

Reproductive Health and Adolescent School Students in Kabarole district, western Uganda: A Qualitative Study

Bannet Ndyanabangi and Walter Kipp

Introduction

As new figures are released, the impact of the HIV/AIDS pandemic on the African continent becomes more and more obvious. The United Nations AIDS Report 1998 indicates that out of the 30 Million HIV infected persons worldwide, 86% reside in 34 countries in sub-Saharan Africa and that 91% of all AIDS deaths are occurring in these 34 countries. Of an estimated 7,000 new HIV infections globally every day, half of the HIV infection affects adolescents and young adults in the age group of 10 to 24 years (Barongo et al., 1992). The benefit of modern antiviral therapy is not available to the general population in these most affected countries. Also, the development of an effective vaccine against HIV is taking longer than estimated. In this scenario, behavioral change through appropriate and effective education programs is the only choice remaining to reduce the risk of acquiring an HIV infection.

In sub-Saharan Africa there are also serious health problems among women related to child bearing. As compared to the other continents, globally it has the maximal burden of disease due to childbearing. In sub-Saharan Africa there were 79.9 million Disability-Adjusted Life Years (DALY) lost in 1990, compared to 78.2 million DALY in India, 25 million DALY in China, and 18 million DALY in Latin America on account of causes related to maternity (World Bank, 1993). The countries in sub-Saharan Africa have the highest number of early childbirth in the world. On average, more than 50 percent of young women in this region give birth before the age of 20 years. In some African countries, as many as 40 percent of women have their first child before age 18 years (Crews, 1989). In 11 countries in sub-Saharan Africa, for which data were available, adolescent fertility contributed between 15 and 20 percent to the overall fertility (Population Reference Bureau, 1992).

In addition to the overwhelming need for reproductive health care/education for adolescents in sub-Saharan Africa, the lack of appropriate, "youth friendly" services is well documented and researched (Hughes and McCauley, 1998). Adolescents are not seeking services for many reasons such as - financial inaccessibility, cultural factors, geographical issues, and some service related issues. Consequently, adolescents don't get the information they require for safe reproductive behavior. In many countries, the traditional ways of communicating sexual matters between the generations have broken down due to lifestyle changes. For example, in Namibia, the main source of sexual education for girls has been an aunt of the family. Now, most girls in the age groups of 14-18 years are in boarding schools and contact with their aunts have broken down. Therefore, these girls now have to look for other sources of adequate, reliable, and confidential information. Most adolescents do not consider parents as a source for sexual information (Nichols et al., 1987; Kumah et al., 1992). Although health clinics might seem to be the right place both for accurate and confidential information as also services, they are not always helpful in appropriately servicing adolescents. For example, case studies in Senegal and South Africa have shown that when adolescents visit clinics for help, they were often scolded, refused information, or turned away (Population Council, 1991; Abdool et al., 1992).

Young people do not ignore health clinics because they have no need for reproductive information and services. Rather, if they can find a source of adequate, reliable, and confidential information, they will use it. Data from Cameroon and Nigeria indicates that adolescents avoid the formal health care system and instead often treat themselves with home remedies or pay visits to traditional healers (Joseph et al., 1997; Leslie and Defo, 1997). When a radio call-in show for reproductive health in Nairobi, Kenya, went on air, the phone lines quickly jammed and a crowd of young people gathered outside the studio building in the hope of being able to ask some questions (Kiragu, 1997).

In Uganda, the government has recognized and addressed reproductive health as a serious concern. Impressive successes in combating the HIV/AIDS epidemic have been achieved with significant reductions of the HIV-1 prevalence in young pregnant women in several parts of the country. However, family planning and safe

motherhood programs have been less successful, leaving many women in need of services and without access to reliable contraception. In Kabarole district, the situation is similar to other parts of Uganda with impressive successes in AIDS control programs (Kilian et al., 1999). However, fertility data and family planning services are below the low national level. Unmet need for family planning in Kabarole district is 48 %, in Uganda 38 %, and in sub-Saharan Africa 25% (Population Action International, 2001). In 1998, the German Agency for Technical Cooperation (GTZ) supported Basic Health Services Project in Kabarole district, mounted a special effort in order to improve reproductive health services, especially family planning, in the whole district.

The purpose of this study was to generate data to facilitate the planning process for reproductive health programs in Kabarole such that the reproductive health needs of adolescents could be better met by service delivery. The study had the following objectives:

- Identify opinions about various issues regarding sexuality and reproductive health in adolescents and adults
- Identify major sources of information regarding sexual behavior and reproductive health of adolescents
- Determine perceptions, attitudes, and use of modern contraceptive methods in adolescents
- Assess the extent to which the current services in reproductive health are oriented and geared towards the needs of young people.

Background information

Data collection took place in 1995 in Kabarole District, a rural district in western Uganda. The Republic of Uganda covers a total land area of 241,139 km. sq. in the East-African region. The country has a total population of 21 million inhabitants and a female/male ratio of 96/100. The population growth is estimated at 2.9% per year (Ministry of Finance, 1991). Uganda has a young population with over 50% of its population below the age of 15 years. Uganda is one of the least urbanized countries in sub-Saharan Africa with only 8.7% of its population living in towns. A majority of the urbanized population lives in the national capital Kampala (Ministry of Finance, 1991).

Uganda is especially hard hit by the HIV/AIDS pandemic. Kabarole district is one of the districts that have been more heavily affected by HIV/AIDS than other districts in Uganda. Ever since 1990, sentinel surveillance of pregnant women attending antenatal clinics has been carried out in Kabarole by the District Health Office . This surveillance has shown marked differences in HIV prevalence in relation to geographical location of the health centers: 28 % in urban areas, 14 - 18 % in semi-urban or main trading centers, and 8 - 10 % in rural areas. In 1996, Adeokun found that of 1,036 randomly selected households in Kabarole, 356 (34.4%) had a family member ill, dying or deceased from an HIV-related illness. The number of HIV affected households in Kabarole was higher than in Masaka and Rukungiri districts (Adeokun, 1996). Contraceptive prevalence rate (CPR) for modern contraceptives was reported at 6 % during a district wide survey in 1994 (Tindyebwa, 1994). During the same period the CPR for Uganda was 10 %, for sub-Saharan Africa 24 %, and for Eastern Africa 18 %. The Total Fertility Rate (TFR) in Kabarole district is estimated at 8.0 while the TFR for Uganda is 7.0, for sub-Saharan Africa 5.8, and for Eastern Africa 6.0. During the last census, the population growth rate for Kabarole district was 3.3 % while the population growth rate for Uganda was 2.9 and for sub-Saharan Africa 2.6 (Population Reference Bureau, 1999).

Methodology

The main study population was school going youths in Kabarole between the ages of 14 - 17 years. In keeping with suggestions from the District Education Officer, the willingness of the principals, and the consent of parents, three secondary schools were selected. Two schools were located in an urban area (district capital) where there are separate schools for boys and girls. In order to get the views of study participants from rural areas, one rural school was chosen which was located over a 100 km from the district capital. The rural school was a mixed school, i.e. admitted both boys and girls. In each school, participants were randomly selected, using simple random sampling without replacement. The random sampling procedure was based on a list of students in the respective age groups which was provided by the principal of the school.

Students from different classes were asked to participate in groups of six students - each of similar age and of the same sex. A total (see [Table 1](#)) of 12 focus group discussions were held with 75 participants. A pretested focus group discussion guide was used. The focus group discussions were held in the classrooms during the weekends such that it would not interfere with the ongoing school activities. The classrooms chosen offered privacy and were quiet. The focus group discussions lasted between one and a half to two hours. Data from the focus group discussions were tape recorded and transcribed into notes. Only the age and sex of the participants were recorded. Notes were taken to describe the group dynamics and to summarize the key statements. The written transcripts of the focus group discussions together with the notes were the basis for the thematic analysis of the text. They were entered into Microsoft Word. English was the language in the discussions and in the transcribed notes. A surface analysis or first look at the data was achieved by re-reading the transcripts, reflecting on the data in its entirety, extracting major categories, and looking for deviations from the categories (Roth, 1994). Deeper analysis included search for commonalties, divergent or unique perspectives, as well as interrelationships between themes. Key themes were extracted from the transcripts and compiled. A coding framework was developed from the list of key themes and was used to code the transcripts for analysis. Quotes from focus groups were used to provide an accurate and realistic portrayal of participants perceptions.

Fifteen key informant interviews were conducted. Key informants were opinion leaders in the community such as principals, teachers, minister, chiefs, and village headmen. All of them, with the exception of some of the teachers, were parents themselves. They were recruited from the same area where the three participating schools were located. Participation was voluntary. The questionnaire contained open-ended questions. The interviews lasted forty-five to sixty minutes. Results of the interviews were recorded on the prepared questionnaires. Data from the key informant interviews were analyzed in the same manner as the focus group discussions.

The simulated client method used to study client-provider interaction was applied to assess the reception and services to young people in the district government hospital family planning clinic, in a health center in a smaller township, and in commercial condom outlets. The participants, two male and two female students between 14 and 15 years of age, were sent to these places to try and buy condoms. The two female students were also asked to attend family planning clinics in government health facilities and to ask for oral contraceptives. The students were trained for several hours to prepare them for their role and to minimize any harm from their visit experiences. They were instructed to return immediately after their visits to be interviewed.

Three male and three female research assistants helped us with the focus groups and the key informant interviews. They were selected from 21 students with prior research experience who applied for the positions. Students with the highest score on a written test were selected. Training of interviewers followed the guidelines of the "Practical guide for health workers on interviewing and recording of community health surveys" (WHO, 1986). The training session lasted three days. Following this, pilot testing of the focus group questions and the key informant questions was done using five persons for each set of questions and all in different geographical locations.

Consent for the study in writing was sought from the district authorities (District Medical Officer and District Education Officer) and from the principals of the schools involved in the study. Each school class and each individual person, who participated in the study, was informed about the purpose of the study and verbal consent was obtained and recorded on the data collection sheets. In order to keep results anonymous, no names were recorded. Also the names of the schools were kept confidential. Since many participants were under the age of 18 years, parents' consent was required. We followed the procedure which had been used in the district before and which had been accepted in earlier studies: the principals of the school gave consent on behalf of the parents after consulting with them. The chief of the area was also asked to give his consent. The National Council for Science and Technology in Kampala approved the study.

Results

Results were available from all 12 focus groups. The age of the participants ranged from 14-17 years. The groups were assembled in the following way (see [Table 1](#)):

Results were available from six teachers and/or principals from government and religious schools and nine community leaders/parents.

Knowledge and perceptions on reproductive health

Most male participants felt that the appropriate age for first sexual contacts should be 15 years. This view was expressed especially by the younger males of 14 years of age.

"One should start sex at the age of 15 years, because at that age one produces sperms and is powerful" (14 year old male)

Female participants were worried that early sexual activities would lead to pregnancy before they would be able to support themselves and a child. Thus, they favored the age of 18 years and above for the first sexual contact.

"Above the age of 18 years someone is mature and knows what she/he is doing" (female 17 years)

Several participants thought that if a boy and a girl of 15 years of age or less have sexual contact, the girl could not become pregnant, because "the sperms and ovaries are not ripe yet". While several students were of the opinion that age did not matter for sexual contact as long as responsible sexual behavior was shown.

Many of the male and female participants had a fear of negative outcomes as a result of not having sex regularly. There were fears that one could be embarrassed in the later life when one did not know what to do.

"The partner may laugh at you if you don't know what to do" (male 16 years)

Medical side effects of being abstinent were mentioned as well by many: becoming impotent, having backaches, becoming hysterical, having difficulties in delivering a baby.

"Obviously there are side effects; I heard from a friend that if you stay a virgin for a long time, you will feel a lot of pain when you start sex" (female 16 years)

Both male and female participants identified pressures that foster sexual activity. The leading factor was peer pressure for males.

"If you say you never had sex they say you are not a boy" (male 14 years)

Female students mentioned material things provided by men, leading some to repay in the form of sex. Some girls also mentioned pressures from their teacher to engage in sexual activities. Other influences mentioned were alcohol, disco visits, drugs, and seductive dressing of girls. Alcohol was widely thought to be an important factor leading to sex, because it is so cheap and readily available.

"When one drinks alcohol one loses his senses and gains courage to try out things he/she would otherwise not do" (female 17 years)

Attitudes towards modern contraceptives

Regarding condoms, there was a perception in some groups that condoms are not suitable for young people.

"We young people are not supposed to use condoms, because our penises are still small. Condoms are manufactured for adults only" (male 16 years)

There was fear that condoms could slip off and remain in the girl's reproductive organs, causing disease and even death of the girl. Several participants thought that condoms are to prevent pregnancy and not HIV/AIDS.

"Condoms are supposed to be for stopping pregnancy and not the HIV virus" (female 16 years)

Some participants (both male and female) thought that condoms were not safe to protect from being HIV infected.

"Pores in the condoms are nine times bigger than the virus therefore it can pass through" (male 16 years)

"I don't believe that condoms stop the spread of the AIDS virus in humans; if one partner has the virus it will go through" (female 14 years)

A few participants expressed positive views on condom use. In approximately half of the groups, participants felt that condoms are useful and necessary to fight HIV/AIDS.

"Condoms, although not a hundred percent, can protect against pregnancy and disease, so they should be encouraged"(male 15 years)

"Condoms if properly used can prevent AIDS" (female 16 years).

Compared with condoms, views on oral contraceptives were generally much more negative in both males and females.

"I don't think these methods are good for use by young people of our age group. When we use them they can end up destroying our reproductive system" (female 15 years)

"Girls who take pill for a long time, when they give birth, the babies die or a have only one arm" (female 17 years)

Boys were also concerned about infertility and miscarriage.

"If used for a long time there will be a lot of miscarriages" (male 16 years)

"They should not be used because they may block the oviduct of the girl and cause infertility" (male 15 years)

None of the female participants acknowledged having ever used contraceptive pills. In adolescents, fears of oral contraceptives was based on the belief that they do have physical side effects such as infertility, congenital malformation of child, and physically harm to the body. In contrast, key informants considered oral contraceptives to be dangerous for moral and spiritual reasons (e.g. oral contraceptives encourage promiscuity and pre-marital sex, the church does not allow the use of modern contraceptives, etc.). A few participants made positive comments about oral contraceptives.

"They are good to prevent pregnancies for people who wish to space their children" (female 17 years)

The discussions revealed that young people have little access to integrated reproductive health services, where they can get curative and preventive services and appropriate information on reproductive health. Especially for the younger age groups, it is difficult to buy condoms and pills.

"We don't feel comfortable when buying condoms because they ask us too many questions" (male 14 years)

"They think we are young and it is bad for us to use condoms" (male 15 years)

"Condoms are not available at the school clinic. If you are found with condoms you might be expelled" (male 17 years)

"For collecting pills I would feel shy because everybody would know I am going to play sex" (female 17 years)

When asked where participants would go for treatment of a STD, almost all said that they would not use the school nurse, but any clinic far away - in order to not be recognized. There was also a problem with the payment for the STD treatment. Most of the discussants said that they did not ask their parents, but borrowed the money instead from friends. There was a strong opinion in all groups that the present health care system does not meet the needs of young people.

The perception about condom use was mixed in the key informants. Most of them objected to the fact that young people are using them. Like with students, they also had misconceptions about condoms, e.g. they break, leak the AIDS virus, have side effects in women, etc.

"I have not heard of any one who used it and it helped. If we encourage it, more people might get infected with AIDS" (village women leader 47 years)

"I am happily married. I don't need a condom, but I think it helps those who are promiscuous" (village chairman 43 years).

Negative views of key informants on condom-use were mostly held for moral and spiritual reasons similar to those held for pills.

Family context

Most of the discussants found it extremely difficult to discuss sexual matters with their parents. Some discussants felt that parents fear that if they talk about sex they make their children more interested in exploring and practicing sex. On the other hand, young people also feared that by raising the topic of sexuality for discussion, their parents would interpret it as actual evidence of sexual involvement.

"In my case I fear because my parents may think I am becoming a bad girl" (female 15 years)

"My parents talked to me when I was joining a mixed school. It was a warning to me to behave and to be careful. I didn't ask. They just cautioned me. We didn't discuss" (female 15 years)

"My father tells my mother to advise me because he is too busy" (male 15 years)

Teachers and schools were also not considered as a good source for information on sexual matters.

"There is not much discussion on sexual matters in class. The teachers tell us to be careful, but do not tell us the means of being careful" (female 15 years)

"There is not such a thing as sexual education in our schools. They just tell us that we are not ready yet" (male 15 years)

"We would want to know how to handle boys when they approach us; advantages and disadvantages of using contraceptives and more about pregnancy" (female 16 years)

Most of the community leaders/parents had a negative view about sexual relationships of adolescents. They felt that sexual behavior should be practiced only after being married. Appropriate ages for marriage were considered 18 years for boys and 16 years for girls. Only one of the nine interviewees said that he had discussed sexual matters with his children. The remaining said that they have warned their children against being sexually involved while in school. Some of the parents acknowledged that they are "tough" and their children fear them.

"I just warn them; their mother should do the talking" (male teacher)

"I never discuss with the children. It is difficult to start because the children fear"(male community leader)

Eight of the nine community leaders said they would punish their children, if they found out that they had sexual intercourse. Only two mentioned the possibility of counseling and professional help. One interviewee said that he would give money to his daughter to buy the pill, while the other nine categorically opposed the idea of giving their children money or permission to acquire contraceptives. Most of the parents who had adolescent children did not think that their children had started to have sexual contacts.

Preferred sources of sex information were friends and peers. Often mentioned was a newspaper insert "Straight talk". Some female participants mentioned their aunts, because in some areas it is traditional that aunts educate their nieces on sexual matters.

"We would prefer to get information from friends or relatives who are not harsh to us, those we don't fear and those we are used to" (male 15 years)

"We prefer other young people with whom we can exchange ideas better than older people" (female 15 years)
Medical personnel, television, video, health information centers were less acceptable in being a source suitable for information on sex.

Response of the school system

The teachers' view on sexuality in adolescents was quite strict with some saying that sexual behavior of school students should not take place, while others said extra-marital sex is immoral and should not be allowed. One principal of a religious school questioned the effect of condoms on HIV transmission. Teachers felt that sexuality is appropriately taught (e.g. four hours on the subject in religion). Teaching on family planning issues was seen by most of them as a problem, because they feared the parents who do not believe in family planning. Also, teachers believed that if they taught sex education to their students, they would encourage them to engage in sexual activities.

In all schools it was prohibited to be in possession of condoms or pills. If a student was caught having a condom, he would be punished. Punishment ranged from chores such as cutting grass on the school compound to expulsion from the school. All teachers said that if a female student becomes pregnant, she has to be expelled from school according to the school laws and could not be re-admitted after delivery of the child. Only one teacher said he would recommend a pregnant student to be admitted to another school after delivery of her child. School nurses were not mentioned at all as a source for sexual information.

Response of the health care system

Four participants (two male students and two female students aged 14-15 years) visited health centers and shops. The two girls attended two different family planning clinics and went to two shops, while the two boys went to four other shops, which sold condoms and where they wanted to buy condoms. In all places the students were generally well received except for one shop where the reception for a female student was hostile. She was asked why she wanted to get involved in sex at such a young age and she was not able to buy a condom. The other female student also could not buy a condom. The two male students were able to purchase condoms in two different shops. All students were asked by the shopkeepers about their age. In the health center the female students were asked if they stayed with boys permanently. If they replied with a 'No' they were advised to use the condoms, but were not counseled by the health center staff when and how to use them. In one health center, a female student was cautioned about the pill and was warned by the nurse in charge of the family planning clinic not to use the pill, because "it destroys the reproductive organs". When the student asked several times for the pill, the nurse, however, refused to give it to her and sent her away.

Discussion

In this study we determined both the perception on reproductive health and the reproductive behavior of adolescent students in Uganda. We also assessed if the reproductive health services are geared towards the needs of young people. In order to get a balanced view, we included both rural and urban schools. Random selection of

study participants in each school was done in order to get unbiased study results for each school. As the three schools were not selected at random, a selection bias can not be excluded, this may compromise the interpretation and generalizability of the data. Random selection was difficult because in many areas parents did not consent to the study. However, as the District Education Officer confirmed that the selected schools were typical of Kabarole district, we were reassured that the selection bias may have been somewhat reduced.

We used qualitative methods, including the simulated client method (mystery client method). The simulated client method to assess family planning services has been used in Nigeria and Senegal (Nare and Katz, 1997; Olowu, 1998). Madden and colleagues provide a comprehensive review of this method and conclude that in spite of some ethical issues (blindedness of subjects, no consent, deception) this method is acceptable and generates unique and essential information for measuring provider's behavior (Madden et al., 1997). Also, the current guidelines of the Council for International Organizations of Medical Sciences state that researchers may be justified in not seeking consent if to do so would be impractical or frustrate the purpose of the study (Council for International Organizations of Medical Sciences, 1991).

Many participants had misconceptions about reproductive organs and their functions. An interesting finding was that participants thought that adolescent girls under the age of 15 couldn't become pregnant, because the reproductive organs of those adolescents are not "ripe and functional". Both males and females expressed this belief, the younger ones as well the older ones. Another important finding was that many adolescents believed that not being sexually active would harm their bodies. These findings were quite widespread in all groups and indicate that the existing information programs on sexuality are not sufficient and/or not effective.

Misconceptions about condom use were expressed, but the overall acceptance of condoms in young people has increased in the past years. When we compared our findings with earlier studies on perceptions regarding the use of condoms in Kabarole district, we found that young people have developed a more positive attitude towards use of condoms (Kabwa et al., 1991). This is in line with other data in Kabarole district on condom use where a significant increase in condom use from 10% to 60% was found between 1990 and 1997. Simultaneously, many misconceptions tend to prevail, in spite of the fact that the Ugandan Condom Promotion program is probably one of the most aggressive ones in sub-Saharan Africa. This persistence of misconceptions regarding the use of condoms - in spite of very vigorous condom promotion - has also been reported from other parts of Uganda (Nuwaha et al., 1999). Interestingly, some participants stated that condoms were useful for preventing pregnancies but not useful to prevent HIV/AIDS. In Kabarole district, this perception of condoms being beneficial in preventing pregnancies but not HIV/AIDS may be a result of the fragmented/non-integrated delivery of the family planning services and the HIV/AIDS control program. Lack of cooperation between staff from both programs may have led to different health messages and advice which may have led to the confusion among the clients and further fueled misconceptions.

Of concern is the widespread view of adolescents and key informant that oral contraceptives are dangerous, have many side effects, and can lead to infertility. Also one family planning provider considered oral contraceptives as dangerous and refused to give them to one of the mystery clients. This corresponds to experiences in the Kabarole family planning program where several instances have come to the attention of the District Health Management Team, that providers have discouraged women from using oral contraceptives (Okwero, 1994). Our findings are similar to another study from Mbale, Uganda, where most adolescents considered oral contraceptives as dangerous (Agyei et al., 1994). The limited knowledge and use of modern contraceptives in Uganda may explain the high teenage pregnancy rate in Uganda. Here 34% of adolescent girls under the age of 19 years already have a child (Demographic and Health Survey, 1995). Many health professionals in Kabarole believe that the teenage pregnancy rate in this district is very high too, although no detailed information is available. None of the participants in the focus groups said that he/she used oral contraceptives. As most participants expressed mainly negative views on pills, those participants who actually used oral contraceptives may have been too shy to talk about it openly, but we believe that those were not many.

The average age of the first sexual contact of adolescents was reported by most of the respondents around 15 years. This is in line with other studies from Uganda. In Mbale the first sexual experience occurs at 15 years for males and 16 years for females (Agyei et al., 1994). Measured at the national level, the age at first intercourse for

females was found to be 16 years (Demographic and Health Survey, 1995). In Kenya, the age of the first sexual contact was even lower i.e. between 13 and 14 years (Ajayi et al., 1991). The early start of sexual activities in adolescents in Kabarole is in sharp contrast to the belief of most parents who thought that their teenage children had not engaged in sexual activities. These parents have either a real lack of information or else they do not want to recognize and accept the reality that young people begin sexual activities early. The many contradictions between attitudes of adults towards sexual activities of teenagers and the actual sexual practice of teenagers pose many serious questions and demonstrate the need to re-examine reproductive health policies and educational programs.

The reproductive health services in Kabarole are not always adolescent-friendly. This was clearly expressed by all participants. In addition, the results of the simulated client method also show that family planning providers as well as other adults (e.g. shop-owners and parents) are not yet prepared to discuss and accept sexual activity in teenagers. We were surprised by the teenagers limited acceptance of the school health services (e.g. school nurse) as a source of information on sex, as none of the participants mentioned them. The low acceptance of reproductive health services in our sample is comparable to findings from other countries. For example, four decades of experience from the Population Council and others in reproductive health services delivery in developing countries show that adolescents are underserved, ill-served, and programs do not match their needs (Catley-Carlson, 1997). In Dakar, Senegal, adolescents were disappointed with providers' reception and response to their needs. The content of counseling was moralistic and encouraged them to abstain from sexual intercourse until marriage (Nare et al., 1997). In Liberia, adolescents cited limited accessibility to reproductive health services as the main cause for limited knowledge and non-use of contraceptives (Nichols et al., 1987). In Nigeria, it was found that providers had inadequate knowledge and skills to correctly apply the appropriate treatment methods for STDs. Furthermore, among all providers, there was evidence of poor counseling of adolescents (Okonofua et al., 1999). In another study in Nigeria, it was found, that only two percent of family planning clients were adolescents (Olowu, 1998). In Zimbabwe, adolescents were reluctant to seek advice at health facilities because of legitimate concerns about privacy, providers' attitude, and the narrow focus on reproductive health (Kim et al., 1997). Lacking accessibility to reproductive services has resulted in adolescents seeking care from other providers (traditional healers, staff in illegal clinics, etc.) who are not regulated and supervised by the government and who may put adolescents at risk of harmful practices.

Conclusion

Adolescents in Kabarole District have serious misconceptions about oral contraceptives. All groups (young males and females, teachers and parents) expressed a strong belief that oral contraceptives are dangerous. However, the encouraging finding was that misconceptions about condoms in adolescents seems to have decreased compared to earlier studies. The significant discrepancy between the attitude of parents towards teenage sex and the actual sexual practices of teenagers (i.e. early start of sexual activity) needs to be addressed in educational programs for parents. As indicated by all adolescent participants, peers are the most suitable and desirable source of sexual information. Therefore, the Kabarole reproductive health care services need to be expanded to include a strong peer education component for young people.

In Kabarole district, examples for adolescent peer education could be the following:

Training of adolescent peers as part of the ongoing Community-based Distribution program (CBD) for modern contraceptives. These adolescent peer educators could be linked to the CBD program for training and supervision. In addition, the "peer CBDs" could not only provide information, but actually deliver the contraceptives e.g. condoms. The "peer CBDs" could be sustained by principles of recognition and non-monetary incentives. This would not require new and/or big budgets since this peer component would be an integral part of the CBD program with reduced and feasible opportunity costs.

Innovative use of existing youth organizations such as sports clubs, church groups, and other youth clubs to provide relevant and accurate reproductive health information through specially trained volunteers. These groups have shown in the past to be very interested in such programs, but have rarely been approached or invited by officials to participate in the dissemination of reproductive health information (except for HIV/AIDS).

Existing CBD volunteers in the family planning program could be specifically trained to gain the knowledge and skills required for serving young people. These training sessions could be added into the ongoing training program for CBD volunteers in the family planning program. Similarly, supervision visits of CBDs by professional family planning staff could be expanded to include quality assurance of reproductive health services appropriate for adolescents. These program expansions could be provided with little extra costs involved.

Some staff of reproductive services were reluctant to provide the contraceptives asked for by adolescents. A major constraint for the acceptability of reproductive services by adolescents is the moralistic attitude of some providers. One option for program improvement could be to enforce the existing government policy that contraceptives including pills should be provided to all in need, irrespective of age and gender. Therefore, the provision of reproductive services to adolescents is not optional, but is an obligation for the staff. This situation could be rectified by policy directives and adequate staff supervision. In addition, guidelines and protocols detailing reproductive services for adolescents, could be developed and made readily available. Furthermore, political leaders at the district and the national level should emphasize the rights of all age groups to receive unbiased family planning services. Violations of these guidelines by health staff in providing responsible services (for example refusing services to adolescents) should be investigated and appropriate disciplinary action taken.

Other options could be improve school-based information regarding reproductive health by fostering more open discussions on reproductive health matters between teachers and students. Usually, teachers have not acquired the knowledge and skills to handle sensitive sexual matters in front of a class. Training programs regarding sexual education and individual student counseling skills on sexual information could be offered jointly by the Ministry of Education and the Ministry of Health as a multi-sectoral initiative. In addition, contraceptives could be easily made available on school campuses.

The resources for family planning are scarce and the political commitment to this program is still ambiguous at both the district and the national level. Some of the program recommendations resulting from this study could be implemented as an "add on service" to the existing family planning program with limited additional costs involved, as outlined above. However, the expansion of universal, district-wide reproductive health services for adolescents would require an increase in financial resources. Some, but not all, of the needed funds are available. As the health reform process in Uganda has effectively improved the availability of health funds at the district level, policy makers and health workers at the national and the district level and the public need to be convinced that it is cost-beneficial to invest in family planning programs for this age cohort.

How will policy makers be persuaded to increase the allocation of resources for adolescent health? Perhaps if family planning was more closely linked to the solution for the HIV/AIDS crisis, that is, if both programs could be seen by all levels of policy/decision makers as related issues, then an integrated approach to resolving adolescent reproductive health issues would begin. There would be multiple benefits of a solidly integrated FP/HIV prevention program with significant cost-reductions:

- Sharing of health staff by both programs, therefore reducing duplication
- Sharing program objectives/processes (e.g. counseling, condom promotion)
- Sharing program outcomes, e.g. more consistent information to the public regarding condom use
- Positive spill-over effects from the well developed/well received HIV/AIDS program to the less established family planning program, e.g. credibility of HIV/AIDS program staff
- Reducing the ethical dilemma of which program should receive funding priority.

Since both programs target adolescents, it is logical to develop integrated approaches/systems. In order to realize this strategy, policy makers and health workers need to be reoriented. As Kabarole district has put enormous human and financial resources into HIV/AIDS control and has set up one of the most successful HIV/AIDS control programs in Uganda, it should be possible to make a similar effort to improve family planning services - if the successful concepts and models in HIV/AIDS prevention are applied. It is ethically imperative that the HIV/AIDS pandemic not be allowed to drain most of the available resources at the expense of other desperately needed programs such as family planning services for young people.

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