ACCESSIBILITY OF SEXUAL AND REPRODUCTIVE HEALTH CARE SERVICES BY YOUNG PEOPLE IN KIBAALE AND HOIMA DISTRICT, UGANDA.

Acknowledgements

Eco-Agric Uganda, would like to extend its sincere thanks to the Government of Uganda, through the Young Mothers Network, who funded this study. It would not have been possible without their financial support. A number of people have played critical roles in the conception and development of this research, up to the completion of writing this report. We sincerely thank them all.

The organization is grateful to all the people who participated in the study, whose views and discussions form the basis of this report. We are most grateful to the Young people for their thrilling discussions and cooperation, which made the team, enjoy fieldwork.

List of Abbreviations

STD	Sexually Transmitted Diseases
HIV	Human Immuno Virus
AIDS	Acquired Immune Deficiency Syndrome
UNICEF	United Nations Children's Fund
AMREF	African Medical and Research Foundation
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
NGO	Non Governmental Organisations
FGD	Focus Group Discussions
PRA	Participatory Rural Appraisal
AFHS	Adolescent Friendly Health Services
MoH	Ministry of Health
UNFPA	United Nations for Population Activities
MoFEP	Ministry of Finance and Economic Planning
ICPD	International Conference on Population and Development
UDHS	Uganda Demographic Health Survey
DMO	District Medical Officer
CBHC	Community based Health Care
CRHW	Community Reproductive Health Worker

Operational Definitions

Accessibility to health services

The concept of the access to health services implies not only the existence of facilities. It implies that people have the information, but they need to use it properly, that facilities can be reached, that the cost of care is reasonable, that supplies and equipment are adequate and that services are provided in an acceptable manner (WHO, 2015). Others defined it as something to do with personal behaviour in relation to health and sex, and whether people seek care when they need it. Access to sexual health is about the ability to negotiate safe sex, including contraceptive and condom use where required, with ones sexual partner. When it comes to sexually transmitted infection including HIV/AIDS, it is about people ensuring that they do not put themselves or those they are most intimate with at risk. At the health service level, access to reproductive and sexual health is about the quality of training and services, treatment and care, but also about the laws and policies that hinder or make good services possible (Reproductive Health Matters, Volume 7, Number 14, 1999).

Young people

The term young people refer to those aged between 10 and 24, and adolescents are those between 10 and 19. The youth fall between 15 and 24 (WHO, 2015). For this study, the whole of 10-24-age range is covered.

Abstract

The provision of sexual and reproductive health services to unmarried and married young people has become an issue in the era of HIV/ AIDS. Many young people who become sexually active do so without accurate information about reproductive health. This lack of information puts them at risk of unplanned pregnancies or sexually transmitted diseases. In an effort to improve the reproductive health of this group (young people), serving organisations need to incorporate the gender aspect into sex education and service delivery. Educating boys that reproductive health is not for girls only can greatly improve access to services. Cultural expectations, such as a prime value on marriage, encourage young girls to bear children at an early age. Poverty leads young people into prostitution for money to earn a living. The legal and cultural barriers to reproductive health leave many young people poorly prepared to protect themselves against STDs and unintended pregnancy. Programmes need to work with specific target groups defined by age, school status, marital status and other social factors like gender. Recognizing that most young people in the age category 10-24, have common biological and developmental issues can improve access in reproductive health. Although the government of Uganda is trying to legislate and enforce laws that protect sexual and reproductive rights of young people, there are still challenges in the process to develop programmes that can inform young people about these rights. Existing laws and Regulations in Uganda impede the implementation of the ICPD-Programme of action in specific areas such as sexuality education and access of young people to reproductive health information and services.

This study therefore explores the extent to which sexual and reproductive health to young people in Kibaale and Hoima district have accessed reproductive health services, by identifying critical sexual and reproductive health problems based on gender and occupation; and secondly, identifying existing legal, medical and social barriers. Finally, the study, basing on the identified gaps, recommends some of the appropriate interventions that can improve accessibility of sexual and reproductive health of young people. The information for the study was gathered from the two sub counties of Kiziranfumbi and Mataale. The respondents in the study included the young people, service providers, non-governmental organisation representatives, local leaders and planners at village, Sub county and district level. Participant observation, focused group discussions and individual interviews were the main research tools used. Some of the discussions are based on the information that was gathered during a needs assessment for adolescent friendly health services that was conducted in Kibaale And Hoima district, in 2015.

BACKGROUND TO THE STUDY AND METHODOLOGY

1.1 Background to the study

There is increasing worldwide concern about the health and development problems of young people. These health concerns relate particularly to reproductive health and to psychosocial and behavioural aspects that put them at risk of ill health and death. Other factors that make young people particularly vulnerable include their dependency on other people, inexperience, shyness especially on the part of girls, lack of clear legal structures and conflicting social value systems (Uganda Ministry of Health, (MOH), 2014). The explosion of telecommunications across cultural boundaries and the increase in travel, tourism and migration also appear to be influencing the sexual behaviour of young people by providing models, pressures and opportunities for sexual encounters (Tumbo- Masabo, Z and Liljestrom, R, 1994). Reproductive health is a major concern of young people because of early sexual maturation (Sendorowitz, 1997). In Uganda, studies also indicate that young people frequently engage in early sexual activities (Kaharuza, 1991; Ssammula et al, 1991) and (Uganda Demographic and Health Survey (UDHS), 1995). In a study carried out in primary schools in Kibaale And Hoima district, 78% of young people were sexually active. Studies in sub Saharan- Africa indicate that the youth are initiated into sexual activity as early as age 12 for girls and 13 for boys (International Planned Parenthood Federation, 1995). Teens are initiating sexual intercourse at younger ages than ever before, and adolescent sexual activity frequently occurs without any form of protection, as evidenced by the estimated annual rate of one million teen pregnancies (Lustig SL, 1994). The Youth in Uganda form nearly 78% of the total number of those infected with HIV/AIDS, with a male to female ratio of 1: 4 for teenagers compared to 1: 1 for adults (MOH, 2014)

Due to limited knowledge of contraceptive use, disapproving parents, and poor access to sexual and reproductive health care services/health messages, young people engage in unprotected sex to satisfy their sexual desires and curiosity. According to the needs assessment for adolescent friendly health services carried out in Kibaale And Hoima district, (Arinaitwe and Turinde,1999), young people fear to discuss these sexual desires and actions with adults. Parents expect teachers to take responsibility while teachers expect parents to be responsible for such sexual and reproductive health education. Each party feels inadequately prepared to handle the situation. In the end, nobody answers questions or provides the required information and services. Religious leaders, who strongly advocate that young people should not be given sexual and reproductive health information and services, make the situation even more confusing (African Medial and Research Foundation (AMREF), 1996). This leads to unpleasant consequences; unwanted pregnancies, sexually transmitted diseases (STDs) and Human Immune Deficiency Virus (HIV/ AIDS) occur. An unwanted pregnancy curtails the goals and hopes of a girl who may be thrown out of school with her future prospects lost. There is no opportunity for rehabilitation, employment and being put back into school. This may lead to prostitution as the alternative way of earning a living.

In trying to save the situation, some girls attempt illegal abortion (Agyei, 1991; and Turyasingura, 1994). This is very frequent but many girls never survive it (Wasswa, 1991). Those who survive abortion might have their reproductive system damaged and end up with no prospects for normal pregnancy in married life (The World's Youth, 1996). A girl with unwanted pregnancy conceals it from hostile parents and hence does not seek or receive antenatal care (Arinaitwe and Turinde, 1999). The risks of pregnancy are not attended to, and further health problems might develop (AMREF, 1996). It is widely believed that family life education should lead to enlightened behaviour (Bygdeman, M. And Linda, K. (1994), (SIDA, 1994). Such education enables young people to understand their reproductive health and sexuality thus reduce the incidence of Sexually Transmitted Infections (STIs) and

unwanted pregnancies. Emphasis therefore has been placed on sex education programmes while little attention has been given to the need to make contraceptives accessible alongside this sex education (Bagorogoza M.P.K, 2015). As a result, illicit abortions and teenage pregnancies are still rampant.

1.2 Access to Health services in Uganda

Uganda has an estimated population of 20.8 million, which is growing rapidly at the rate of 2.5% per annum (MoFEP, 1994). The country has the youngest population in the whole world, (World Population Report, 1999). About half (47.3%) is under the age of 15 years. One in every three (33.5%) is a young person (10-24) (National Adolescent Draft Policy, 2015). Most of the young people (90%) live in rural areas (Turyasingura, 1994). The cumulative effects of continuing poverty, gender discrimination, HIV/AIDS and illiteracy levels are still at large in Uganda. Half of Uganda's population (51.0%) has no access to health facilities (National Population Policy for Sustainable Development, 1995). The health infrastructure is characterized by uneven distribution and poor access to facilities, inadequate services and low per capita expenditure *(see table 1.1).* The health sector as a whole is dependent on donor contributions both for capital investment as well as operational costs (MOH, 2015).

1.3 Statement of the problem

Historically, Uganda and other African societies had well-established traditional systems for preparing young people towards a responsible sex life that were mediated by aunts and uncles (Kizza-Wamala, and Kajura, 1991). However, today such systems of initiation have disappeared in many societies, and in others they are only practiced in fragments. They have lost their meaning and function as a mode of initiation in most socio-cultural contexts (Fuglesang, M., 1994), (Tumbo-Masabo, Z and Liljestrom, R., 1994), (Mbunda, F.R.D., 1991), (Ahlberg, B. M., 1991). However, these institutions have not been effectively replaced and today young people are being fed with conflicting values, no clear guidance on standards of behaviour and little information about matters of Sexual and reproductive health. Peers, not parents, are the most important source of knowledge, but young people's perceptions are coloured by myths and misconceptions and are often misled (Mwateba, R., 1993). This compounded with the changes in the sexual behaviour and the threat of HIV/AIDS and other STDs imply that there is need to strengthen this area.

1.4 Significance of the study

According to the needs assessment that was done in Kibaale And Hoima district, lack of access to health services and rights in decision-making appeared to influence all other components of young people's sexual and reproductive health (Arinaitwe et.al, 1999). Although the study team found numerous programmes that addressed young peoples related issues, like CARE, Uganda Red Cross, Kibaale And Hoima branch, World Vision, the MOH programmes, etc, most of them (programmes) targeted a wider audience (more than young people). It was only AMREF project that focused on young people that are in school. Specific sexual and reproductive health educational interventions targeting young people out of school were few. Adults in the study recommended that people promoting young people's sexual health should respect the socio-cultural values of their society. On the other hand young people recommended immediate changes in the cultural and traditional practices that limit their access to services. Issues of quality of care at the government public health facilities were of great concern to the young people, but alternative suggestions to remedy this problem were not exhaustively discussed. It is against this background that a rapid anthropological study about the fore mentioned issues was conducted in Kibaale And Hoima district, as part of the Master of International health course.

1.5 Broad Objective

The overall objective of the study is to find out the extent to which unmarried young people in Kibaale And Hoima district have accessed reproductive health services.

Specifically the study was carried out to:

1. Identify critical Sexual and reproductive health problems of young people based on gender and occupation

2. Identify existing legal, medical, economic and socio- cultural barriers to young peoples access to information and services.

3. Based on the identified gaps and their determinants, recommend some of the appropriate interventions that can improve accessibility of sexual and reproductive health services

1.6 Material and methodology

1.6.1 Study area

The study was carried out in Kibaale And Hoima District, Uganda. The selection of Kibaale And Hoima district was based on the fact that it was one of the five districts where a needs assessment for adolescent friendly health services was conducted. The aim of the programme is to enhance the health and development of adolescents. The minimum package entails recreation, information, life skills education, and counseling and health services. The programme also focuses on substance abuse prevention, control of HIV/AIDS and providing links to family planning. Kibaale And Hoima district was selected because there were some activities taking place and sensitization for adolescent services had already started under the Basic Education for child survival and Adolescent Development (BECCAD) programme supported by UNICEF. Other programme activities, in young people's reproductive health, by international and local NGOs like African Medical and Research Foundation (AMREF), CARE, and Programme for Enhancing Adolescent Health (PEARL) were present.

1.6.2 Study design and sampling technique

A cross sectional qualitative study using a descriptive and analytical approach was conducted. Two pilot sub-counties of Kiziranfumbi and Mataale were purposively selected with the assistance of the District Director of Health Services (DDHS) for both districts, based on selected criteria, (rural/ urban setting, and under-served areas). Kiziranfumbi is a rural sub-county while Mataale is a semi-urban sub-county bordering Kibaale And Hoima municipality. The researcher worked directly with the young people, and closely with the district technical staff in health, education and community services, that are directly dealing with the young people. A number of NGOs active in young people's health were also involved in the study. Participatory data collection methods were used to achieve the study objectives. They included:

- 18 Focus group discussions (FGDs) with in and out-of-school young people, for both sexes, and in separate groups; parents of young people (mothers and fathers in separate groups; teachers, in a mixed group; and traditional birth attendants. Other people who constituted focus group discussions were female adolescent parents aged 15-19 years (see Annex two for further details.) The aim of the FGDs was to determine opinions, attitudes and knowledge held by different stakeholders in relation to accessibility of SRH services by young people.

Pparents in focus group discussion

sharing session in progress

- 18 Key informant interviews with young people in- and out-of-school, service providers (teachers, health workers, religious leaders and NGO representatives), local leaders and planners at village, sub-county and the district level. The selection of the key informants was based on their roles and level of knowledge in relation to SRH of young people.

- A range of documents (international, national and district sources) on young peoples programmes and activities were reviewed, including project proposals and plans, programme implementation activities, as well as policy documents.

- Social mapping of local services and problem ranking of perceived major health problems by groups of young people were used. Formal and informal interviews were also used whenever potential respondents would be met. There were also site visits and observations. Different tools were developed and used to collect information during the key informant interviews and FGDs (see annex 1).

1.6.3 Data Analysis

The recorded tapes from FGDs were transcribed, typed and edited. Data was then summarized using flow charts and matrices. Texts were coded and clustered along themes and sub-themes for subsequent analysis. Key phrases or statements (quotes) on any of the topics or emerging themes were quoted verbatim and integrated into the report.

1.6.4 Limitations in the study

- Early marriages of young people (10-24 years) in Kibaale And Hoima district are very common and socially acceptable. This led to young married girls unwilling to participate in the study; although the initial plan was to involve both married and unmarried young people. According to their traditional standards, a girl who is officially married is recognized as a fully-grown woman irrespective of her age.

- At the district level, the legal aspects concerning SRH of young people were not clear to most respondents met during the study. Most people interviewed as advocated for at the ICPD conference in Cairo, did not know the notion “young people have the same right to reproductive health as their elders”. The government’s recommendations to provide comprehensive framework for the promotion of reproductive health and rights is still largely on paper at the national level. This report therefore largely relies on the literature review other than the views of the respondents on this matter.

Table 1.1 Key Indicators of KIBAALE AND HOIMA District and National status 1997/98)

Indicators	District	National Status
Demographic total Population (1991)	417,218	16,700,000
Urban population (%)	7%	18%
Rural population (%)	93%	82%
Young peoples Population (10-24 years)	190,535 (34.1%)	6,772,800 (33.2%)
Infant mortality rate per 1000 live births	114	88
Maternal mortality	-	500
Number of health units	31	1637
Population radius of H/U (%)	71.4%	49%
Population per Doctor	55,830	18,600
Access to safe water (%)	58.3	46%
Total dependency ratio	115.4	-
people, 1995		
Total births Among young Number of primary schools	33,415 289	43% -
Primary schools enrolment	166,222	82%
Number of secondary schools	40	-
Secondary schools enrolment	11,652	13.5%
Literacy rates (%)	51.9	61%
Projected population (2015)	558,300	20,400,000
Young people HIV/AIDS	-	17,300

Source: Statistics Department MoFEP, 1991 Vision 2025,1999 HIV/AIDS Surveillance Report, MoH 1999 UDHS Results, 1995

Table 1.2 Key Indicators in the two Study Sub-Counties

Indicator	Mataale sub-county	Kiziranfumbi Sub-county
Total population	53,399 (28,403 females; 24,996 males)	24,676 (12,097 females; 24,773 males)
Primary schools	25	16
Secondary schools	3	4
Public Health Facility	3 Sub dispensaries	Health Centre
NGO Health Facility	Nil	1 Catholic Mission Centre
Private clinics	Nil	4
Drug shops	Nil	4
Number of trained TBAs	9	11
Number of Traditional Healers	14	
Community centres	1	1
Police Post	Nil	1
Reproductive health Programmes	AMREF, CARE, DMO/MOH programmes(STI, CBHC, CRHWs, TBAs), Mataale Youth Association and Bwindi Youth Association	AMREF, CARE, DMO/MOH programmes(STI,CBHC, CRHWs, TBAs).

Source: KIBAALE AND HOIMA District Population Office and Field Notes

CHAPTER TWO: RESULTS

2.0 Main health and development problems of young people in Kibaale And Hoima district

Young people in Kibaale And Hoima district have varying problems they are faced with. The leading health and service delivery related problems mentioned in the two sub-counties include diseases like malaria; limited, inappropriate and deficient health services; inadequate formal education; poor parenting; poverty and unemployment. Young people and other people interviewed agreed that all the mentioned problems stem from the wide spread poverty in the district.

Some of the community members giving their views

2.1 Reproductive health problems

The main sexual and reproductive health problems of young people mentioned include: early/ unwanted pregnancies, illegal abortions, early marriages and STDs including HIV/AIDS. Other problems reported were lack of access to contraceptives, lack of information on sexual matters and inadequate counseling services. Despite a fairly reported high level of awareness about the dangers of HIV/AIDS, some young people still indulged in unprotected sex. Such indulgence in sexual activities was reported to be the same for both in and out school young people. However, in a focus group discussion of female parents, they noted that the consequences of these problems affected girls more than boys as expressed in their statements:

Female parents during the sharing session

"Sex does not leave a mark on the boy, but girls become pregnant which is socially unacceptable" (FGD, Mothers of young people, Kiziranfumbi).

"Fathers do not mind when their sons have sex with other peoples daughters although they do not want their daughters to engage in sex before marriage" (FGD, Mothers of young people, Kiziranfumbi).

2.1.1 Lack of information on reproductive health

Most key informant interviews indicated that lack of sexual and reproductive health information is the major problem of young people. The district technical staff and village health team members said that the girls who drop out of school due to pregnancy shows how young girls lack information about what to be done. They said that the situation starts in homes where parents are not talking to their sons and daughters about sex due to cultural barriers. It was reported that the children lack information about their changing bodies and how to control the sexual urges that come up naturally at puberty. In all the FGDs of young people, most parents expect their sons and daughters to abstain from sex before marriage. Interviews with young people in school indicated that information on growth and development are taught in the science subjects. Girls reported that senior women teachers teach them about menstruation and the consequences of early pregnancies. Senior women teachers on the other hand said that there are some girls who get to puberty when their parents have not told them the change that come along with it (puberty). They commented that some girls reach the age of menstruation when they are totally ignorant about it. A senior woman teacher narrated how a young girl was terrified when experiencing her first menstruation. That she cried and thought she was ill, and went to the health centre and reported that she had a problem of bleeding from her body. Senior women teachers also reported that young girls are deceived about pregnancy occurrences. They said that some girls are deceived that a girl who has not gone in menstruation cannot become pregnant. On their part as teachers, they are not supposed to teach about pregnancy prevention in school. However, they reported that some young girls discover through other means to access such services, where some girls are fed with wrong information Some girls reported misinformation amongst themselves. Young girls in primary schools said that some of their friends are deceived and end up becoming pregnant. They reported a myth that "wearing your knickers out" the first time one is going to have sex prevents a pregnancy. Others are deceived that having sex in a while does not require a girl to take pills every day.

Key informants sharing their views

2.1.2 Early/ unwanted pregnancies and marriages

Both FGDs and Key Informant interviews reported high incidences of early pregnancies in the two study sub-counties. Unplanned pregnancies were reported common among young girls in school. The problem reported among the out of schoolgirls, was early voluntary or involuntary marriages. It was reported that girls who marry off at a young age are subjected to hard labour in shambas and at home throughout their marriages. In a FGD of female parents, husbands of such girls refuse them to use family planning. For young girls in school, an unplanned pregnancy means permanent expulsion from school as illustrated in the following quotation:

A group of female parents after the discussion

"Seven girls became pregnant at Mataale primary school this term and they were chased from school". (FGD, young girls in school)

A key informant from education department at the district level noted that adolescent pregnancies are one of the causes of school drop out for girls. He further reported that boys who make girls pregnant are not punished. I believe there could even be higher numbers in other schools in the district, depending on the way people lamented about the problem. It was not possible to get the district statistics about the prevalence rate of young people's pregnancy. In a FGD of young mothers in Mataale sub-county, being pregnant often means resentment from friends, the community and harassment from their parents. Young mothers further reported that parents do not give them help after delivering, not even the food for both the baby and the mother, or even clothes. It was reported that such young mothers are sent away from home while others are given away in the name of "house maids" to distant relatives or friends for money.

The district inspector of schools addressing the members

Unsafe Abortion

All the groups of people interviewed agreed that illegal abortion among young girls takes place. Study findings indicated that in case of unwanted pregnancy, especially for young girls in school, abortions were carried out using local herbs, taking over-dose of drugs like chroloquine and aspirin or drinking concentrated tealeaves. Young girls in Kiziranfumbi sub-county said that traditional healers or friends who have gone through the same process prescribe herbs. Asked as to why they do not go for counseling and abortion services in the public health facilities, the girls fear that they would be reported in the community or to the police for having performed an illegal act. Young girls out of school said that qualified doctors in Kibaale And Hoima town perform illegal abortions at expensive services, which most girls felt was unaffordable for them as illustrated below:

"Girls with rich boyfriends or "sugar daddies" are the ones who can afford safe illegal abortion " (FGD, young girls in school, Mataale).

Traditional Birth Attendants in both sub-counties reported getting pregnant girls seeking for abortion services. Two TBAs from Kiziranfumbi reported two young girls who had died in the previous two months due to abortion effects (retained placenta, excessive bleeding and infection). Both girls were reported to have died on the way to Kibaale And Hoima hospitals. We only get those who get problems in the process of aborting. The problem, they come when it is already late when the necessary referral cannot be made, remarked by TBAs. They also reported that other girls from neighbouring districts also visit them for the same services. They reported a girl from Kabwoya sub county that died in Kiziranfumbi before reaching the TBAs. On their part, the TBAs said that they did not offer abortion services.

***"I think these girls should be taught about family planning instead of seeing them die. One of the dead was a re known saved girl in the village" (FGD, TBAs, Kiziranfumbi*).**

Meeting with traditional birth attendants in Kiziranfumbi

2.1.4 Contraceptive use

Young girls out of school in both sub-counties expressed some degree of knowledge about the use of contraceptives and their sources. They said that drug shops and private clinics sell contraceptives pills and condoms. The girls were also aware that public health facilities provide family planning services. However, girls reported that there is a lot of stigma attached to the use of family planning when you are not married. They reported that community members have a perception that if one is no longer in school, she should immediately marry off, but not practicing prostitution in the area. Because of this, they go to areas a bit far from their homes where such services can be rendered. On the other hand, young girls in school reported inadequate knowledge about the use of contraceptives. In depth discussions with young people revealed that there is lots of wrong information about contraceptive pills. In One FGD with girls in Kiziranfumbi sub-county, some girls believe that swallowing two pills before and after sex prevents a pregnancy, others are informed that pills make one infertile which is feared most, while others think and have been told by friends that taking half packet of pills can terminate a pregnancy. The girls further reported that they fear keeping such oral contraceptives at home where parents would learn about it. Even in boarding schools, girls

noted that the person keeping pills has to ensure that nobody sees them, including their friends who would start discussing about that person, especially those who are not yet sexually active. In addition to oral contraceptives, condom use and abstinence, adolescent mothers knew about injectables and implants. They however said that it was expensive to use those methods. Adolescent mothers in Mataale sub County noted that an injection at the government health facility is given at 1000 Ugandan Shillings (0.6 Dollars), which they could not raise with ease. They reported a local myth that implants affect women's workload. Adolescent mothers preferred injectables to pills because of convenience (visiting a health facility once in a period of three months, and nobody else would know that they use family planning). According to the problem ranking of major SRH problems of young people, boys and girls came with different priorities. The boys listed HIV/AIDs/STDS as problem number one, while the girls' concern was unplanned pregnancies, shame and finally HIV/AIDS as expressed by their statements:

"*Pregnancies are girls' businesses. We are concerned about death" (FGD, Boys out of school, Mataale).*

"Anybody can get HIV/AIDS including married people, but becoming pregnant before marriage is the worst that can happen to a girl. You become hopeless throughout your life" (FGD, young girls out of school, Mataale).

Through health education, most young people know that a condom can prevent both the pregnancy and HIV/AIDS. However, girls were reported not to negotiate condom use. Culturally, boys noted that it is their responsibility to ask for sexual encounters to the girls... girls who suggest use of condoms are labelled promiscuous- who have been moving around with men. One male youth said that some girls are shy at that time to discuss condom use. There is a myth held by girls that a condom can enter the woman's uterus. Some discussions with young boys especially those in school still indicate some lack of skill and knowledge to use the condom. Unlike in the communities, health educators are not supposed to demonstrate condom use in schools. The following statements indicate the level of inaccurate information:

"Some boys put on two condoms to guarantee safety. If one breaks, the second one protects you"
"Some boys tie condoms with rubber bands so that they do not fall off". "Condoms are meant for those with big private parts, there are no small sizes for young ones"
"Some condoms have holes" (in-school, boys)

Sharing with boys on condom use

Asked as to whether the condoms were available and accessible, they said that condoms are available but stocked in the "wrong" places like government health facilities where most young people do not go. They further said that a packet of three condoms costs 100 Ugandan shillings. Boys in Kiziranfumbi expressed need to have free condoms and supplied by a trusted person by the young people like a youth leader in the village.

2.1.5 Sexually Transmitted Diseases

Personal interviews with some health workers indicated that some young people (15-24 age bracket) suffer from Sexually transmitted diseases. The common ones reported were gonorrhoea and syphilis. At one private drug shop in Kiziranfumbi, the attendant reported receiving some young boys asking for tetracycline, chloramphenicol or Penicillin injections. He said that girls go to his shop for contraceptive pills only. The Drug shop Attendant was concerned about the way young people treat themselves. He reported the habit of sharing the doses that were meant for one person. His assumption was based on the fact that the same boys would keep going back for the same drug before the days for treatment would be over. Health workers at the government health units reported receiving few young people in need of STD treatment. According to the records of Mataale Sub County, no young person had visited the dispensary for Sexually transmitted diseases in the last six months. Discussions with boys in and out of school indicated that cases of STDs do not go to public facilities due to fear of being disclosed. The district technical staff in health attributed this to fear of seeking health care due to stigmatisation, non- compliance to drugs given and use of alternative therapies like herbs, or self medication with antibiotics from private clinics or drug shops, which, usually, is determined by the availability of cash.

Health officials during the discussions

2.1.6 Problems related to poverty and unemployment

Parents in the two sub-counties reported existence of many out of school young people who lack paid employment. They were generally reported to depend on their parents for survival. Girls out of school reported helping their mothers in cultivating the fields to produce food for family members. Others reported having communal groups where they dig for money. In both cases, respondents mentioned lack of enough money on the side of girls, to cater for their basic items in life. Parents also admitted finding it difficult economically to provide the basic needs of their children due to poverty. Because of this, girls are motivated by money, and giving sexual favours in exchange for material life comforts. In such situations, girls have no bargaining power over safe sexual practices.

Poverty is the leading cause of our problems because it makes us lack control over our lives and have to depend on other people for support; this may even force some girls into promiscuity in order to acquire the basic needs of life" (FGD, young girls out of school).

Parents during the discussions

2.1.7 Education and related problems

Many young people were reported to be out of school. Even with the introduction of compulsory universal primary education (UPE), for four children per family, some parents fail to provide for them due to poverty. Lack of basic things like clothes, school uniforms, sundries and other scholastic materials may lead to leaving school. Girls in particular drop out early, and may end up marrying early. Poor health and lack of proper nutrition resulting into fatigue or lack of concentration were some of the problems mentioned affecting the education of young people.

Few pupils in UPE schools

2.1.8 High- risk behaviour related problems

High- risk behaviour related problems reported in the two sub- counties included: substance abuse; sexual abuse (rape and defilement) and sex in exchange for money, affecting mostly girls. According to the parents of young people and the district planners, these problems were largely attributed to ”idleness”, negative peer pressure, lack of recreation activities, desire for material items, defying of the law and a ”hostile” and unsupportive environment, especially at home.

Parents during high risk behavior related problems

2.3 Coverage of Sexual and reproductive health services in Kibaale And Hoima district

In Kibaale And Hoima district, the homes, schools, health centres, community institutions like churches and the media were reported to be some of the avenues used to promote and provide young people with reproductive health services. Whereas there are many health programmes run by government and non-governmental organisations (NGOs) in the district, there is general lack of those specifically targeted for young people. Existing programmes address issues of HIV/AIDS than other young people's reproductive concerns. In principle, family planning and antenatal care services are also available to the young people through CARE and Family planning Association of Uganda, but young people did not view such services as meant for them. A number of health facilities exist in the district, which offer curative and preventive services, but no special attention is paid to young people in service provision. Reproductive health services are mainly delivered in public, NGO, community-based facilities and in schools (see table 1.2 and the social maps). Information, Education and Communication (IEC) materials and supplies are available from the District Director of Health Services (DDHS), NGOS, Education department, the Newspapers (like "Straight Talk" and "Young Talk") and local FM Radios. Young people get access to such IEC services like any other person. All the young people met said that they get advice from some parents, older siblings, elders, church leaders and friends about SRH related issues like sexual relationships and pregnancy. Senior women and science teachers were reported to offer some counselling services to the in school youths. Issues addressed include sexuality, menstruation, problems of pregnancy and HIV/AIDS. However, some young girls in school expressed their doubts about the benefits of being given guidance by older senior women teachers, who, according to the young girls, are too old and have fixed views about their sexuality, and therefore were not the best to assist them.

" Senior women teachers are mostly adults who have personal or religious views about sexuality that influence how they want to assist young people, they have difficulty seeing the situation from the point of view of the young person. So young people often hesitate to tell them that they are sexually active and to talk about contraception".

2.4 Existing Barriers to service utilisation

2.4.1 Legal barriers

There are several legal issues related to young peoples health and development, some of which protect them while others negatively affect them. The maximum age for sexual consent is 18 years, below which is regarded as defilement. The maximum punishment is death penalty. By legal definition, a child is 18 years and below. Abortion is illegal in Uganda except on medical grounds. The right of access to reproductive services, including family planning, maternal and child healthcare and STD prevention was not clear to most of the respondents' interviewed, apart from a few district technical staff. The following statements indicate the level of inadequate information about reproductive rights:

The right to sexual and reproductive health of young people is vested in their parents. When the girl gets married, the husband should control her sexual rights. This issue of sexual rights is causing problems everywhere with women. I understand marriages are breaking in towns because of sexual rights. What do women want? (Elderly father)

I have never heard of anybody talking about the issue of Sexual and reproductive rights of young people in this area. May be rights for young men but not young women. Young girls, in fact all women, live in a society that promotes the values of submission and the silent suffering under their husbands. No sexual rights at all!"(Retired female teacher)

" Talking about sexual rights of young people means improving their education, especially the girls. You cannot ask a young illiterate girl about her sexual rights. She will think you want to break her home"(male extension staff).

Legal constraints such as age of eligibility for services and consent requirements impinge on the implementation of young peoples programmes. These situations are compounded with limited accessibility, affordability and acceptability of health services. Other factors associated with poor reproductive health and reproductive rights are some socio-cultural practices, beliefs, values and inappropriate attitudes. Most of the African societies are patriarchal. Men are the decision makers in most of the household spheres including that of reproductive health. This makes young women very vulnerable. It is believed that having many children, especially boys, allows women to secure their marriages, gain social status, and gain access to family property. Such values have had implications on the women's reproductive health and rights.

2.4.2 Medical barriers to service utilization

Young people's perception is that the SRH services at the public health facilities are generally not meant for them. Young girls in and out of school mentioned that all the people that surround them, be it at school, at home, the health centre, and in the community, do not want them to use SRH services. When asked whether they knew about the services offered, and which are meant for them at the health facilities, they mentioned family planning and Sexually Transmitted Infections services. They were also asked to rank the factors that influence their decisions to seek SRH care from such facilities. Among the factors listed included confidentiality/ privacy, honesty, respect, and age difference, gender of the provider, inadequate and expensive drugs and the long distances travelled. The major limitation to service utilization mentioned by young people was lack of confidentiality at public health facilities. They reported using private facilities as possible alternatives, or prefer to go to faraway places where the providers will not know the young person seeking the services. For instance girls in Mataale reported that they find it easier to walk down to Kibaale And Hoima town than using the sub dispensaries in their area. Informal discussions with some doctors in Kibaale And Hoima town confirmed that girls from far away sub counties travel to come and buy contraceptive pills. Few young boys said that private practitioners are preferred because of keeping " top " secrets. They liked the way drug shops operate-not writing down people's names. They further reported that private practitioners are efficient, do not run out of stock (drugs and contraceptives) and they are welcoming. One constraint mentioned with the private facilities is the issues of high cost for the services.

" Even if you tell him (health worker) that you had a" terrible accident" and contracted an STD, this man will treat you and nobody would know" (FGD, Boys)

Young people expressed concern about the procedure of writing down their names in the register when they go for family planning or STD services at public health facilities. The girls out of school said that if the service provider comes from that local area, she may tell your parents or other people. Young boys commented that somebody who knows you can see the records; and if you have been taking condoms frequently, then people may loose confidence in you. It was reported that girls who fear such situations send their boy friends to buy pills for them. Young people also did not like the idea of some health workers who do not close the consultation rooms, and people sit very close which makes young people uncomfortable. Because of this, young people use the private facilities.

"The old people you are lining up with, will first make their diagnosis when they see you physically fit; then they conclude that this one has come for contraceptive pills. We are always monitored". This discourages us from seeking those services (FGD, girls out of school.

Contraceptives and STD treatment were reported to be expensive as a result of cost sharing policy. All the people visiting a health unit have to pay a compulsory user fee of 300 Uganda shillings (0.2 Us dollars). Young people said that it is not easy to get that amount of money, given the fact that some have to incur transport costs in the range of 300- 500 Uganda shillings (0.2- 0.3 US dollars). Another medical barrier mentioned was lack of drugs. Young people did not like the idea of paying the consultation fee and later be informed that the drug is not in stock. Waiting for some time before being served was also indicated as a barrier to utilisation of government facilities. However, the district technical staff mentioned that there is a limited number of staff to run such health facilities. The district health visitor gave an example of the three sub- dispensaries in Mataale Sub County, which are manned by one Enrolled Nurse and two Nursing Aides, in each case, thus creating delays in some instances. Some young people also commented that there are some health workers who are always in "bad moods" which discourages young people from using the services.

"You are also pregnant at this age? What a shame"!

"Where did you get this problem from? You are not even 18 years, how did you get this STD?" (FGD, Young Boys in school).

Discussions with sub- county planners on the other hand, revealed that health workers are poorly motivated. They sympathized with them and wondered how they survive in a month. Asked as to why some health providers are labelled unfriendly by young people, one Key informant had this to say:

"You can not expect a hungry Nurse to keep smiling at the young people who want a packet of pills to go and enjoy sex".

2.4.4 Socio- cultural barriers to utilisation of sexual and reproductive health services

Cultural values influence almost all facets of people's lives in Kibaale And Hoima district. The leading weakness in the area of culture affecting the health of young people in Kibaale And Hoima is lack of voice in the family and community affairs. This is linked to a culturally- based low opinion of the young, more particularly girls (Turyasingura, 1994). Most of the social mechanisms operate in the principle of cutting off girl's options and opportunities right from birth. Male children compared to female are accorded higher value (ibid). There is often little commitment to girls' education. Traditionally, young women lack property rights including right to land. Women's decision-making power within the family is restricted and it is men who usually make decisions. Kibaale And Hoima district still has a custom of paying bride price, which is linked, to a cultural perception that the wife is a property of the husband; and explains why some girls are forced into early marriages where they live with minimum decision-making power. Today, young people are living in a time of socio- cultural transition where traditional practices that formerly limited young people's sexual experimentation are breaking down (opcit). Traditionally, an aunt discussed matters related to sexuality with adolescent females while community elders educated males. Parents did not discuss sexual matters with their children (opcit). Culturally, extra marital sexual activities are tolerated for men but condemned for a woman. The subject of sexuality is still considered a "taboo" in Kibaale And Hoima

CHAPTER THREE DISCUSSIONS AND CONCLUSION

One of the greatest threats facing young people in less developed countries today, in addition to political and economic insecurity, is from reproductive health problems. In Uganda, which is one of the countries greatest hit by HIV/AIDS, the young population are living at high risk. Although pre-marital sex is condemned in nearly all societies, and the young, unmarried people, especially girls, are not expected to be sexually active, the gap between the expected and actual behaviour is enormous world over. Early sexuality and experimentation among the young people is increasingly becoming the norm in Uganda, with severe consequences of early-unwanted pregnancies, early marriages, prostitution, abortions and STDs including HIV/AIDS. The consequences of sex affect boys and girls differently. Whereas both boys and girls are at a risk for STDs and HIV/AIDS, girls are at an additional risk for unplanned pregnancy leading to abortions, expulsion from school, punishment by parents, social stigma and the burden of premature motherhood. In Uganda, the prevalence rate of adolescent pregnancies stands at 43%, which is considered one of the highest in the sub- Saharan Africa (MOH, 1999). In Kenyan study, some 10,000 girls leave school annually due to an unplanned pregnancy (Ngwana A, Akwi- Ogojo A., 1996).

Another difference between boys and girls is the apparent double standard by which the Kibaale And Hoima society, and Uganda as a whole, judge girls who are sexually active. Boys are encouraged to acquire and demonstrate sexual experience while girls should remain virgins until marriage. Fidelity is expected to be practiced by girls /women only. Studies done in East Africa show similar imbalances. In Kibaale district, men indicated it as vital for their self-identity to have sex frequently and with different partners, showing their capacity to "conquer". Young and old men revealed that if they abstained from making approaches to girls, they would be conceived as impotent and unmanly (Minou Fuglesang, 1997).

Gender perspectives, which are largely defined by social and cultural conditions, shape the way young people view sexuality and play an important role in gaining access to information and services. Throughout childhood, boys and girls receive different messages about behaviours that

are expected of them- messages from parents, society, peers, religious, the media- messages that some behaviours are accepted for boys but not for girls, and vice versa. In Kibaale And Hoima district, extramarital sexual practices are tolerated for young men and condemned for a young woman. Men are even legally allowed to have more than one sexual partner. This inequity in sexual rights and norms is well known from other societies: A survey of more than 100 factory workers in a sugar factory in Kiziranfumbi indicated that, ages 15 to 24, found that the majority of men said premarital sex was accepted and expected for them, and that boys who had not yet had intercourse were ridiculed by their peers. Young women said premarital intercourse was unacceptable for"respectable" women and could damage the family's reputation. (Ford NJ, Kittisuksathit S., 1994). In Kidoma of Hoima district, young people ages 14 to 20 were interviewed, about gender roles. When girls were asked, " What does being a woman mean to you?" their answers were that women were dedicated to love and home life, they cried easily, and they did not have sex until they met the "right" man. When boys were asked what it meant to be a man, they replied that men were physically strong and often thought about sex.

Poverty was mentioned as a factor that influences young peoples reproductive health problems. According to Kibaale And Hoima District Local Government Action Plan, 2015-2001), most of the population in Kibaale And Hoima district lie below the poverty line. The household income survey put over 70% of the households in Kibaale And Hoima below the subsistence line of Uganda shillings 5000 (about 3.3 us dollars) per week. The Ministry of Health, also pointed out that poverty, illiteracy, unemployment and cultural issues are some of the factors that impinge on young peoples' health and development.

MOH further stated that there is a big portion of young people in rural areas who are not targeted by the limited health services in those areas. Many of these are not employed; they end up getting married to the equally young illiterate and unemployed people, thus starting a vicious cycle of poor and unhealthy families.

Due to such poverty, it was reported normal for a young girl to have an affair with an old man, if he is able to offer her financial support. Coupled with lack of employment and the general negative attitude towards girls in the district, the young girls with numerous needs simply give in to such men. The social set up in the district does not freely allow young girls to involve themselves in casual labour. Some of these girls have resorted to sex trade as the immediate alternative to sort out their problems. This exposes young girls to further risks of HIV/AIDS because they will be at the mercy of the customer whether he wants to use a condom. The girl, who is shy, may not be able to afford to buy a condom or may be lured into unprotected sex with more money. In Hoima town, the men refer to the young girls as "spring chickens" and "luxury cars" as they are regarded as new, "clean" and "pure" and therefore free from HIV/AIDs infection (opcit). Another problem among the out of schoolgirls related to poverty was school drop out, which also lead to early forced marriages. Respondents expressed concern about young girls sufferings' in such marriages where they had no voice in decision-making including determining the number of the children to have. Their duty is to work in the gardens and rearing the children. Studies done in other parts of the world show similar hardships for young women. In a study carried out among the Brazilian women, a 31-year-old woman had this to say.

" I wish a wonderful future for my daughter. One thing I will tell you, which I have said to my friends as well. I do not want my child ever to be a domestic worker. Never, ever, ever. I will do anything, with or without him (her husband)... for her to be somebody. But never a domestic, because I have seen it. I know it is the saddest profession in the world- the most distressing, the most discriminated against" (Cathy Berinda…et…al 2015)

”

Another one lamented about the repetitiveness of labour in the house and field in the same study:

”I had no youth because I got married at 18 and life became routine. Work, heat your belly at the stove and chill it at the sink. That is all you learn. Move, chicken! Shut up, boy! Today many things are changing, but for me, nothing has changed. It is always the same- field, home, kids, wash... I take a basin of clothes on my head, a kid in my arms, another on my belly, and another walking slowly beside me with my skirt clutched in his hands. Everyday is like the day before.” (Annet Kusiima 28 years)

To some extent, it was noted in this study that sometimes there are competing and conflicting messages about explanation of social roles in relation to SRH. Religion and culture still ”sound very strong” in Kibaale And Hoima district. The programmes working with the young people in both sub- counties reported fearing direct confrontations with some of the religious and community members on the subject of young people’s sexuality. Parents want their children to receive sex education minus contraception lessons, contrary to what some young people would wish to learn about. For the church, young unmarried people are only taught about abstinence irrespective of whether one is sexually active or not. Although the Government of Ugandans respects the Christian doctrines, the experts on HIV/AIDS have been requested to lobby for consensus from the church leaders, to see if other ethical guidelines may be formulated where sexual abstinence is difficult to maintain.

Ultimately, NGOs and other service providers want to play it safe while taking the softer and less controversial options. This could be a similar reason why areas of abortion and post abortion care

are not dealt with, or condoms and other contraceptives for young people still remain largely at the whim of the individual, and promoted as a quiet strategy rather than as an agreed on position. A lot of effort is still needed to enable young people, especially the girls, access to SRH services. Cultural values are a major obstacle to health services access and utilisation on the lame pretext that SRH of young people is against religion / culture and that it makes the youths more promiscuous. Although some studies have been done to dispel this myth, efforts to implement sex education programmes especially in the schools still meet stiff resistance especially when it comes to address the issue of contraception. The situation is worse for young girls, whose knowledge of the implications of their sexual behaviour is minimal and who very much need reproductive health information. Indeed, it was encouraging because all the young people interviewed in the study had positive attitudes towards sex education. They expressed eagerness and willingness to participate in programmes that would try to address their issues in a sensitive manner. Therefore, there is need to orient community and family perception on seeking health services, since these determine whether or not their children, especially girls are allowed to attend.

Young people are generally unemployed and depend on their parents or relatives for subsistence. This is true for those who are in school as well as for many of those out of school. As such, there are serious constraints to getting access to services due to economic factors. Youths expressed willingness to work and earn a living but job opportunities were reported to be scarce. On the other hand, the economic dependence on parents makes it difficult to ensure

confidentiality regarding contraceptives and STDs, which they were particularly concerned about. If the medical services were free, the young people would walk in and out without having to inform their parents, thus making accessibility to reproductive health care easier. Seeking the money from a parent might mean disclosing the purpose for it. Young people ranked the issue of confidentiality as number one major obstacle to the utilisation of existing services. Young people have a fear of meeting older people they know at the health facility and often get a feeling of "shame" and " guilt" to present a particular case like an STD.

A general mapping of services revealed that some young people have inadequate knowledge about SRH including points for services, and how to make good use of existing services and information. While potential services like health units, schools, churches, police and private clinics were mapped; the services of TBAs and Traditional healers were not plotted. We couldn't establish whether this was intentional since it was reported in most FGDs that young people normally seek services from them. The level of health services provision is determined by the morale of the health workers. Young people reported that health workers are unfriendly when handling their SRH problems. Adults on the other hand said that the health workers are poorly motivated to maintain the standards at the health facilities. Although health workers reported to be getting some incentives from the money raised through cost sharing, they still felt that the salaries were very low to maintain them. Lack of adequate support to the staff, leads to low morale, lack of commitment, uncontrolled temper towards patients and stealing of drugs for survival strategies (MOH, 1993). Staff motivation is necessary to improve quality of care at government health facilities.

The findings indicated that there is misinformation or total lack of information about their bodies, conception, family planning (oral contraceptives and condoms) and the risk of HIV/AIDS. There are lot of myths about menstruation and pregnancy. Studies in other societies indicate similar situations. Two dramatic examples from Kibaale, shows how lack of knowledge and/ or incomplete information affects young girls:

"Once I saw that a young woman had blood on her feet, and they said she'd been raped, that a man had abused her. I did not know how that could happen, I mean, I didn't even think they would put their thing inside you. Then, when I got my period, I started to cry. My sister asked me what happened and I said I'd been raped. So they started beating me up and asking, ' who was it?' and I said 'Nobody'. 'Then, ' they said, ' how were you raped?' I don't know, blood is coming out of me', but they didn't say I could get pregnant, they didn't say anything". (Rosaline Kugonza)

" I didn't know anything about menstruation before I saw it... I ran to my aunt who told me how to use rags and keep the rags clean. She… added that I was now mature and that if a man should touch me, I would be pregnant. When I was menstruating one day in school, a boy touched me and I started crying, thinking I was pregnant. It was a female teacher who saw me and called me to explain that one has to sleep with a man before one could get pregnant (Bacuusa Mary)

Lack of information could be one reason why young peoples' use of family planning was reported inadequate in Kibaale And Hoima districts. According to the Uganda Demographic Health Survey, 1995, the national contraceptive prevalence rate is also low. Use of any method in the age group 15-19 was 7.2% compared to the national average of 13.4 percent. Studies of young people in other regions show a similar lack of accurate information about family planning. In Bubango for example, of 100 girls who came to a hospital seeking abortion, 80%

did not know that sexual intercourse could lead to pregnancy or STDs, and 90% did not know about contraception (Akuha s., 1992). A study of Kibaale adolescent' knowledge of AIDS found that, among 370 high school students surveyed, only 25% of the girls and 35% of the boys knew that condoms should be used just once.

Policies and law about young peoples health and sexual rights were not known in the district, which partly hinders their accessibility to services. Although the government policy says that all sexually active young people are eligible for contraception services, young people in Kibaale And Hoima did not have adequate information about it. There is need for the government to disseminate the information to the young people, so that they understand the services they are entitled to. In line with this, Uganda with other countries from Eastern and Southern Africa, recently agreed on a common stand, in regard to reproductive health rights and legislation (27-29 September, 1999). A number of resolutions were made to provide a comprehensive framework for the promotion of reproductive health and rights in the two district. Some of the issues that could directly improve young peoples access to reproductive health services include:

- Advocating for adoption of a patient's Bill of rights, which would protect the rights of patients', interralia, the right to receive adequate information to make informed decisions, the right to confidentiality, the right to receive treatment of high quality, the right to affordable drugs and contraceptives.

- Liberalising restrictive abortion laws. That in all cases, women need to have access to quality services for the management of complications arising out of abortion.

- Advocate for the creation of adolescent friendly reproductive health services for provision of family life education in schools, and for the provision of information and services for out of school youths.

- Adoption of education policies, which provide free compulsory primary education for girls and boys, and to allow girls who become pregnant to continue their education

According to the Nordic countries that are the pioneers in providing youth with Sexual and reproductive rights and information, they have been able to achieve a number of achievements. Adolescents (15- 19 year olds) deliveries are rare (Norway 1997: 5,1 per 1000, Iceland 1995: 5,56 per 1000)

- The number of teenage abortions has decreased significantly (Uganda: from 25 per 1000 in 1975 to 10 per 1000 in 1997)
- No significant changes in age of first intercourse have occurred in the last 20 years (e.g. Uganda: 17 years both male and female, Norway: 18 male and 17, 5 female)

- Use of contraception is high (Finland: 16-year-old girls in 1997, 87% used condom or pill in the most recent intercourse (The Nordic Resolution on Cairo+ 5 and Adolescents, 1999).

They indicate that this has been made possible by a liberal legislation and governments' involvement. They further state that to achieve such indicators related to reproductive health and rights, the communities have to accept the fact that young people are sexually active and by making a serious commitment to address their needs putting great emphasis on preventive work. They recommend that granting young people education, freedom and rights, they are able to make informed choices and take responsibility of their own sexuality. They finally conclude

that there is distinct evidence that sexual education does not provoke young people to start sexual relationships earlier, as many societies tend to believe.

"What disturbs me even more are the social attitudes towards adolescent mothers. I cannot understand how our society remains so hypocritical in refusing to address such a serious situation. We are saying education is a right for every child yet when a girl becomes pregnant, we throw her out of the education system never to find a way in which she can re-enter or be rehabilitated".

At the national level, unsafe abortion contributes to about 22% of maternal deaths and many more morbidities (MOH, 2015). Considering its legal implication, abortion is done behind doors and usually in unsafe way.

At the national level, approximately, 15% of young girls who had ever been pregnant had terminated a pregnancy (Agyei, 1992). Turyasingura (1994) indicates that among the 15-18 years, 17% have had an abortion and the number increases by age, 53% among the 22-24 years. In Mulago Hospital, Kampala, 44% of the women who die as a result of abortion and its complications are young people under the age of 20 years (Wasswa, 1991).

3.2 Recommendations

From this study, young peoples sexual contacts often lack knowledge about sexuality and reproduction. Their first sex is often experimentation and those involved do not prepare for it by accessing contraceptives, even if they know where to get them. Other main reasons given for non-use were lack of knowledge, beliefs that they are not safe, and their non-availability due to cost. The discussions on unwanted pregnancies and the resultant abortions point to the need for a clearly contraceptive policy. The study also revealed that pregnancy outside marriage carries severe social sanctions e.g. being rejected by the family and the community. All these call for improvements in family planning education and in accessibility of contraceptives.

The gender roles of the submissive female and dominant male culture affect reproductive health of young people. Becoming pregnant is not always from lack of information, but to a certain extent it can be determined by society's expectations for girls and boys. As a result, young girls lack power, confidence and skills to say no to sex. Men need to be educated that reproductive health is not for women only, which may improve the health of women, whose access to health services is controlled by either their fathers, husbands or boy friends.

Although HIV/AIDS awareness was high in the study, the girls' most concern was pregnancy but not HIV/AIDS. They seem resigned about the condom use because they think they have no right to negotiate about sexual issues. Such young girls need to know that if condoms are not used, they risk the problems of STDs and HIV/AIDS as well.

The discussions with young people showed that public health facilities are not commonly used. Reasons for this were lack of knowledge about the services offered, fear to be known that they are using the services, unkind treatment by the health workers, lack of drugs and lack of money to access the services. Young people recommended for free contraception services to be delivered in a confidential manner. They also recommended fellow young people like their leaders to be in charge of distribution of such contraceptives.

Young people reported buying contraceptives and other pharmaceutical from the drug shops. They also seek other sexual and reproductive health care from other informal providers like TBAs, traditional healers etc. Support supervision from the district technical staff to such

informal providers is needed to check the misuse of drugs. Alternatively, the informal providers could be trained in basic issues about family planning, post abortion care, and STD prevention, so that necessary referrals could be made for the serious cases.

The 1994 ICPD declared that sexual and reproductive rights of young people are the same rights as those for adults, because sexual and reproductive rights are human rights. The role of the government to develop the policies and programmes, which act to inform young people about their rights, needs to be strengthened so that young people have self-confidence in exercising and protecting their own sexual rights. Education in this area is still needed and men in particular have to appreciate that sexual rights are not women's rights as some study participants believed.

On the whole, all the people working with the young ones need to be open to them. Information can help them understand how their bodies work and what the consequences of their actions are likely to be. Hiding information about them cannot make them less interested in sex. More open sex education programmes need to be designed for both in and out of school young people.

References

1. World Health Organisation: Improve the Quality of Maternal Health Services, in the World Health Day: Safe Motherhood, 7 April, 2015, fact- sheets WHO 98.8

2. Rosalind P. Petchesky and Keren Judd: Negotiating Reproductive Rights. Women's Perspectives Across Countries and Cultures. Zed Books, London and New York, 2015.

3. Simone Grilo Diniz, Cecilia De Mello E Souza, and Ana Paula Portella: Reproductive choice and Emergency of Citizenship Among Brazilian Rural workers, Domestic workers and Housewives; in, Negotiating Reproductive Rights. Women's Perspectives Across Countries and Cultures. Zed Books, London and New York, 2015.

4. Grace Osakue and Adriane Martin- Hilber: Women's Sexuality and Fertility in Nigeria. Breaking the Culture of Silence; in, Negotiating Reproductive Rights. Women's Perspectives Across countries and Cultures. Zed Books, London and New York, 2015.

5. Alanagh Raikes: Pregnancy, Birthing and Family planning in Kenya: Changing Patterns of Behaviour. A Health Service Utilisation study in Kisii District. CDR Research Report No. 15, Centre for Development Research, Copenhagen, 1990.

6. Adriana Ortiz Ortega, Ana Amuchastegui and Marta Rivas: 'Because they were born from me' Negotiating Women's rights in Mexico; in Negotiating Reproductive Rights. Women's Perspectives Across countries and Cultures. Zed Books, London and New York, 2015.

7. Knut- Inge Klepp, Paul M. Biswalo, and Aud Talle: Young people at Risk. Fighting AIDS in Northern Tanzania. SCANDINAVIAN UNIVERSITY PRESS, Oslo- Stockholm- Copenhagen- Boston, Norway, 1995

8. Amy O. Tsui, Judith N.Wasserheit, and John G. Faaga: Reproductive Health in Developing Countries. Expanding Dimensions, Building Solutions. National Academy Press, Washington, D.C 1997.

9. The Monitor News paper, Wednesday, May 10, 2000.

10. The Republic of Uganda: National Population Policy for Sustainable Development, 1995.

11. Uganda Ministry of Health: Draft National health Policy, 2015-2006, Entebbe Uganda.

12. Minou Fuglesang: Lessons for Life- Past and Present Modes of Sexuality Education in Tanzanian Society. Division of International Health Care Research (IHCAR), Karolinska Institutet, S- 17177, Stockholm, Sweden, 1997

13. The World's Youth 1996. Chart. Washington: Population Reference Bureau, 1996

14. Ford NJ, Kittisuksathit S: Destinations unknown: the gender construction and changing nature of the sexual repressions of Thai Youth. AIDS care 1994

15. Paira V: Sexuality, condom use and gender norms among Brazilian teenagers. Reproductive health Matters, 1993

16. Ngwana A, Akwi- Ogojo A: adolescent Reproductive Health Rights in Sub- Saharan Africa. Washington: CEDPA, 1996

17. Chhabra S: A step towards helping mothers with unwanted pregnancies. Indian Journal of Maternal and Child Health, 1992

18. Millan T, Vlenzuela S, Vargas NA: Reproductive health in Adolescent students: knowledge, attitudes and behaviour in both sexes, in a community of Santiago, 1995

19. Uganda Ministry of Health: Sexual and Reproductive Health Minimum Package for Uganda. Reproductive Health Division and SRH Stakeholders, 1999

20. Tumbo- Masabo, Z. And Liljestrom R: Chelewa, Chelewa. The Dilemma of Teenage girls. Institute of African Studies, Uppsala, 1994

21. Mbunda F.R.D: Traditional Sex Education in Tanzania: A study of Twelve Ethnic Groups. WAZAZI (The Parents association of Tanzania) and UNFPA, Dares salaam, 1991

22. Ahlberg B.M: Women, sexuality and the changing social order. The impact of Government policies on Reproductive behaviour in Kenya, Gordon and Breach, London, 1991

23. Mwateba, R: Effects of Intervention Strategies on Selected Aspects of Teenage Reproductive health: A case Study from Tanzania. UMATI, Dar as Salaam, 1993

24. Health Facility Programmes on Reproductive Health for Young Adults. Focus on Young Adults Research Series. 1201 Connecticut Avenue, NW Suite 501 Washington, D.C 20036.

25. Uganda Demographic and Health survey, Statistics Department, Ministry of Finance and Economic Planning, Entebbe, Uganda and Macro International Inc, Calverton, Maryland USA, 1995.

26. The 1991 Uganda Population and Housing Census, National Report, 1992.

27. Turyasingura G.B: Adolescent Health and Sexually Transmitted Diseases. Paper presented at a workshop, Research Priorities in Reproductive Health in Uganda, Mukono, 1991

28. Kaharuza, F: The Knowledge, Attitudes and Practices of Contraception and Sexuality of Adolescents of Kampala, Uganda, 1991. Dissertation, submitted for M.Med, Obstetrics/Gynaecology, Makerere University, 1991.

29. Wamai, Barton, T and G. Equity and Vulnerability: The Situation Analysis of Women, Adolescents and Children in Uganda, Kampala, 1994.

30. Bagarukayo, Henry: An operational study relating to sexuality and AIDS prevention among primary school students in KIBAALE AND HOIMA district of Uganda, AMREF.

31. World Health Organisation: Coming of Age: From facts to Action for Adolescent Sexual and Reproductive Health, Geneva, Switzerland. 1997

32. Friedman, H C: Adolescent sexual and Reproductive health: Research Needs and Approaches. WHO, Geneva, 1993.

33. Bygdeman, M and Lindahl, K: Sexual Education and Reproductive Health in Sweden in the 20th Century. Official Report No. 37, Swedish Government, Stockholm

34. Bachou, H and Barton,T: Teenage Mothers and their Children: Needs, Resource Availability and Constraints to Care in Kiyeyi. Child Health and Development Centre, 1992

35. Wimberley K: Adolescent Girls and HIV prevention/AIDs education in Ankole, South Western Uganda. University of Copenhagen, unpublished Report, 1994

36. Loyce K. Arinaitwe and Turinde Asaph: Needs Assessment for Adolescent Friendly Health Services in KIBAALE AND HOIMA District, Child Health and Development Centre, 1999

37. The Nordic Resolution on Cairo + 5 and adolescents, 1999

38. Dr. Bagorogoza M.P.K: Prevalence of condom use among Adolescents in Tororo District, Field Report, IPH, Makerere University, 2015

39. Reproductive Health Matters, Access to reproductive health: a question of distributive justice. Volume 7, Number 14, 1999

40. Lustig SL: The AIDS prevention magic show: Avoiding the tragic with magic. Public health Rep 109: 1990.

41. SIDA: SIDAs Action Plan for SRH. SIDA, Stockholm, 1994.

42. AMREF: A guide to Adolescent sexual and Reproductive Health, 1996

43. Kibaale And Hoima District Local Government Council: Action Plan 2015-20001

Appendix 2: Persons interviewed and the methods of data collection

Area	Key Informant Interviews	Focus Group Discussion	Other Methods
□ Mataale Sub County	□ Local council 1 chairman □ Local council 1 youth representative □ Senior woman teacher □ Female parent □ One protestant lay leader □ In-charge Mataale sub County □ Local council 3 chairman	□ Girls in school □ Boys in school □ Girls out of school □ Boys out of school □ Female adolescent parents □ Traditional birth attendants □ Male parent □ Teachers (mixed group) □ Male parent	□ Observations at Service delivery points (public health facilities) □ Peoples ways of living in the communities □ Problem ranking of health problems and factors that hinder utilisation of services □ Social mapping of existing services
□ Kiziranfumbi Sub County	□ Local council 3 chairman □ Senior woman teacher □ In charge Kiziranfumbi Sub dispensary □ 2 Female parents □ Drug shop attendant □ Private clinic attendant □ Protestant lay leader □ Catholic lay leader □ Male elder	□ Girls in school □ Boys in school □ Girls out of school □ Boys out of school □ Female adolescent parents □ Female parents □ Extension staff □ Male parents □ Traditional birth attendants	
District Level	District Health Visitor □ District	District Service Commission Members	Informal discussions with doctors in KIBAALE AND HOIMA

	Population Officer Assistant District Inspector of		town

	Schools - AMREF representative - CARE Representative - District Gender/ youth Officer - Family Planning Association - Community Development Officer		

Appendix 1: Research instruments

Topic guides for young people (respondents): Young people in and out of school, married and unmarried, males and females in separate groups.

1. What are the main problems faced by young people in this area (differences between boys and girls, in and out of school)
2. What are the main healths problems faced by young people in this area (differences between boys and girls, in and out of school)

Probes:

- Health services (STI counselling, screening, treatment, follow up, contraception, referral, etc)
- Information, education and communication (IEC), including health education
- Guidance and counselling
- Life skills (social skills) development
- Recreation

1. What services exist in this area to address some of the problems mentioned above. (OR) Where do you go when you have a SRH problem (heath units, schools, community, home, work place, etc).

Probes:

- Coverage, geographical and scope of the services provided.
- Particular providers of the service
- Access to service including days of the service, opening hours, distances, costs etc
- Utilisation, who are the main consumers of these services (girls or boys, in school or those not in school).
- Quality: standard with respect to programme definition, user expectation of the product and delivery process.

2. How did you learn about these service points?

Probes:

- Government heath workers
- Friends and relatives
- Religious Leaders
- Community/local leaders
- Teachers
- Radio, television, magazines etc
- NGO representatives, etc

3. What would encourage young people like you to utilise existing health services.
4. What hinders some of the young people from utilising existing services (legal, medical and socio cultural factors)?
5. What are the SRH problems that are not met by the existing health services (probe for gender differences, in and out of school)?
6. What factors contribute to the above reasons (given in No. 7) (management, planning, financing, implementation etc)?
7. What does the Ugandan law say about SRH of young people?

8. Are there any other community by-laws that govern the SRH of young people in this area?
9. What suggestions would you give to improve utilisation of SRH services by young people?

Probes:

Services that should be provided
Access (distance, costs etc)
Settings (where should they be located)
Providers (who should they be)

Topic guides for parents of young people (mothers and fathers in separate groups).

1. What problems related to SRH do young people in this community or families face?
2. How do they differ among the girls and boys, and, between those in and out of school?
3. What factors contribute to the presence of such problems in the lives of the young people?
4. What strategies are in place at household, community and government levels to solve these problems (IEC, guidance and counselling, life skills and rules and policies).
5. As parents, in what ways are you involved in solving these problems of young people?
6. What kind of factors hinder young people from accessing and utilising these services?
7. How can young people be encouraged to utilise these services.

Topic guide for service providers

Respondents: (service providers at schools, health facilities, community centres, churches and the district level managers etc)

1. Problems of young people

- What would you say are the SRH problems of young people in this area?
- How are those problems distributed among the boys and girls, in and out of school?
- What factors contribute to the presence, severity and effects of such problems in the lives of young people?

2. Quality of services

- What services do you offer to young people related to SRH?
- What factors encourage/hinder young people to utilise your services.

3. Accessibility

- Is it within reach of those who need it (physical, social, economic etc)
- Coverage: the proportion of the district (geographical) reached by the services in question.

3. Utilisation

- Are both boys and girls, in and out of school, using the services?

5. What does the policy say about utilisation of SRH services by young people?