ADOLESCENT SEXUAL

AND

REPRODUCTIVE HEALTH

IN

UGANDA

Results of the

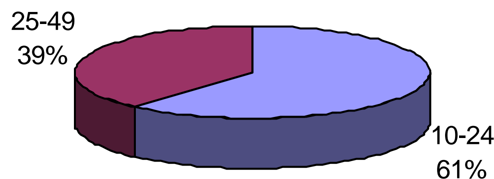
AYA BASELINE SURVEY

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN UGANDA.

1. Introduction.

The current special attention being devoted to the sexual and reproductive health of adolescents and young people (aged 10-24 years) is justified on several grounds. The first justification is the sheer size of this sub-population: in sub-Saharan Africa there are about 630 million people in this age group. In Uganda a third of the population is aged 10 –24 and teenagers contribute more births than older women. About 15 percent of births occur to mothers below 20 years of age (too early) compared to 12 percent among those aged 35 years and above (too late). Secondly, this period of growth is characterized by major physical and emotional changes that make young people especially vulnerable to many health and social problems. These include unwanted and risky pregnancies, the risk of HIV infection, unsafe abortion, dropping out of school and unemployment. Thirdly, young people are usually not in a position to influence their reproductive health since they often do not possess the information, skills, services and the means to do so.

Figure 1.1: Age Distribution of Women in Childbearing Ages



The median age at sexual debut is 16.6 years for girls and 18.8 for boys and by age 19, 54.6 percent will have become mothers. Only 18.4 percent of those aged 15-19 will have ever used a modern method of contraception

As a result, a number of initiatives have been instituted to address the special needs of young people. In sub-Saharan Africa, the African Youth Alliance is a

five-year multi-country programme that is being implemented in Botswana, Ghana, Tanzania and Uganda. While the focus is on the age bracket 10-24 in all the four countries, the specific project contents differ to reflect the priorities of each particular country.

The AYA project has six components within which the thrust is varied to mirror the concerns of each country:

- Policy and advocacy
- Behavior change communication
- Youth friendly services
- Life and livelihood skills
- Institutional capacity building
- Coordination and dissemination of information.

2. The Baseline Survey

The principal purpose of the study was to generate data against which to gauge the progress of the AYA interventions over the next five years. The AYA project is being implemented in phases and will cover twenty (20) out of Uganda's fifty-six (56) districts. These are spread throughout the country and include districts in the central region (2), the east (10), the north (1) and west (7).

3. Data Collection.

Map of the AYA Baseline survey Districts showing AYA Districts and controls.

Since the implementation of the AYA project was intended to be placed in the district specific context, it was desirable that all AYA experimental districts be in the sample. It was also deemed necessary to obtain robust estimates for each district; hence the relatively large sample sizes. In addition, in order to be able to assess the impact of the AYA project in future, four districts were included in the sample as controls.

The data presented and analysed in this report were collected from a variety of sources including;

- Documentary and literature review
- Survey questionnaire administered to young people (10-24)
- Focus group discussions
- Key informant interviews
- School and health facility questionnaires

A total of 10,549 individual questionnaires were successfully administered during the survey. There were 144 focus groups, 256 key informant interviews, 137 health facilities and 104 educational institutions covered in the survey.

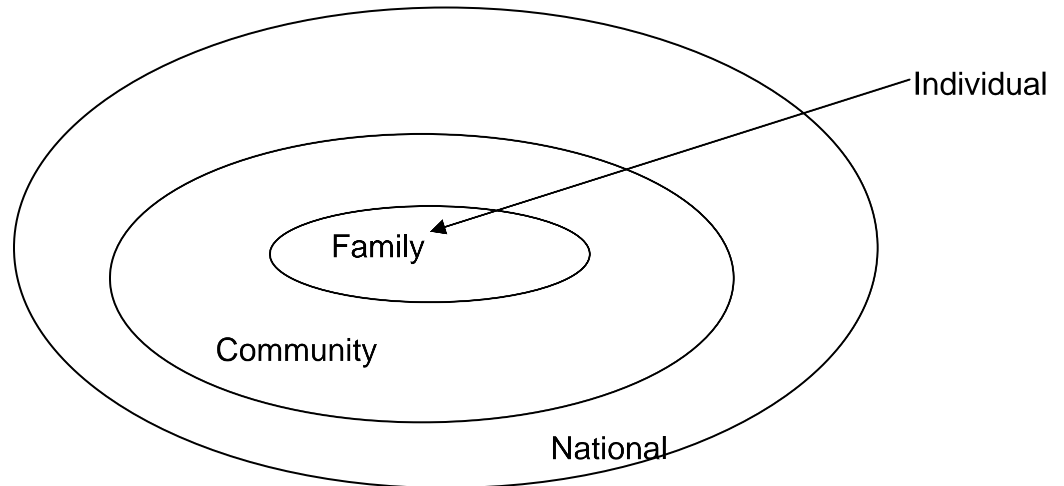
The rationale for the identification of these stakeholders as the main sources of information on adolescent sexual and reproductive health lies in the conceptual framework for the AYA project.

4. Conceptual Framework

The overall aim of the AYA project is to ensure the delivery of high quality sexual and reproductive health to young people (aged 10-24) on a sustainable basis. This process involves several stakeholders operating at different levels. First, the national social, cultural and political environment must be conducive for the delivery of such services. At the next level, the different communities (and families) in which individuals live should be supportive of provision of such services. Further, the services have to be available and address the needs of the individuals concerned.

This framework recognizes that while individuals ultimately make the decision to use or not use a particular service, this decision is circumscribed in the first instance by the other members of the family (e.g. parent or partner) and at the next level by the community in which they live. Thus the AYA project

apportions its target group between the primary beneficiaries (the 10 – 24 age group); key intermediaries such as parents, teachers and service providers; and policy makers who include politicians, civic, cultural and religious leaders, and the media.



The documentary and literature review focused on the national policies and programmes regarding ASRH. Through focus group discussions with different stakeholders (such as civic and religious leaders and parents) data was collected on the communities' views on ASRH. The school and health facility surveys were intended to gauge the availability of ASRH services at these outlets. The individual questionnaire gathered information on individuals' knowledge, attitudes, beliefs, and practices regarding ASRH services.

5. Results

This section presents the highlights of the survey results. The first part presents the current indicators of ASRH focusing on the AYA project objectives. The second part provides some brief explanations for the prevailing situations and indicates the likely future trends on survey responses. These are arranged according to the main output indicators of the project.

5.1 Current ASRH Indicators

The data collected in this survey established the benchmark against which the effect of AYA interventions will be measured in future. The survey results also present the context in which the programme is to be implemented and could form the basis for fine tuning the intervention strategies.

5.1.1 Background characteristics

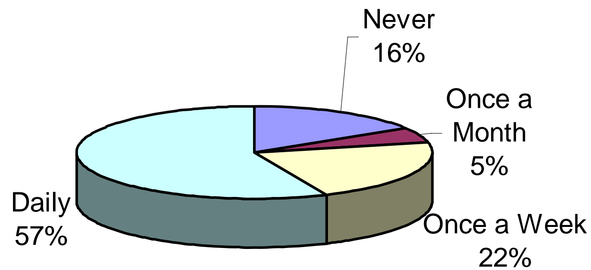
The majority of the youth (over 85%), were rural, still in school (about 70%) and had both parents surviving (about 70%).

The sample of respondents was predominantly rural; 89.4 percent among the male population were rural residents. This proportion was slightly lower among females, 87.4 percent. The majority were still at school, 73.2 and 67.5 percent among males and females respectively. About the same proportions had both parents surviving; 70.8 percent of male youths and 72.5 percent of females had both parents alive.

Male youths, urban residents and those in school had an advantage in access to media.

Radio is the commonest type of medium that adolescents have access to and 56.6 percent stated that they listened to a radio daily. Females were less likely to listen to a radio and 18 percent said they never did compared to 13.5 percent among male adolescents. Access to television was less common and only 7 percent watched TV daily. Newspaper readership was extremely low and only 5 percent reported reading newspapers regularly.

Figure 5.1: Access to Radio

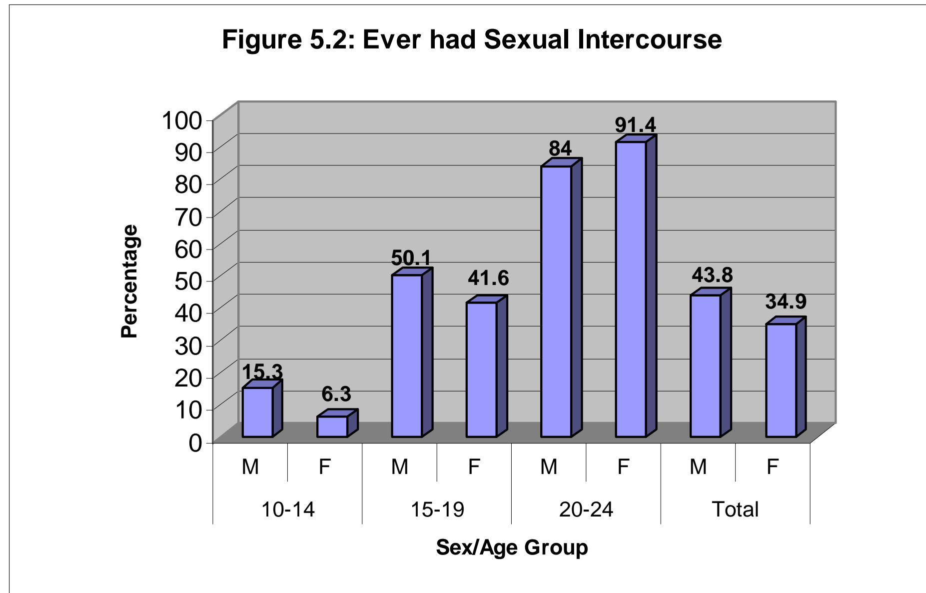


Males, urban residents and in-school youths had an advantage in access to the three types of media over their corresponding counterparts.

5.1.2 Age at First Intercourse

> Within the 15-19 age group, half the boys and 405 of the girls have experienced sexual intercourse. However, it was more likely to have been desired by the boys than girls. Ten percent of the girls had been coerced.

The data reveals that boys and girls exhibit different patterns regarding age at first intercourse. Within the age group 10-14 a higher proportion of males (15.3 percent) stated that they had ever experienced sexual intercourse compared to 6.3 percent among girls. However, within the 20-24 year age group, a higher proportion of females had ever had sexual intercourse. Most adolescents had had their first sexual intercourse with partners of similar age and the majority were intimate friends (girl or boy friend). However, females were more likely to have older partners. The mean age of the partners of male adolescents at first sex was 14.5 years while the mean age of partners for female adolescents at first sex was 19.1 years.



These data confirm that on average sexual activity among boys starts later than among girls. The UDHS 2000-2001 showed that the median age at first sexual intercourse for women 20-49 years was 16.7 years. The corresponding figure for men and was 18.8 years

5.1.3 Circumstances of sexual intercourse

About 80 percent of males and 62 percent of females reported that they desired to have sexual intercourse at their first sexual activity. These data confirm the impression that boys tend to have the upper hand in sexual relations. Further, female adolescents were more likely to have their first intercourse in marriage than male adolescents indicating that fulfilling conjugal rights was a major factor for females engaging in sexual activity. Only 5.7 percent of the males had their first intercourse within wedlock compared to 22 percent of the females.

About 10 percent of the girls reported that they had been coerced into their first intercourse.

There were also unfavourable circumstances in which first intercourse took place. About 10 percent of the girls reported that they had been coerced into their first intercourse, 4 percent had done so in exchange for some reward

while 8 percent did so at a party or out of drunkardness. Interestingly, about 5 percent of the boys had been coerced or given a reward in exchange for sex and 10 percent had done so at a party or having been drunk.

At one time or another, 13.5 percent had engaged in sex for gain. Unexpectedly, the proportions which had engaged in sex for reward were the same for boys and girls. The commonest form of reward was money, cited by 80 percent of the respondents. It is significant that 11 percent of the boys and 7 percent of the girls approve of the practice of exchanging sex for gain.

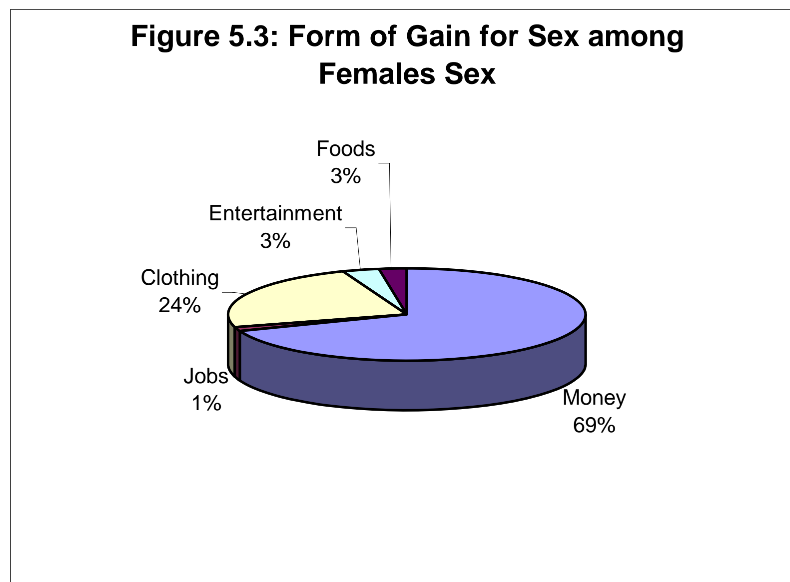


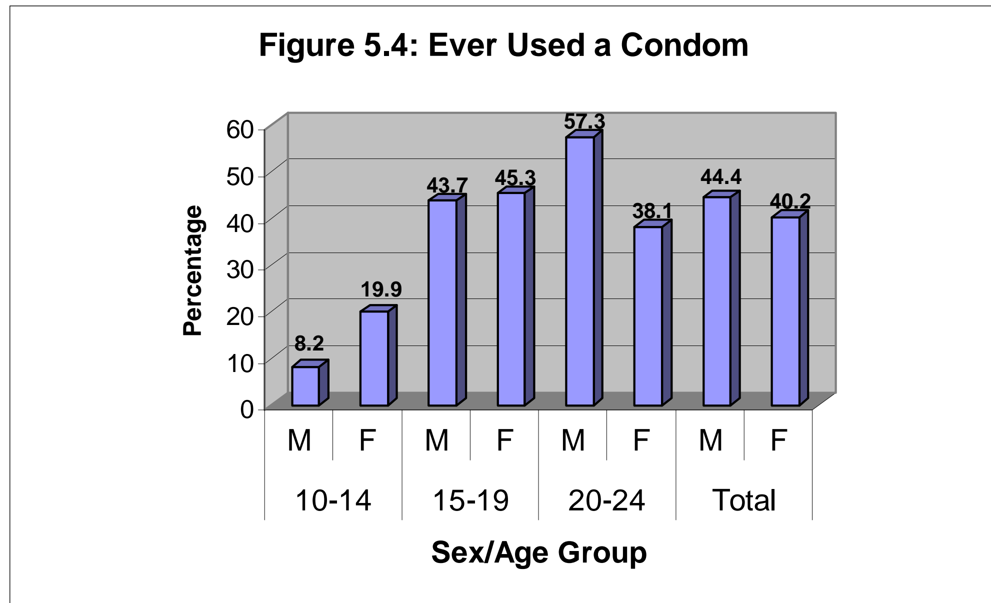
Figure 5.3: Form of Gain for Sex among Females Sex

5.1.4 Condom Use

Condom use, especially its consistent use, is a major determinant of the risk of both unwanted pregnancy and contraction of sexually transmitted infections (STIs). It is also important for effecting decisions in sexual relations and the choice of partners.

Within the 20-24 age group, knowledge of the condom is nearly universal and 99 percent of the males and 96 percent of females reported that they had ever

heard of the condom. However less than half (44 percent among males and 40 percent females) had ever used the condom. As expected, this proportion increases with age, from 8.2 percent among 10-14 year old boys to 57.3 among those aged 20-24. The corresponding figures for girls are 19.9 percent to 38.1 percent respectively.

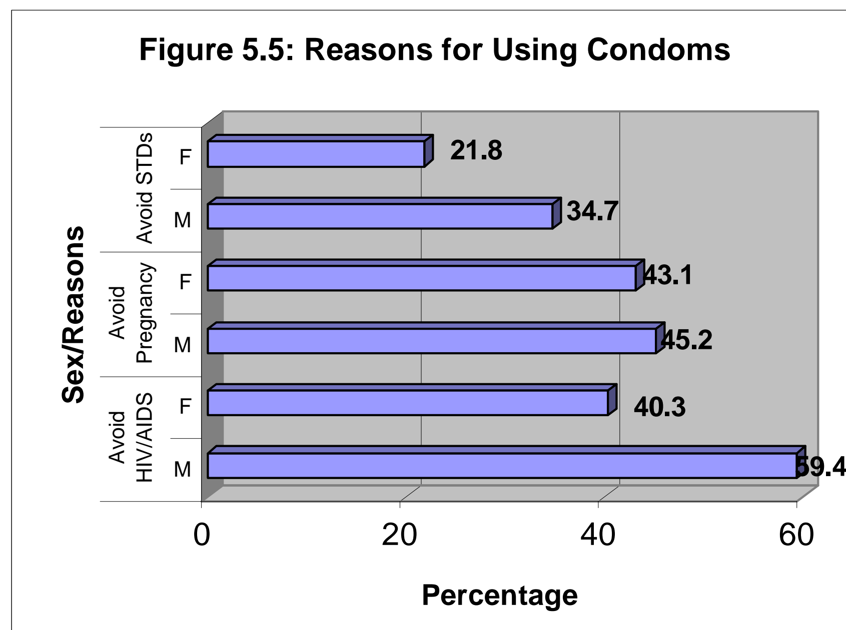


Adolescents were asked whether they used condoms during their first sex and the last sexual intercourse. Nearly equal proportions (24 percent males, 26 percent females) reported use of condoms during their first sexual intercourse. Condom use during the last sexual intercourse was found to be higher among males (32 percent) than among females (22 percent). This is not surprising considering males were more likely to initiate condom use; 86.5 percent among males compared with 58.4 among females.

Avoidance of HIV/AIDS, other STIs and prevention of unwanted pregnancies were the main reasons for using condoms. Male respondents were less likely to use condoms with a regular partner (58.4 percent) versus 74.4 percent among females.

Table 1: Knowledge of condoms and their use

	Males	Females
Heard of condoms (Yes)	91.8	97.4
Ever used condom (Yes)	44.0	40.2
Condom use at first sex (Yes)	23.6	25.6
Condom use at last sex (Yes)	31.7	22.3
Sexual partner (Regular)	58.4	74.4
Initiator of condom use	86.5	58.4



5.1.5 Unwanted Pregnancy

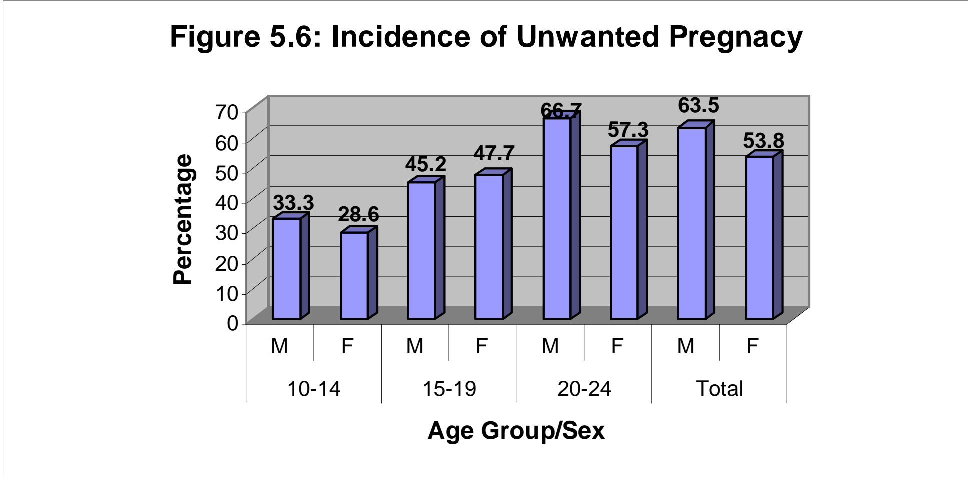
Respondents were asked whether they had desired their first pregnancy when it occurred. They were also asked the same question about the most recent pregnancy. These questions were also put to male respondents regarding their having made their partners pregnant.

The data shows that pregnancy occurs early; the median age at first pregnancy was 18 years. The median age at first impregnation among males was 19.0 years.

About half of the women did not desire their first pregnancy when it occurred. A similar fraction did not desire their most recent pregnancy.

Overall, about two-thirds of the males had wanted the first pregnancy when it occurred compared to 54 percent among females. The incidence of unwanted pregnancy was higher at the lower ages both in the case of first pregnancy or the most recent one.

These data reveal significant levels of unwanted pregnancies. Nearly a half (46.1 percent) of the females did not desire their first pregnancy when it occurred and a similar proportion (43.9 percent) did not want their most recent pregnancy. The pregnancies also occur in rapid succession: within the 20 – 24 age bracket, 34.6 percent of the women reported having had three pregnancies.



5.1.6 Abortion

A significant proportion, 9.1 percent of males reported that they had ever encouraged their partners to abort and 3 percent of the females stated that

they had actually procured an abortion. The decision to abort was most commonly made by those directly involved. In more than 70 percent of the cases the decision was made by oneself or the partner. Relatives play a significant role and 21 percent of the respondents reported that the decision to abort was made for them by relatives.

Only a small proportion (12.4 percent males and 11.5 percent females) had ever gone for HIV testing although a majority (75 percent) were willing to undergo such a test.

5.1.7 HIV/AIDS

Only a small proportion (12.4 percent males and 11.5 percent females) had ever gone for HIV testing. As expected, this proportion increases with age.

Most respondents, (74.7 percent and 69.6 percent among males and females respectively knew that a healthy-looking person could have HIV. Loss of weight, skin rash and frequent illness were the most cited symptoms of HIV.

The majority of the respondents (about 75 percent) were willing to take the HIV test and most where to obtain such a text. About a quarter of the respondents perceived themselves to be at risk of contracting HIV/AIDS. The commonest reason given for this perception was the practice of unsafe sex followed by having multiple partners.

5.1.8 Sexually Transmitted Infections

Awareness of the different STIs was not uniform. While more than 80 percent had ever heard of the AIDS disease, this proportion dropped to 56 percent for syphilis and further to 5 percent for other STI conditions.

More than 70 percent of those who had experienced an STI symptom said they had visited a health facility. However, a smaller proportion advised their partners to seek treatment.

5.2.1 Enabling and supportive environment for ASRH

The political environment in which the sexual and reproductive health services are delivered is defined by the enabling laws and regulations that determine acceptability, availability, accessibility and the conditions under which such services are rendered. These stances have undergone discernible changes over time. These transformations have resulted into increasing the number and diversity of providers as well as expanding the scope of services provided.

Family planning services were introduced in Uganda in 1957 when the Family Planning Association of Uganda (FPAU) was formed. The Association concentrated on offering methods of contraception. The curative services offered through the Association's outlets focused on removing contraindications for the various methods of family planning. Meanwhile, government and faith-based (mission) outlets continued to focus on antenatal, delivery, and postnatal services. This situation arose out of family planning services being viewed as controversial.

In 1984, Government took a decision to integrate reproductive health into the other services offered by its network of outlets. The Government adopted family planning as one of the methods of the Primary Health Care (PHC) strategy. Since 1984 the main trends in the delivery of SRH services have been the proliferation of civil society organizations and private practitioners offering these services. Human rights issues have also been brought into the fold of SRH concerns. Advocacy against violation of sexual and reproductive health rights of individuals is the main approach being used in this regard.

Uganda has a draft National Adolescent Health Policy that is meant to mainstream adolescent health concerns into the national development process. The document contains statements directed at key ASRH issues such as:

- Increasing availability of contraceptives to young people to avoid unwanted pregnancies
- Reviewing the abortion law
- Reduction of harmful traditional practices
- Re-admission of schoolgirls to the education system following delivery.

The study found that premarital pregnancies are generally resolved through marriage or abortions. The use of contraception to prevent unwanted pregnancies was not often mentioned as a strategy.

'……. Pregnancy signals marriage and when any of my daughters gets pregnant, they have to get married immediately to avoid subsequent problems', (male parent,)

'….. **if a girl does not want to marry the father of her baby, then she should abort and return to school' (in school females).**

Many harmful practices related to ASRH were cited by respondents. Prominent among these were;

- Early sexual activity
- Early and forced marriages
- Abortion
- Defilement
- Multiple sexual partners

They also cited cultural practices such as widow inheritance, funeral and circumcision rites (which include sex orgies) as detrimental to SRH.

The survey found that the promotion of education for the girl child was viewed as a major strategy for reducing harmful practices. Other strategies suggested include counseling, sex education in school and the provision of family planning services.

There was support for the policy of readmission of young mothers into the school system since this would enhance the education and eventually social status of women in the country. However, it was pointed out that the implementation of such a policy greatly depends on the wishes of the young mother and her parents. Some mothers may opt to marry and in many cases, parents hard pressed to find fees may encourage them to do so.

The contrary argument was that readmission of young mothers would encourage premarital pregnancies and give a bad example to those who are still in school. It was also argued that those who are readmitted often become pregnant again before completing school.

Promotion of education of the girl child was viewed as a major strategy for reducing harmful practices

'…….. this has shown that such girls get pregnant as soon as they are taken back to school. For example, the daughter of Mr.---- first got pregnant in primary six (6) and when they took her back to school, she got pregnant again and she is not married' (female parents/guardians).

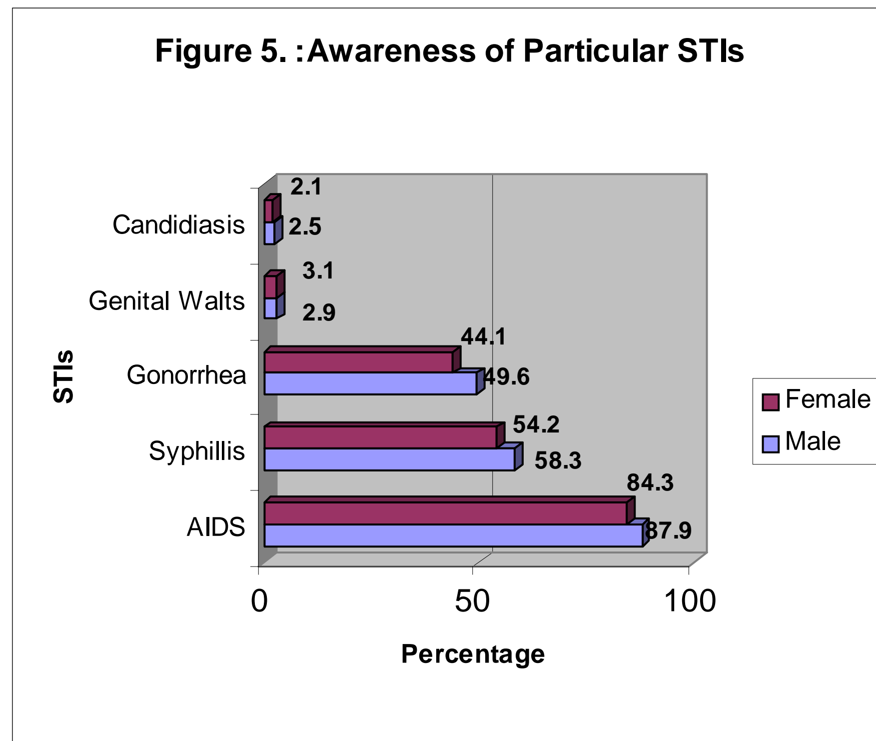
5.2.2 Knowledge, life planning skills and attitudes towards adoption of safer sexual practices.

A large proportion (75 percent) of the youth were willing to undergo the HIV test.

Knowledge

The survey collected information on the adolescents' knowledge of various aspects of SRH. The data revealed high levels of knowledge: 92 percent of males and 87 percent of females said they had ever heard of the condom. An overwhelming majority (97 percent) had ever heard about the AIDS disease.

However, many common STIs were less well known. The majority of the youth (87.6 percent among male and 88.5 percent among females) had not gone for an HIV test at the time of the survey. However, a large proportion (75 percent) was willing to undergo the test. Hospitals were the most cited source for HIV testing. The data further reveal that 1 in 4 respondents (25.5 and 26.3 percent of male and female respondents respectively) consider themselves at risk of contracting HIV. However, many common STIS were less known.



Life skills

Focus group discussants and key informants were asked to state what they consider to be the life skills that would be required by adolescents in the world of today. The results indicate general agreement on a number of skills necessary for the well being of adolescents. The following were mentioned:

- Critical thinking
- Creativity

- Self awareness and realization
- Self reliance
- Community skills
- Human values/self esteem

Adolescents were asked about what they would do if their partner refused to use a condom. This was asked to determine the adolescents' ability to resist unsafe sex. About 80 percent of both males and females reported they would refuse to have sex if their partner did not want to use condoms.

The survey also sought information on the needed skills for improving the economic standing of young people. The following were commonly cited:

- **Modern agricultural skills**
  '…. **Modern farming skills should be disseminated to youth since most of them are involved in agricultural activities. … this would involve provision of high yielding seeds, exotic animals like goats, cows and pigs…"**

- **Business Management skills**
  '…. Government should train us in business management. This will help us identify what we can do profitably and how it can be marketed…'

- **Agro-processing industries and skills**
  '…. Most young people detest farming but we have plenty of passion fruits and pineapples in the area. Government should train youth in agro-processing so that they process some of these fruits and thereby create employment.

Other skills mentioned include construction, mechanical work and fishing.

5.2.3 Attitudes towards safer sex practices

Prevention of HIV/AIDS infection and avoidance of pregnancy were given by adolescents as the main reasons for using condoms. Lack of sexual satisfaction, being a sign of mistrust and the desire to get pregnant and the fear of condoms remaining in a woman were cited as reasons for refusal to use condoms; 26 percent of the male and 19 percent of the female adolescents reported that they had ever refused to use condoms.

'……. If you suggest to a partner that we use a condom, she will say that 'do you think I have HIV/AIDS… just abandon those things' –out-of school, male

'… a condom may enter the womb and cause complications' – out-of-school female. About 80 percent of the respondents reported that they would refuse to have sex if their partner did not wish to use condoms, only 8 percent said they would have sex even if their partner refused to use a condom.

8 percent of the male respondents and 10 percent of the females considered those using condoms to be promiscuous,

The overall perception of condom use was positive. The majority of adolescents (68 percent and 58 percent among males and females respectively) reported that they perceive condom use as being protective of each other. However, a small proportion (8 percent and 10 percent among males and females respectively) considered those using condoms as promiscuous.

Abstaining from sex was also viewed positively and 84 percent of the adolescents stated that they would advise their peers to do so.

Of those who had experienced an STI symptom, nearly 30 percent did not visit a health facility although some received treatment from elsewhere. Nearly a

half did not tell their sexual partners that they had experienced an STI symptom.

In the focus group discussions, participants were asked why adolescents did not want to use contraceptives and a number of reasons were mentioned as follows:

- **Lack of knowledge about contraception**

  '… Girls have never seen any contraceptive like pills and those who have seen them don't know how to use them' in-school female adolescents.

  '… We hear about those methods but most of us do not know what exactly they are, but where are they given anyway' in-school males.

- **Fears, misconceptions and rumors about side effects**

  '… My sister used contraception but she would bleed so much during her periods and she had to give up' – out-of school, females.

  '… We fear to produce deformed babies.' In-school, female

  '…Taking contraceptives for more than 3 months can make girls barren for life' –out-of-school, males.

  '… Contraceptives are not effective at all. I know two women who were using them regularly but they are now pregnant' female guardian.

- ***Beliefs and attitudes about youthfulness.***

  '… Young girls cannot get pregnant,' and another adds:

'…We do not have AIDS and we cannot make girls pregnant even and therefore we don't need contraceptives; shows mistrust for one's partner' female guardian.

While knowledge about contraception has increased over time, the same kinds of obstacles prevent the adoption of the various methods.

These quotations show that while knowledge about contraception among the population has increased over time, the same kinds of obstacles prevent the adoption of the various methods. Some contraceptives remain a myth simply because they have not been seen and fears, misconceptions and rumours about side effects are still rife.

5.2.4 Awareness, Access and Utilization of ASRH services

More than three quarters of the youth were unaware of ASRH services in their communities.

Respondents were asked whether they had ever heard of sexual and reproductive health services that are specifically intended for adolescents. About three quarters of the male and female respondents (77 and 79 percent, respectively) had never heard of such services. Those who reported to have knowledge about the existence of ASRH services were asked to specify the particular services that were available in their communities. The following services were commonly cited;

- Guidance and counseling
- Prevention and management of STIs
- Contraception
- Antenatal care
- Delivery care
- Immunization

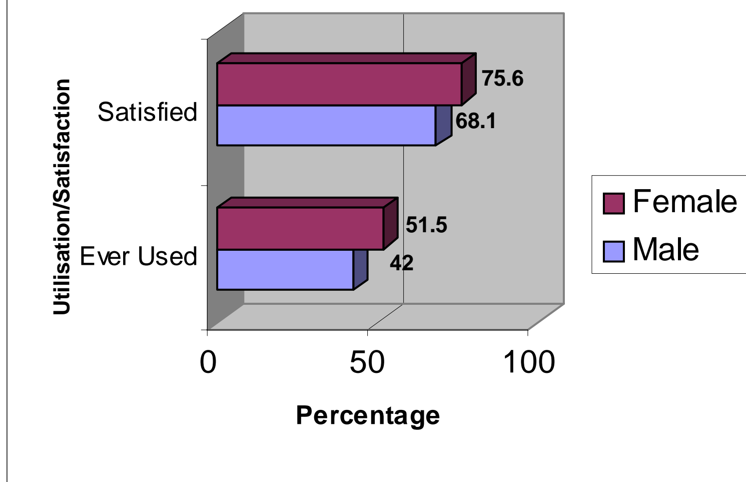
About three quarters of the male and female respondents (77 and 79 percent, respectively had not heard about ASRH services. Post abortion care was least known and reported by around a quarter of the respondents.

About one-third of those who knew of ASRH services reported the availability of HIV testing services in their communities. Post abortion care was least known and was reported by around a quarter of the respondents. This is not surprising given that the procurement of an abortion is often criminal (i.e. without medical sanctioning) and hence done secretly.

More of the female youths (55 percent) than their male counterparts (48 percent) reported that ASRH services were easily accessible to them. When asked why they did not consider such services accessible, close to a half cited ‘inconvenient locations’ of such services while 3 in every 10 stated that the ASRH services were ‘expensive’. A substantial proportion cited either parental or provider disapproval. While about two-thirds described the providers as ‘friendly’, about 10 percent rated them as ‘ unfriendly’.

Girls were more likely (51.5 percent) to have utilized ASRH services than boys (42.0 percent). Girls expressed a higher degree of satisfaction; 75.6 percent reported satisfaction with the service while 68.1 percent of the boys did so. Female adolescents were also more likely to have visited a health facility in the preceding six months (20.2 percent) than boys (16.2 percent).

The main obstacles to accessing ASRH services by the youth included ignorance about their availability, geographical and economic inaccessibility, fear and shyness, availability of (cheaper) traditional options and the quality of services.



'… ***The health centre is very far and one needs money to pay for transport and the services but we are very poor' (out of school females)***

'When we go for these services, parents and other people in the community would for example know that so and so had an abortion or has an STD which is embarrassing' (out of school female).

'We fear to report such problems to health personnel .. medical people ask many questions and we would rather not go there' (in-school males).

'I for one went there and I was told to take my partner for treatment, I never went back because I feared he would know that I had contracted an STD' (out of school female).

'***Herbal mixtures are better and traditional healers do not ask as many questions. They are even cheap' (in-school youth).***

'Some of us cannot speak good English and the nurses at our place talk only English' (out-of school youth).

The survey also revealed that ASRH issues are rarely discussed with the youth's parents; three quarters of the boys (75 percent and 64 percent of the girls had never discussed such issues with their parents. This was mainly attributed to fear of their parents.

5.2.5 Implementing partners' capacity to manage ASRH services.

The AYA programme was intended to be implemented through local implementing partners (IPs) depending on their comparative advantages while at the same time building their capacities to ensure sustainability once the programme ends. In view of the national policy of decentralization, district structures such as the District Director of Health Services were envisaged to play a prominent role. NGOs and CBOs implementing ASRH services would be involved. In addition, the lower tiers (sub-county) would through this program participate in the delivery of ASRH services.

Therefore the baseline survey sought to assess the existent capacity of the various implementing partners to manage ASRH services.

Since schools are the main contact point for the youth, a school facility questionnaire was administered to elicit information on the ASRH services available through such outlets and explore the potential role schools could play in implementing AYA interventions. Information was also collected on NGO programs and the mechanisms for collaboration among agencies offering ASRH services.

Parents and relatives were the least likely source of information on ASRH for their adolescent children.

The school facility survey revealed that formal classes and counseling sessions were the main sources of information on ASRH. These sources should provide more accurate information than peers. Parents and relatives were the least likely source of information. The commonest problems experienced by students were to do with menstruation followed by

pregnancies and STDs. A few schools, 6 out of 404, stated that HIV/AIDS constituted an ASRH problem in their facilities. The main avenue for addressing ASRH problems in schools is through reference to the senior woman teacher Discussion among peers (fellow students) was cited by 19 schools and 12 schools mentioned talking with parents. It is remarkable that only 2 schools stated that "school authorities" were involved in addressing ASRH problems suggesting that the senior woman teacher does so out of volition. The data also show that few teachers had benefited from specific training to address ASRH issues.

FGD respondents and key informants consisting of parents and civic leaders were asked as to who were the actual people and which were the most important institutions in shaping the RH knowledge and attitudes of young people. The most recurring responses were that parents, teachers, religious institutions and schools had the greatest influence on young people. Peers and friends were also mentioned often. Only a few cited health workers as sources of RH knowledge or influencing the youth's attitudes.

When asked where the youth obtained treatment for ASRH problems, the commonest answer was a health centre or hospital nearby. However, traditional healers and herbalists were also mentioned often even in the urban district of Kampala, in addition, self medication, through the purchase of drugs over the counter was a common practice.

There exist enormous variations across districts regarding the availability of ASRH services.

The data revealed enormous variations between districts regarding the existence of ASRH programs. Some districts' key informants could not cite an on-going program. The data also show that the existing programs focus on sensitization and training. Treatment of STDs is mainly associated with the STI project of the Ministry of Health. Even less visible are interventions intended to impart life and livelihood skills.

There exist several opportunities for collaboration among agencies some of which are formal and others non-formal. At the Ministry of Health, the Director General chairs a quarterly meeting of senior management to consider RH issues. Another meeting, held half-yearly involves a broader range of stakeholders including other line ministries, NGOs, donors and other agencies such as the UAC, AIC and so on. The NGO track in the Population Secretariat promotes collaboration among those involved. At the district level, the district team and planning committee ensures collaboration among agencies. There is also the district NGO forum, which meets monthly.

Government has taken the lead by setting policy guidelines that the various players adhere to. This has resulted in achieving synergy among the various interventions. However, these arrangements need to be enhanced by formally adopting the various policies and encouraging more effective networking among CSOs through more formal arrangements.

5.2.6 ASRH coordination and dissemination systems at national, district and sub-country levels.

The information presented in this section is based on a review of relevant documents as well as key informant interventions conducted during the baseline survey. The interviews explored the existence of NGO/CBOs involved in ASRH and the extent to which their work is being coordinated. In particular, the respondents were asked to identify projects that were being jointly implemented by NGOs/CBOs and district authorities. They were also asked to indicate the challenges being faced by such partnerships.

National level.

The Ministry of Health holds quarterly meetings of senior management to discuss reproductive health issues. This initiative arose out of the recognition that the absence of coordination often leads to duplication of efforts and sometimes unfortunate instances of friction among implementing agencies.

Through these meetings, the various aspects of reproductive health are planned jointly. Another forum is called 'Stakeholders in Reproductive Health', meets twice a year. This involves the Ministry of Health, other ministries whose mandate includes reproductive health, and civil society organizations in this field.

The second means through which A SRH activities are coordinated is through policies and guidelines. The draft adolescent health policy outlines the institutional framework through which ASRH services are to be implemented and coordinated.

District level.

The District Director of Health Services (DDHS) is responsible for the majority of ASRH services at the district level. Coordination is ensured through interdepartmental meetings. The other partners include relevant departments, faith based organizations and NGOs. Where a major ASRH project exists, they are coopted on the committee. The forum for NGOs provides an additional avenue for coordinating the work of the civil society organization and harmonizing it with that of government departments.

Lower level activities.

The sub-county is a corporate body and has a budget and draws up plans to address identified problems including those of ASRH. The sub-county has a

council and a nine-person executive, which includes secretaries for youth, women, and mobilization. These are the key offices for addressing ASRH problems. ASRH services are mainly provided through schools and health centres. Other providers of ASRH services include NGOs, CBOs, the private sector and faith-based organizations. The police, by being involved in ASRH issues of rape and defilement, curbing the use psychotic drugs, and arresting prostitutes, has also been seen as a provider of ASRH services. However, there was no evidence of byelaws having been enacted to address ASRH issues specific to the respective districts or sub-counties. In this regard, the Decentralisation Act (1997) which provides such powers to Local Councils is not being fully taken advantage of.

Dissemination

Dissemination of ASRH information depends foremost on its availability and since its generation is usually a by-product of project activities, its publication is closely tied to the structure of the project. Information is often disseminated through project progress reports, seminars and workshops, radio, videos and IEC material and research reports. Each of these channels is targeted at a specific audience and the information is not widely available. However, there existing number of databases from which ASRH information can be extracted these include the most recent censuses conducted in 1991 and 2002 together with the Uganda Demographic and Health Surveys conducted in 1988/89, 1995 and 2000/2001.

6. Summary

This part of the report highlights the most salient observations drawn from the Baseline survey.

- There are a number of unfavorable ASRH indicators that require to be addressed. This is the more important given the numerical dominance of

young people, aged 10-24; dealing with their ASRH needs is a *sine qua non* condition for improving the overall national indicators for sexual and reproductive health.

- The unfavorable indicators include on early age at sex debut, early pregnancy (17.0 years), the presence of STIs and HIV/AIDS alongside the predisposing factors of low condoms use and sex for gain.

- Although most young people in Uganda have heard about many aspects of sexual and reproductive health, few have detailed knowledge. For example, of those who have heard of the various methods of contraception, few had actually seen them. Many could mot cite a facility within their community where such methods could be procured.

- Despite the overall increase in knowledge about contraception, the same kinds of obstacles, fears, misconnections, and rumors about side effects- prevent their widespread use.

- Accessibility, youth friendliness and affordability are still major reasons for not utilizing ASRH services.

- ASRH issues are rarely discussed between parents/guardians and their children.

- Youth had positive attitudes towards condom use and abstinence and there is potential for these safer sex practices. The majority were willing to undergo an HIV test.

- The data revealed enormous variations between districts regarding the presence of ASRH programs.

- These were few interventions intended to impart life and livelihood skills to the youth.

- There exist sound institutional arrangements to ensure collaboration among NGOs/CBOs and government departments working in the area of ASRH.

7. Programmatic Issues.

This section lists some of the considerations that have to be taken into account in the modification of ASRH interventions.

- The main dimension of variation was age for most of the variables considered. The differences between male and female respondents were small. The urban residents showed the expected advantage in accessing services: ever use of contraception was higher in urban areas and they were more likely to receive treatment for STIs. Unexpectedly, the differences between in and out of school adolescents are not significant on most scores although the in-school tend to have slightly more favorable conditions.

- It is difficult to assess the depth of knowledge on the basis of questions like; "ever heard of..." However, it appears from FGDs that the respondents had superficial knowledge on most aspects covered in the survey. The strategy should be to deepen this knowledge through demonstrations, group discussions and question and answer sessions. Since the majority of youth are in contact with the school system, the curricula should be modified to respond to these ASRH needs. Outside of the school system, testimonials of satisfied users are an additional strategy.

- Linking ASRH service outlets to communities is critical. This should entail publicizing widely their location, the services offered and when they are open. In addition, continued interaction between providers and clients should ensure the appropriateness of the services.

- There is a communication barrier between parents/guardians and the youth regarding ASRH issues. This barrier needs to be broken so as to multiply the sources of information and this should constitute a major thrust of the BCC component.

- The baseline survey found survey found that the efforts to impart life and livelihood skills were weak. Yet these have a profound influence on the ability to negotiate safer sex and procure the necessary commodities for SRH (e.g. contraception). The policy and advocacy component should address this gap.