 per year; families must pay for tuition, learning material, and uniforms (RTF 2015).

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