

Utilization and Community Support of Adolescent Friendly Reproductive Health Services , Jinja District Uganda

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Background

- Government of Uganda is implementing a Health Sector Strategic Plan which highlights Sexual and Reproductive Health (SRH) and Rights for all as one of the components of the minimum health care package.
- Current programs by communities, government and Non-Governmental Organizations have not properly addressed the SRH issues among adolescents.
- Although most adolescents are aware of their SRH needs, utilization health services has remained low.
- As a result the SRH of adolescents in Uganda has remained poor as evidenced by high pregnancy rates, low contraceptive use, high STI/HIV/AIDS rates, etc.

General Objective

- To assess utilization of adolescent reproductive health services in view of the adolescent health and social needs, health and social services, and community/institutional response to sexual and reproductive health among adolescents.

Research Questions

1. What is the current knowledge, attitude, perceptions and behavioral practices regarding adolescent SRH issues among adolescents in Jinja district?
2. What is the scope of support from community social and institutional structures in meeting adolescent SRH needs?
3. What factors hinder or promote continuity of provision of quality Adolescent Friendly Reproductive Health Services (AFRHS) in Jinja district?

Study Population

- District Leaders as key informants
- Adolescents 15 – 24 years
- Male and female parents/guardians of adolescents 15 – 24 years
- All government health units
- Health unit In-charges or RH provider if different

Sample Size Estimation

- For household survey – Adolescents
- Single group formula for sample size calculation
- Sample size $n_0 = \frac{z^2 \alpha / 2 * p(1 - p)}{d^2}$
- With an acceptable margin error (d) at 3%, the sample size obtained was 1,290 after adjusting for non response (10%) and design effect (10%).

Methodology (3)

- Data collection was carried out over a period of 3 months (Mid October 2006 to January 2007).
- Raw data was entered using EpiData 3.1.
- Verified data set was exported to Stata program for easy tabulation and analysis.
- Qualitative data was transcribed, categorized and analyzed according to the study themes.

Study Findings

- Background characteristics
- Awareness, attitude and behavioral practices regarding ASRH issues among adolescents in Jinja district
- Scope of support in meeting adolescent sexual and reproductive health needs.
- Determinants of utilization of AFRHS in Jinja district

Background Characteristics

- 1,226 adolescents 15 to 24 years were interviewed of whom 679 (55.4%) were male and 547 (44.6%) were female.
- 61% attained secondary level education, 31.4% primary education, 5% tertiary and only 2.6% had not received formal education.
- 79.9% were single, 19.2% married and 0.9% were divorced/separated or widowed.
- 33.8% lived with both parents, 6.5% lived with their fathers only, 17.8% lived with mothers only and 41.9% lived with none of their parents.
- 51.4% were students, 9.1% involved in farming, 9.6% housewives, 23.3% were involved in other employment which included trading, cyclists, house helps, etc), and 6.6% were not involved in any form of employment.

Awareness about ASRH Problems

- Parents, adolescents and district leaders were found knowledgeable about the main sexual and reproductive health problems that affect the youth.
- Factors known to expose adolescents in Jinja district to SRH problems were multiple ranging from;
 - lack of knowledge about associated risks
 - socio-cultural leading to poor communication with parents
 - economic
 - community / institutional and others
- Economic factors in particular poverty at family level featured prominently.

Attitude Towards ASRH Services

- Most parents were in favor of young people having unhindered access to contraceptives and other ARHS provided it was done under counseling and guidance.
- Adolescents had mixed responses regarding unhindered access to contraceptives and other RH services for young people.
- Some expressed that unhindered access could expose youth to early sexual activity/promiscuity and also fear of side effects of contraceptives.
- Those in favor of unhindered access mentioned advantages such as protection from unwanted pregnancies and STDs/HIV/AIDS.

Behavioral practices (1)

- Female adolescents are nearly twice likely to engage in sex before the age of 18 compared to their male counterparts ($p=0.001$).
- Although not significant the results suggest that females were less likely to have used a form of protection during the last sexual encounter compared to their male counterparts.
- Adolescents living with none of their parents are less likely to use protection compared to those in other categories ($p = 0.001$). This category represents a group that is most vulnerable.

Behavioral practice (2)

- Students were more likely to have used a form of protection at last sex compared to other occupation categories.
- A significant number (71.8%) of adolescents reported not visiting a health facility the last time they had signs of an STI.

Community & Institutional Support for AFRHS (1)

- Local community support for AFRHS was appreciated mainly from political leaders (Local Councilors), religious leaders and some parents/guardians.
- Youth leaders were said to be supportive to a less extent
- Cultural leaders were mentioned by none of the respondents except the Youth Leader from the cultural institution who was also skeptical of the extent of support given.

Community & Institutional Support for AFRHS (2)

- Some adolescents had reservations about the extent of parental support saying; *“Parents do not always support youth because some fear telling their children the truth and it depends on the parental love and respect of the children for their parents”*.
- Only the female parents mentioned offering counseling and guidance to adolescents
- A key informant was of the view that; *“.. Some parents/guardians have done their job and others have failed. They claim “abaana b’enakku dhino tibasoboka” (youth of these days are very difficult to manage), but have tried their level best especially those who are a bit educated”*.

Community & Institutional Support for AFRHS (3)

- Level of district support for ASRHS varied depending on the roles and responsibilities of the various district departments/sectors.
- Education department was more evidently involved in ASRH issues especially in the area of creating awareness.
- DEO *“Education department has conducted teachers’ workshops and trained peer clubs in schools. ARH was integrated in the health science syllabus from primary four to seven. Health messages are read every week on assemblies and even in many school compounds there are health messages warning children”*.

Community & Institutional Support for AFRHS (4)

- The District Local Council Chairman, acknowledged that district involvement is curtailed by financial constraints (*...the district is able to plan and implement efficiently after donor funding and training. Local revenue is low so the district is incapacitated. Too many issues competing for small revenue*).
- Although district leaders were aware of several organizations working to help youth avoid adolescent health problems, parents and adolescent were aware of very few (AIC & TASO)

Determinants of Utilization of ARHS in Jinja district

- From the community perspective determinants of young people's choice to seek or not to seek RH services ranged from;
 - Attitude of parents. A young male out of school said *"When parents are harsh. This stops children from looking for services hence ending up in problems like death"*.
 - Knowledge about services available and distance
 - Affordability *"You can go to government because it is free"*, and availability of medicines.
 - Fear was another cause of not seeking care. Example *"If I have fears about the health workers then I won't go. Youth go to TASO because the health workers there don't know them"*.
 - Perception of the cause of disease

Knowledge Contribution (1)

- In order to make RHS attractive to young people.
- Need for **health systems strengthening**. This is an area which most programmes have neglected.
- At institutional level, most recommendations were geared at **integrating AFRHS** in schools by creating favorable school environment for AFRH activities and collaboration with NGOs & CBOs involved in AFRHS.

Knowledge Contribution (2)

- At community level
 - Increasing accessibility at family level through active participation by parents / guardians
 - Youth involvement important in terms of listening and taking up advise from parents / guardians.
 - Government support by training parents/guardians in youth counseling and guidance, provision of equipment and supplies at youth centres

Conclusion

- Despite the high level of awareness about ASRH problems in Jinja district, ASRHS are still not prioritized at institutional, community/household and individual level and as result services remain poor.
- A family/household centered approach enabling active participation of parents / guardians and adolescents is key in sustaining improvements in adolescent reproductive health.