FACTORS INFLUENCING UTILISATION OF ADOLESCENT
REPRODUCTIVE HEALTH SERVICES IN IGANGA DISTRICT

MPH
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BY

DR. MUWANGUZI DAVID GANGU

SUPERVISORS:

DR. DAVID NDUNGUTSE
DR. CHRISTINE NALWADDA

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DECLARATION

I, David Gangu Muwanguzi (Dr) hereby declare that the work presented in this dissertation is my own work with assistance from my supervisors. Information contained here in has not been presented to any institution for any academic award, publication, or other use. Where work or information of other persons is quoted, appropriate references have been given.

I hereby wish to present it for the award of Degree of Masters of Public Health of Makerere University.

Author

..................................................

David Gangu Muwanguzi (Dr)

Date 12/12/2007

This dissertation has been submitted with the approval of the following supervisors:

Dr. David Ndungutse

..................................................

Date 21/11/2007

Dr. Christine Nalwadda

.............................................

Date 13/12/07
DEDICATION

This dissertation is dedicated to my dear father the late Yovani Gangu and my mother Alitulonsi Gangu.
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I wish to acknowledge Makerere University School of Public Health for the support and education given to me.

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Recognition also goes to Iganga Chief Administrative Officer for allowing me time off to study, the Research Assistants and the Respondents for the parts they played in the development of this work.

Sincere gratitude goes to all in my family for the support given.
List of Abbreviations

AIDS  Acquired Immune Deficiency Syndrome
ANC  Antenatal Care
ASRH  Adolescent Sexual Reproductive Health
DDHS  District Director of Health Services
DEO  District Education Officer
DHT  District Health Team
DISH  Delivery of Improved Services for Health
FGD  Focus Group Discussion
FP  Family Planning
HC  Health Centre
HCWs  Health Care Workers
HH  House Hold
HIV  Human Immune-Deficiency Virus
HSD  Health Sub-District
KI  Key Informant
MOH  Ministry of Health
<table>
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<th>Abbreviation</th>
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<tr>
<td>MOF</td>
<td>Ministry of Finance</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>PI</td>
<td>Principal Investigator</td>
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<td>U.A.C</td>
<td>Uganda AIDS Commission</td>
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<td>UBOS</td>
<td>Uganda Bureau of Statistics</td>
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<tr>
<td>UDHS</td>
<td>Uganda Demographic and Health Survey</td>
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<tr>
<td>UNCST</td>
<td>Uganda National Council for Science and Technology</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
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<td>W.H.O</td>
<td>World Health Organization</td>
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Operational definitions

ASRH services- Package of health care services given to adolescents to address their health needs.

Child: Person below 18 years of age (Uganda Constitution)

Formal Health Care – Health services delivered in biomedical health facilities.

General Hospital: - District health referral facility serving about 500,000 people.

Health Centre II: Parish out Patient health unit serving about 5,000 people

Health Centre III: Sub-County health unit with Maternity and wards serving about 20,000 people

Health Centre IV: Electoral Constituency health unit with Maternity, theatre and wards serving about 100,000 people

Health Facility- An establishment where routine health care consultation is carried out by qualified health care workers

Household: A set of people living together and having meals from same source.

HIV Infection-Having the HIV virus in one’s body

Marital Status: whether somebody is living with a partner of opposite sex and they have conjugal rights.

Private Health Care: All health care providers working outside the direct control of the state
Social Mobilization - Efforts aimed at raising awareness for a service, and convincing people to go for the service.
ABSTRACT

Introduction and background: Low utilisation of Adolescent Sexual Reproductive Health (ASRH) services is a global problem especially in the developing countries. Iganga District is one of the districts in Uganda where the ASRH services are not being fully utilised by the community. According to Iganga District Director of Health Services (DDHS) report, only 40% adolescents are utilizing the services. Reasons for the non utilization of ASRH services in the district are not very clear.

This study aimed at identifying the factors responsible for low utilisation of ASRH services in Iganga District.

Methodology: This was a cross sectional survey. It was conducted in 24 randomly selected villages (clusters) in the district. Semi structured questionnaires were administered to adolescents to collect quantitative data on socio-demographic, knowledge, attitude and accessibility to ASRH services characteristics. The quantitative data was analysed using Epi Info 2002 and SPSS 10.0. Qualitative data was collected from 4 focus group discussions and 17 key informant interviews; data was analysed manually using a master sheet.

Results: A total of 738 adolescent were interviewed. Factors that were associated with utilisation of ASRH services included: Location of LC I Village - "urban or rural (OR= 7.00, 95%CI: 2.04 – 24.04), whether respondent ever engaged in sexual activity (OR=28.82, 95%CI: 7.13 -116.60), perception of providers (OR=4.51, 95%CI: 1.29-7.61), and being knowledgeable about ASRH services (OR= 11.56, 95% CI: 3.54 – 37.76). Belief that utilization of ASRH services requires payment inhibited service utilisation (OR=0.21, 95% CI 0.10 – 0.62).

Conclusion: In Iganga district, the adolescents are not aware about existence of ASRH services and don’t know the importance of such services. Adolescents feel that the
providers are rude and they think there are payments to be made before one accessed services. These factors are influencing utilisation of the ASRH services.

**Recommendations:** The Iganga District health team (DHT) should sensitise adolescents about ASRH services. The best strategy is through facilitation of health workers to disseminate ASRH education on local FM radio stations and during out reaches. The DHT should train adolescent community peer educators, who will educate adolescents and mobilise them to utilise ASRH services.

There is need to conduct further research to establish the reasons why these factors are present in the district and the ways of addressing them.

**Dissemination and use of results**

The study findings will be disseminated to Makerere University School of Graduate Studies, Makerere University School of Public Health, Iganga District Health Team and any other interested party. Information generated by this study will be used by the DHT to plan and implement feasible strategies for improving utilisation of ASRH services and address barriers.
CHAPTER ONE

Introduction and background

Adolescent Sexual Reproductive Health services are a package of health care services given to adolescents to address their health needs and whose goal is to address the adolescent's sexual and reproductive health issues such as early and un-protected sex, unwanted pregnancies, substance and drug abuse, unsafe abortion, and STIs including HIV/AIDS. It is part of the broader term (Reproductive Health).

The Adolescents and Adolescence

Adolescence is defined in physical, temporal, psychological and social terms. In temporal terms, W.H.O. defines an adolescent as an individual female or male aged 10-19 years (WHO, 1993). Adolescence is also understood to be a period of physical, psychological and social transition from childhood to adulthood. It is a stage of experiencing changes and of great variation in its timing and duration. It is characterized by biological, social and psycho-social changes that characterize the period of transition and most cultures consider it to begin with puberty (marking the establishment of reproductive capacity). Physically, the changes include the adolescent growth spurt, in which the size and shape of the body change markedly and the differences between boys and girls are accentuated.

Accompanying the transition is the dilemma adolescents face between a desire to adventure and experiment on one hand and the need to become socially acceptable adults on the other hand (AYA, 2001). Indeed the period of change introduces a lot of challenges to adolescents that require proper guidance and management in what is termed
generally as Adolescent Reproductive Health Services. These services are intended to keep the adolescents healthy.

More than ¼ of the world’s population is between the ages of 10-24yrs (WHO, 2006). Most (86%) of the world’s 1.7bn young people live in developing countries (UNICEF, 2003). In Africa, Adolescents make up 45% or more of the population (Gyepi-Garbrah, 1985). In Uganda, adolescents contribute a big proportion of the population 23.3% of 27 million, which is approximately 6.3m people and the majority of them (more than 50%) live in rural areas where they have limited access to reproductive health services (UBOS, 2001). In Iganga District, adolescent contribute up to 33% of the population of 716,311 people (UBOS, 2002) which is approximately 236,383 people.

The Reproductive Health Services

In the international conference on population and development (ICPD) of 1994, reproductive health was defined as a state of complete physical, mental and social well being and not merely absence of disease or infirmity in matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people should have a satisfying and safe sex life, have the capability to reproduce and the freedom to decide if and when and how often to do so.

Epidemiology of Utilisation of ASRH services

Low utilisation of ASRH services is a global problem (WHO, 2002). World wide, more than 20% of the total fertility is due to adolescent child bearing (WHO, 1999). The contribution of adolescent fertility to total fertility in Africa is highest in Central Africa (26%), intermediate in East Africa (23%) and the rest of Africa represents about 17% (Gyepi-Garbrah, 1985). The high contribution to fertility made by adolescents is believed
to occur as a result of failure to utilise ASRH services. African Medical and Research Foundation (AMREF) in their study in East Africa discovered that in Uganda, 40% of adolescents were not accessing and not utilising ASRH services leading to increased sexual activity of these youths, the commonness of premarital pregnancies which was leading to forced marriages or expulsion from schools and rising cases of HIV/AIDS (AMREF, 1997). It is believed that globally, 40 million people were living with HIV/AIDS in 2004 (UAC, 2005). The AIDS pandemic is most evident in the developing world which accounts for an estimated three quarters of all HIV infections (Byamugisha, 1998). It is estimated that the youth comprise of 50% of those infected with HIV/AIDS in Uganda (MOH/DISH, 2000). It is believed that non-utilisation of ASRH services in Iganga District is 60% (DDHS, 2005).

Package of ASRH services

A full package of ASRH services is one where youth friendly health services are provided to the youth and these must include among others: Family Planning, Antenatal Care, Natal Care, Post-Natal Care, Provision of Condoms, Health Education, Sex Education, VCT, PMTCT, Management of STIs, Abortion Services, Post Abortion Care, and Safe Deliveries. These should sum up to reduction in maternal and child mortality if utilised well especially by the adolescents.

The ASRH program in Uganda

Sexual and Reproductive Health and Rights is an important programme in the Uganda Health Sector Strategic Plan in view of the high maternal mortality ratio of 505 per 100,000 live births (MOH, 2001a). Effective implementation of the Reproductive Health Programme was a focus for the HSSP I (2001-2006) in which it was expected to have
contributed significantly to reduction of maternal, peri-natal, infant and under-five morbidity and mortality rates (MOH, 2006). ASRH services were among the interventions to be employed in the HSSP 1. One of the strategies in the HSSP was to establish adolescent friendly services at all HC IIs and above facilities (MOH, 2001a). It was believed this would improve access and utilisation of such services. According to the MOH annual report of 2005, a remarkable increase in funding to the health sector from 2001 to 2005 was observed which would attract utilisation of services including ASRH services (M.O.H, 2005).

In Uganda, family planning methods (traditional and modern), and the ASRHS have not been adequately utilised by adolescents despite government’s initiative to provide the services. This has led to poor reproductive health indicators. For example, the MMR has stagnated at 505 per 100,000 live births from 1990 up to 2005 (MOH, 2005). The use of contraceptives has improved minimally from 15% at the beginning of HSSPI in 2001 to 19% by the end of HSSPI in 2006 (MOH, 2006).

The ASRH program in Iganga District

In Iganga District, the situation is not any different but is even worse in some parameters because of non-utilisation of ASRH services. The average age at first marriage is 15 years for females and 17 years for males (AYA, 2001). The contraceptive prevalence rate is only 14% (DDHS, 2005). The VCT coverage is only 10% in the youth (UAC, 2004). The usage of condoms is 10% for male youths and 5% for female youths (UAC, 2004). Anecdotal evidence points to a high rate of abortions due to unwanted pregnancies in Iganga District (DDHS, 2005). The fertility rate in Iganga District is 7 children per woman and it is the highest in Uganda. The HIV prevalence is 7% in Iganga District compared to the national value of 6% (UAC, 2005). Adolescents especially females drop
out of school at tender ages despite the free Universal Primary Education (UPE) programme and the school drop out rate is 20% for boys and 45% for girls (DEO, 2005).

Health education on issues of ASRHS is provided in the school health programmes with the aim of reducing school drop outs due to teenage pregnancies and for increasing awareness of HIV/AIDS/STI (DEO, 2004). The PEARL and AYA programmes, the Family Planning Association of Uganda and Marie Stopes have tried to provide ASRH packages to adolescents. The problem is of failure to utilise these ASRH services. There has been need for Iganga District Health Team to identify and address the factors responsible for non-utilisation of ASRH services by the youth in the district.
CHAPTER TWO

Literature Review

Description of ASRH services

Adolescent Sexual Reproductive Health services are a package of health care given to adolescents and the package includes: FP, Information, maternal health care such as ANC, PNC, management of STI/HIV/AIDS including VCT, post abortion care, support and counseling for unwanted pregnancies amongst others (MOH, 2001b).

The Cairo International Conference on population and Development (ICPD) of 1994 outlined adolescent reproductive health and family planning as components of reproductive health (UNFPA, 1994).

In Uganda, the policy on Family planning is supportive. It states that “all sexually active males and females in need of contraception are eligible for family planning services provided they have been appropriately educated and counseled on the available family planning methods and attention has been paid to their current medical, obstetrical contraindications and personal preference. No consent is needed from a parent, guardian or spouse before a client can be given family planning services” (MOH, 2001b).

Ministry of Health and DISH in their work on best practices in adolescent sexual and reproductive health noted that most adolescent were articulate about their need for information on sexual and reproductive health and the services (MOH and DISH, 2000). They also established that the needs vary from place to place hence the necessity to identify the requirements for the adolescents in Iganga District through this study.
In a related study, Kiirya noted that contraceptive use among adolescents in the Muslim community was low and often occurred infrequently (Kiirya S, 1999). According to Kiirya, use of condoms, pills, was low because of the negative attitude towards their use and because they were inaccessible and un-affordable. Earlier in her study, Birungi had alluded to the low contraceptive use especially condoms among Christian adolescents because the religious leader’s knowledge and attitude towards adolescents’ reproductive health needs and contraceptive use in particular were low/negative (Birungi, 1998). Since then, a lot of effort has been directed towards religious leaders in the country especially in the advent of HIV/AIDS and therefore the need to assess the current position of the leaders in Iganga District lest they may still be misleading their flocks. The UDHS has established that there are several myths and misconceptions regarding early sexual activity, early marriage and sexually transmitted infections (UBOS, 2001). They have also established that adults are particularly wary about speaking to their children on sexual relations, sexuality and sexually transmitted infections including HIV/AIDS.

There is evidence that leaders’ and parents’ attitudes towards talking to adolescents about sexual and reproductive health issues are negative (MOH/DISH, 2000). Community leaders were reluctant to provide reproductive health services to adolescents in Mpgi District (Birungi, 1998). The above detail agrees with the package of ASRH services prescribed by the Cairo Conference of 1994 and would form a basis for determining what services are available and are being provided in Iganga District.

**Knowledge of adolescent reproductive health services**

In a study done in Bangladesh among rural and urban adolescents, it was found out that the knowledge of adolescents regarding contraceptive use increased with age and education (Quamrun, 2000). In Kabale, it was established that knowledge on
contraception among adolescents was as low as 50% and so was their contraceptive practices (Nalugwa, 1991). In use of ASRH services, the UDHS data puts knowledge on use of family planning among adolescents in Uganda at 92% for females and 96% for males (UBOS, 2001). In Soroti District, adolescents received ASRH messages from teachers and were knowledgeable especially when in schools (Ntozi, 2001). In kabale, Bazirake established that the majority of rural women received information from friends/relatives (54.4%) and health workers (36.7%) (Bazirake, 1987). A study done in Jinja District showed that adolescents who were receiving services from health units with adolescent friendly services were two and half times more knowledgeable than their counterparts who got services from health units without ASRH services (Mbonye, 2002). There is variation from place to place therefore the justification for a study to establish the status in Iganga District about the level of knowledge of the adolescents and the source of that knowledge.

Accessibility of adolescents to ASRH services

According to Uganda’s Ministry of Health plan of 2001-2006, adolescent friendly services were to be established in all health units to improve coverage and utilisation (MOH, 2001a). Whether this has been achieved in Iganga District and how well distributed the ASRH services are to people requires to be established.

There are many factors that have tampered with provision of ASRH services efforts in many countries (WHO, 2006). Among others, the following have been cited in the WHO (2004) report; Shortage or inadequate capacity of staff, insufficient funds, and weak political commitment. Ethiopia, Mozambique, Nigeria, South Africa, Thailand and Zimbabwe reported limited commitment to ASRH services from central and peripheral levels (WHO, 2006). Brazil, China and the Russian federation reported significant
progress of legislation to support the adolescent sexual reproductive services WHO, 2006). The bother with these challenges is that they do not mention the fact that even when legislations have been put in place, there is their deliberate rejection by political heads, misuse of resources, poor prioritisation, and therefore breeding disgust on the part of the community who then shun services. Hence the need for studies to establish the factors responsible for non-utilisation of ASRH services in Iganga district.

Many writers have identified distance to health facilities as a key determinant to utilization of services in developing countries (Gish, 1990). In his study in 1994, Katende found out that geographical access to services increased utilization rates in Uganda (Katende, 1994). The Uganda Aids Commission in one of their studies discovered that utilization of health services varied according to location and distance from health facilities with those proximal to the health facilities utilising VCT services more than those far away (UAC, 1998). However, Sengooba and Mcpake in their study concluded that geographical access and being near to health facilities does not necessarily translate into utilization of health services. These are already conflicting views and therefore the desire to establish the reasons why adolescents are shunning ASRH services in Iganga District.

Attitude of adolescents towards ASRH services

Utilisation of services depends on the degree of courtesy and humility of the HCWs and the time the consumers have to incur in the utilization of services. Where HCWs observe their ethical code of conduct, utilization is bound to be optimum (WHO, 1999). Where HCWs give respect for persons, provide confidentiality and the right to personal information, provide autonomy on choice of therapy, then utilization has been observed to improve (WHO, 2000). Utilisation of services is influenced by the attitude of employees
towards their work and their clients (Gish, 1990). The above cited factors play a role in attitudes of clients towards utilisation of services.

The quality of services that is provided influences utilization. By quality is meant that there is little waiting time, there is confidentiality; there is good doctor-patient relationship with good attitude of HCWs and drugs are available (MOH, 2001c). Clients should spend not more than 30 minutes in a service (M.O.H, 2001c). In their study in 2004, Sengooba and Mcpake found out that there were inadequate service providers in Uganda especially in rural health units (Sengooba and Mcpake, 2004). The ministry of Health of Uganda also recognises that there are significant staffing gaps in the country in terms of quality and quantity (MOH, 2004a). This statement is too much of generalisation which must be truly established for Iganga District so that if it is the constraining factor for utilisation of ASRH services, then it is addressed.

Studies and reports of the Ministry of Health have shown that availability of drugs in health units encourages consumers to utilise services. In 2003, an estimated 60% of all health facilities had stock-outs of essential supplies, with HC IIIs and HC IIIs being affected mostly (MOH, 2004a). In the same year, the method of supplying reproductive health items was changed from push to pull but little effort was paid in training the HCWs (DDHS, 2004). It is therefore important to establish whether the HCWs in Iganga are not ordering for ASRH supplies to the detriment of the adolescents in the district or whether the staff lack skills.

Blanchard Horan in his study established that long queues made health care very costly for women who had to choose between attending to their informal business provided they were not too ill to work; and going to seek health promotion and preventive health care (Blanchard Horan, 2003). Bitran and McInnes in their study in 1993 found that the time
spent by a client during the consumption of a service influences utilization (Bitran and McInnes, 1993). Whether long time spent at service points is the cause for non-utilisation has not been established in Iganga District therefore the justification for this study.

Socio-economic and demographic factors

This refers to income of the community, poverty levels, gender issues, education levels, among others. The World Health Organisation found that individual and family income determines the degree of utilization of health services (WHO, 2003). This is exemplified by the difference in utilization between developed countries where it is better due to better economy than developing countries where it is un-satisfactory.

Poverty, homelessness, joblessness, low-income, poor sanitation and various social breakdowns including the family unit are significant contributors to poor utilization of reproductive health services in refuge camps (UNHCR, 1999).

Meininger observed that women tend to use health services more than men (Meininger, 1986). It is important to establish what the position is for adolescent boys and girls in Iganga District.

Educated people are more aware of the existence of health services and are more likely to utilise the care provided (Bitran and McInnes, 1993). This is the expectation especially in the advent of UPE in Uganda where it is believed that the literacy levels have gone up. It would be interesting to find out why the ASRH utilisation is not improving in Iganga District in view of UPE programme consequently leading to poor reproductive health indicators in the district.
Early sexual activity is common in adolescents but its magnitude varies from place to place (Ntozi, 2001). In a study done in Nigeria, it was found that 26% of 14 years olds were sexually experienced (Unche et al, 1997). In Uganda, early sexual activity is common in most communities. By 15 years, 17% of adolescent girls have already had sex (UBOS, 2001). In Kabale and Hoima Districts for example, 28% of girls are sexually active by 15 years of age (Nalugwa, 1991). It is important to find the ages applicable for Iganga District. In a study done in Rakai District, it was established that out-of school adolescents were less likely to talk about sex with friends and more likely to have sex than the in school adolescents because the former were less knowledgeable about causes of STI/HIV/AIDS and pregnancy (Atuyambe, 1998). In Hoima District, the adolescents are encouraged to marry as soon as they start having periods even though they are believed to have inadequate knowledge in ASRH services including pregnancy and complications Kirya, 2000). Bohmer and Kirumira in their study revealed that sexual activity at very young age (10 to 14 years) is encouraged by factors like peer pressure, bad examples set by parents and older siblings, media and financial pressures (Bohmer and Kirumira, 1997).

The writers quoted in this review have provided information on utilization of ASRH services and the associated problems in different parts of the world. The available literature is relatively informative because it is out there to provide a general view about the study objectives. However, given that numerous areas as brought out in the literature discussed above suggest looming inadequacies, current responses to the objectives are lacking. Therefore, the researcher felt that a fresh investigation as a basis for filling the existent literature gaps was timely and necessary for Iganga District.
CHAPTER THREE

Problem statement:

Low utilisation of ASRH services is a big public health problem in Iganga District. According to HMIS records, 60% of the adolescents in Iganga District are not benefiting from ASRH services compared to the neighbouring Mayuge District at 40% and against the national target level of 80% utilisation. This has left the adolescents unguided and as a result adolescents have frequently got involved in avoidable sexual encounters with regrettable consequences such as un-wanted pregnancies, dropping out of school, complicated abortions, as well as STIs/HIV/AIDS.

A review of HMIS records in Iganga District indicates that adolescents as young as 14 years are already pregnant while 10% and 24% of the pregnant adolescents are already married by the ages 14 years and 15 years respectively (DDHS, 2005) in spite of laws prohibiting such marriages below the age of 18 years in Uganda.

ASRH services are being provided free of charge in public health units and at minimal costs in NGO (FPAU and Marie-stopies) but despite these provisions the level of utilisation is as low as 40% in Iganga District. The DHT attributes the cause of low utilisation of ASRH services as possibly due to long distances to the services delivery points. The DHT initiated friendly ASRH services in all health units and increased mobilisation of adolescents but this has not improved utilisation of the ASRH services. The specific reasons for the low utilization of ASRH services are not known inspite of all efforts by the DHT to improve utilisation. This study therefore set out to establish the factors responsible for low utilisation of ASRH services in Iganga District.
Justification

Utilization of ASRH services by adolescents in Iganga District is low and the reasons are not clearly known. Low utilisation has led to big burden of ASRH problems. It is important to understand the factors influencing utilization of ASRH services so as to address them and consequently the ASRH problems in the district. Attempts to increase advocacy for use of ASRH services among adolescents has been hampered by lack of baseline and reliable information. There has been need for evidence based information that will support the DHT and its partners to improve provision of ASRH services and increase effective use of these services. This study has helped identify the important factors affecting utilization of ASRH services and this information will go a long way to help the DHT design appropriate interventions to improve utilization of ASRH services. This will foster utilization of such services by adolescents and will be one of the ways the district health system will contribute to socio-economic development goals of the district and country. In that sense therefore, this study is most timely.
Conceptual framework

Figure 1: conceptual framework

Communication and teaching media e.g.
- Radio
- Lack of posters
- Lack of health educators
- Newspapers
- Magazines
- Schools
- Parents talks

Knowledge
- Level of education
- Vulnerability (age)
- Knowledge of importance of seeking for ASRH services
- Source of the knowledge
- Knowledge of availability of services

Accessibility
- Quality of services
- Rude health workers
- Charges at the service points
- Un-official fees
- Waiting time
- Staffing of health units
- Distance to service points
Other costs

Attitudes of adolescents
- Perceptions of the ASRH services

Failure to use ASRH services

- Socio-economic and other community issues
  - User fees and other costs
  - Transport costs
  - Roads and vehicles
  - Alternative care like spiritual
  - Social stability
  - Peer influence
  - Parental and religious influence.
  - Community involvement in management of services
  - Poverty

High abortion ratios, high HIV/AIDS prevalence, high adolescent pregnancy and marriages, high school drop out rate, high maternal and child death ratios, and poor social economic development
Conceptual framework narrative

The failure to use ASRH services in an area is as a result of factors which are either lack of knowledge by the community, poor attitude towards services, and bad practices by the community.

Demographic factors: Sex, age, literacy levels, marital status, and religious affiliations may play big roles in the utilisation of health services. The young people may fear to use ASRH services in presence of adults.

Knowledge: Knowledge of existence of services by place, by type, the importance of seeking for the services and the source of the knowledge may influence utilisation.

Attitude: The level of utilising the services may be determined by the attitude of the clients towards the package provided.

Accessibility factors: Quality of services provided, the way health care workers handle clients, availability of qualified providers, waiting time before one is served, distance to services points, costs involved may influence utilisation of ASRH services.

These factors interrelate and compound one another to lead to low utilisation of the ASRH services.
Hypothesis

- Lack of knowledge by adolescents about ASRH services, poor attitude to the services and poor accessibility are responsible for the high level of non-utilisation of these services in Iganga District.

Research questions

1. Do adolescents know the available ASRH services package and where the ASRH services are located?

2. What is the attitude of adolescents towards the available ASRH services in Iganga District?

3. How do adolescents access ASRH services in Iganga District?
CHAPTER FOUR

Objectives

General Objective
To establish factors affecting utilisation of ASRH services among adolescents in Iganga District so as to generate information that will help the DHT to design appropriate strategies to improve utilisation of ASRH services in Iganga District.

Specific Objectives:
- To assess the level of awareness of the ASRH services among adolescents and relate it with the utilization of these services in Iganga District.
- To assess the attitude of adolescents towards available ASRH services in Iganga District and compare utilization of these services among differing attitudes.
- To identify accessibility factors of the adolescents to the available ASRH services and find the discrepancies between the different accessibility characteristics in Iganga District.
CHAPTER FIVE

Methodology:

Study Area:

The study was conducted in Iganga district specifically in 24 sampled level one local councils. The district is in the eastern part of Uganda north of L. Victoria, bordered by the districts of Kamuli and Palisa in the North, Bugiri in the East, Mayuge and Jinja in the West. It has a population of 716,311 (2002 census) and 33% of these (236,383) are adolescents. It has an area of 1346 sq. kilometers (District environment Officer, 1999). The district is among the most underdeveloped and poor in Uganda (MOFPED, 2003). Most of the people live in rural areas and practice subsistence farming mainly growing maize, cassava, potatoes and rice as food crops (District Environment Officer, 1999). There is some small scale retail trade in trading centres of the district. Roads, communications, education and health services are still poor. Most local houses are of mud walls and iron sheets on the roofs (District Environment Officer, 1999).

The district is divided into 3 counties and 4 HSDs, 19 sub counties plus 2 town councils, 113 parishes and 718 LC one villages. It has a total of 79 health units of which 1 is the district hospital, 3 are of health centre IV level, 18 health centre III level, 20 are (NGOs) and the remaining 37 are government level II health centres. ASRH services are only provided in the hospital, health centre IV and health centre III units (22/79). The distribution of these health units is not even in the district. There are a total of 368 trained personnel, with 10 doctors, 140 nurses, 150 midwives, and 60 Para-medicals. The doctor to population ratio is therefore 1 to 71,631 while the nurse to population ration is 1 to 5117 and midwife to population ratio is 1 to 4,775 (DDHS, 2005). The district has 8
ambulances, 4 radio communication bases, a number of walkie-talkies availed to Traditional Birth attendants to assist in providing reproductive health services.

Study design

It was a cross sectional study employing both qualitative and quantitative data collection methods.

Study population

The study population consisted of adolescents in Iganga District where a sample was identified for the study.

Study Unit:

Quantitative

The study units were the adolescents who were 10-19 years of age.

Qualitative

The respondents were the local youth leaders, religious leaders and managers of health services in the district.

Inclusion criteria:

The study included adolescents aged 10-19 years who had been residents in Iganga District for at least 2 years.

Exclusion criteria: 
Adolescents who were not in a sound state of mind, or who were unable to communicate effectively were excluded.

Sample size:

Quantitative

The sample size for the quantitative interview was determined using the formula developed by (Keish and leisle 1965)

\[ n = \frac{z^2 pq}{d^2} \]

Where \( Z = 1.96 \) (Critical value of the standard normal distribution corresponding to error rate of \( \alpha/2 \) (95% confidence interval), \( P \) represents the prevalence proportion of non-use of ASRH services, \( q \) represents \( 1 - p \), \( d \) represents the error allowed and \( n \) represents the sample size. Since \( P \) is 60% (DDHS, 2005) which equals 0.6, \( q \) is 1-0.6=0.4.

Substituting in the formula \( 1.96 * 1.96*0.6*0.4 /0.05*0.05 \) this gave 369 respondents.

Design Effect Adjustment

Since the study was based on cluster sampling, the sample size was multiplied by a design effect (D) to accommodate the effect of cluster variability. The design effect is generally assumed to be 2 for surveys using cluster sampling methodology (http://www.ifad, 2006).

Sample size for this study then =369 x 2 =738 households. One randomly selected adolescent was interviewed per household.

Qualitative sample
• 3 political leaders who were secretaries for Health at the district and the two sub-county councils.

• 4 youth council members.

• District Director of Health Services

• 4 Heads of Health Sub-Districts

• Four religious leaders from the 4 main religious groups

• The District Supervisor of reproductive health services.

The total here was 17 people.

**FGD sample**

The FGD participants were drawn from the adolescents in the LC I Villages and there were ten adolescents per discussion. The Local Council Leaders and Adolescent Peer leaders helped to mobilise them. Four FGDs were held; two in the urban LC I Villages and two in the rural villages.

**Sampling procedure:**

**Qualitative**

For key informants, purposive sampling was used to select political leaders, youth leaders and the managers of the District Health Services.

**Quantitative**

For the 738 community respondents, cluster sampling technique was employed. The study was done in twenty four clusters (14 urban and 10 rural) that were chosen randomly. Thirty households were examined per cluster and one adolescent was
interviewed per household. When a selected household had more than one eligible candidate, the study participant was randomly selected.

Study variables:

Dependent variable

I. Utilisation of ASRH services as a categorical variable with dichotomous responses of using or not using the services.

Independent variables:

Demographic factors:

1. Age
2. Tribe
3. Religion
4. Education level of adolescent
5. Sex
6. Marital status
7. Occupation of respondent
8. Occupation of head of household
9. Location of LC I Village-Rural/Urban
10. Parental influence

Access to ASRH services by adolescents:

1. Formal costs: Costs where receipts were issued to clients
2. Informal costs of services: Costs where no receipts were issued to clients
3. Belief that there were any payments to be made
4. Distance to the services

**Adolescent knowledge attributes**

1. Knowledge of types of ASRH services which were available
2. Source of knowledge
3. Knowledge of location of services

**Adolescent attitude attributes**

1. Beliefs on usefulness of services
2. Perceived attitude of adolescents towards staff providers

**Data collection techniques and tools:**

The data collection methods were both qualitative and quantitative.

Qualitative data was collected in relation to ASRH care practices and perception of ASRH services in the community. This was by key informant interviews using the key informant interview guides administered to Peer Educators, the District Leaders, youth representatives in the councils by the principal investigator and FGDs with the adolescents. The principal investigator personally conducted the interviews with the leaders and FGDs to elicit in-depth elaborations on the subject of study.

Quantitative data was collected in relation to demographic characteristics, social-economic factors, accessibility and attitude of respondents towards ASRH services. A semi-structured questionnaire was administered by the Research Assistants.
Quality control:

1. Training of Research assistants

The principal researcher identified and recruited research assistants who were at the level of senior six, fluent in English and Lusoga language, and trained them for three days in data collection techniques, rapport, accurate recording of data and on how to use the various tools.

2. Pre-testing of tools

The tools were pre-tested on adolescents in a LC I Villages outside those randomly selected for the study and then any necessary changes in questionnaires, key informant guides, and data collection procedures were made.

3. Translation of tools

The tools were translated into the local language (Lusoga) to ensure quality and uniformity of questions asked by all RAs.

Data management

Preliminary editing of the quantitative data was done on all the spreadsheets on daily basis. Thorough checking of missing data was done in the presence of the research assistants. The research assistants promptly corrected any errors where identified.

Data was pre-coded and entered by the principal researcher into pre-prepared computer data-base using Epi Info 2002. Data cleaning was done after running frequencies of all variables. Qualitative data was managed manually using master sheet.
Quantitative data was analysed by computer using Epi-Info 2002 and is presented in the report as narrative text form, graphs, tables and pie charts.

**Ethical considerations:**

Permission was sought from the Makerere University Institute of Public Health Higher Degrees Research and Ethics Committee, from the Chief Administrative Officer and the District Director of Health Services of Iganga District.

Permission was sought from the Uganda National Council for Science and Technology (UNCST).

For the adolescents under age of consent of 18 years, informed consent was obtained from the parents or guardians prior to interviewing them.

Written consent was obtained from all respondents who were requested to sign the consent form after explaining the objectives of the study to them and also stressing to them that no victimization would be meted on those that chose not to participate.

**Dissemination of results:**

The findings of this study will be disseminated to the School of Postgraduate Studies and the Makerere University Institute of Public Health of in form of a thesis for the award of a Master of Public Health Degree.

The findings will also be provided to Iganga District Administration Management, the community, the Iganga District Health Team, Ministry of Health-National Reproductive Health Programme, and articles will be published in journals.
CHAPTER SIX

Results

Socio-demographics

The total number of respondents was 738. All respondents approached accepted to be interviewed. The respondents were in age range 10-19 years, with a mean age of 16 years (SD=2.4168). A majority of respondents were: aged 13-17 years 427/738 (57.9%), female 414/738 (56.1%), Basoga 572/738 (77.5%) and educated to at least primary level 541/738 (73.3%). Most of the respondents were not married 544/738 (73.7%), were still in school 394/738 (53.4%), had both parents alive 506/738 (68.6%) and lived in a male headed household 585/738 (79.3%).

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<th>Frequency</th>
<th>Percentage</th>
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<td>Percentage</td>
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</tr>
<tr>
<td>Father</td>
<td>54</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
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<td>100</td>
</tr>
<tr>
<td>Sex of HH</td>
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<td></td>
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<td>Male</td>
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<td>Brother</td>
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<td><strong>Total</strong></td>
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</table>
Level of Awareness of ASRH among adolescents

Knowledge about ASRH services package

The majority of respondents 401/738 (54%) did not know about the ASRH services package. Knowing was defined as naming at least three items in the ASRH package. Respondents were first asked to spontaneously name items in the ASRH services package. When a respondent failed to name anything spontaneously, the interviewer gave the items and asked the respondent if he/she recognised any. For each item recognized, respondents were asked whether they had ever used it. Information was collected for 8 items in the package-Family planning, STD treatment, VCT for HIV/AIDS, Child Care, ANC, Abortion services, Post Abortion Care, and Condom use. Provision was made for respondents to indicate whether they knew any other item besides the above. A respondent who failed to recognize at least 3 items in the package was deemed to have no knowledge of ASRH services. The criterion for choosing 3 items was adopted from Kiiry S in his book “Sexual and Reproductive Knowledge, Attitude and Practice among Muslims (Kiiry S, 2000).
Figure 1: Knowledge of ASRH services (N=738)

Don't Know, (401), 54%  
Know, (337), 46%

Source of information

Only 140/337 (41.5%) respondents got the knowledge of ASRH from health workers which would be regarded as the best source for quality messages.

Figure 2: Source of information (n=337)

Graph of frequency of source of knowledge

Others included Mass Media, Witch Doctors and Traditional Healers, Grand-Parents and Religious Leaders.
Figure 3: Knowledge of location of facilities offering ASRH services

The majority of respondents 434/738 (59%) did not know the location of ASRH services.

Attitude of adolescents towards the ASRH services

Perceived usefulness of the ASRH services

Regarding the respondent’s views on ASRH services, 419/738 (57%) of the respondents felt that the ASRH services were useful as shown in figure 4 below.
Perception toward the providers of ASRH

The majority of respondents 473/738 (64.1%) as shown in figure 5 below did not know what happens in the sites providing ASRH services. Only 195/738 (26%) thought the providers were friendly or very friendly.
Figure 5: Adolescents’ perception of the providers of ASRH (N=738)

Accessibility factors of adolescents to the ASRH services in Iganga

Geographical accessibility to the ASRH services

Thirty five percent of the respondents (260/738) said that they lived more than 5KM away from an ASRH service points as shown in figure 6 below.
Factors influencing utilisation of the ASRH services in Iganga

Out of 738 respondents, 28% (210/738) had utilised ASRH services. To identify factors that influenced utilisation of the ASRH services, comparison of the distribution of socio-demographic characteristics, knowledge, attitude/perception of services and accessibility to ASRH services among those who had used and those who had never used the ASRH services was done using bivariate analysis.

Socio-demographic characteristics

At bivariate analysis, the significant socio-demographic factors for utilisation after comparing those who utilized and those who were not utilising ASRH services are as shown in table 2 below: older adolescents (≥15 years) were more likely to use ASRH services than their younger counterparts (≤14 years) (O R 4.94 CI 2.98-8.19), females were more likely to use than males (O R 1.75 CI 1.24-2.47), non-basoga used more than the basoga (O R 1.77 CI 1.21-2.59), adolescents who completed at least primary seven used ASRH services more than those who had not completed primary seven (OR 1.66 CI 1.08-1.96), married were more likely to use ASRH services than the un-married (O R
1.54 CI 1.22-1.94), adolescents from households headed by civil servants were more likely to use the ASRH services than those of other occupations (OR 1.59 CI 1.24-2.04), adolescents from urban villages were more likely to use ASRH services than their counterparts from rural villages (OR 10.8 CI 6.85-17.29), and the respondents who had ever had sex used ASRH services more than those who had never engaged themselves into sexual activities (OR 6.53 CI 3.31-13.20). Father as head of household was inhibiting utilisation of the ASRH services more than other heads of households (OR 0.71 CI 0.51-0.99). The result in relation to sexual activeness is in line with the view of one key informant who said that “Since these are ASRH services where (S) stands for sexual services, they should be applicable to individuals who have started sex activity and such issues should never be introduced to the innocent young children who have not yet began sex life” (KI respondent from Bugonoka LC 1 Village).
Table 2 Association of utilisation of ASRH services with socio-demographic characteristics

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<tr>
<th>Variable</th>
<th>Used ASRH services n (%)</th>
<th>Did not use ASRH services n (%)</th>
<th>Total</th>
<th>Odds ratio, (95%CI) &amp; P-value</th>
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<td><strong>Age (years)</strong></td>
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<tr>
<td>15-19</td>
<td>191 (35.0)</td>
<td>354 (65.0)</td>
<td>545</td>
<td>4.94* (2.98-8.19)</td>
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<td>10-14</td>
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<td><strong>Sex</strong></td>
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<tr>
<td>Female</td>
<td>138 (33.3)</td>
<td>276 (66.7)</td>
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<td>252 (77.8)</td>
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<td><strong>Tribe</strong></td>
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<tr>
<td>Others ¥</td>
<td>63 (11)</td>
<td>103 (89)</td>
<td>572</td>
<td>1.77 * (1.21-2.59)</td>
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<tr>
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<td>84 (24.7)</td>
<td>256 (75.3)</td>
<td>340</td>
<td>0.71* (0.51-0.99)</td>
</tr>
<tr>
<td>Others</td>
<td>126 (31.7)</td>
<td>272 (68.3)</td>
<td>398</td>
<td>0.04</td>
</tr>
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<td><strong>Occupation of respond.</strong></td>
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<tr>
<td>Yes</td>
<td>100 (25.4)</td>
<td>294 (74.6)</td>
<td>394</td>
<td>0.72 (0.52-1.01)</td>
</tr>
<tr>
<td>No</td>
<td>110 (32.9)</td>
<td>234 (67.1)</td>
<td>344</td>
<td>0.05</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>93 (29.8)</td>
<td>219 (70.2)</td>
<td>312</td>
<td>1.12 (0.80-1.57)</td>
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<td>309 (72.5)</td>
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<tr>
<td><strong>Gender of HH</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>170 (29.1)</td>
<td>415 (70.9)</td>
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<td>1.16 (0.76-1.77)</td>
</tr>
<tr>
<td>Female</td>
<td>40 (26.1)</td>
<td>113 (73.9)</td>
<td>153</td>
<td>0.5</td>
</tr>
</tbody>
</table>

¥ = Ganda, Samya, Teso, Gisu. ¥ = Teacher, Trader, Casual labour. t = No, Decline to answer.
Knowledge characteristics

As shown in table 3 below, the adolescents who knew the ASRH services package were more likely to utilize these services than those who did not know the package OR 23.11 95% CI=13.84-38.91. Among those who got informed of ASRH services from other sources other than from health workers, 113/193 (58.5%) were not utilizing the ASRH services. This is in line with FGD results where one respondent mentioned “Some times, the adolescents are misled by their friends, their aunts, witch doctors and parents. They end up fearing to use the services” (FGD participant from Bugonoka LC I Village). Of the adolescents who did not know anything about ASRH, 380/401 (94.8%) were not utilizing the ASRH services and this finding agrees with qualitative results where one respondent from Kirowa-Ward LC I Village in Busembatia Town Council remarked: “How can one use what he/she does not know? We can not venture into the un-known like we are angels or experimenters who always dangerously experiment on their lives”.

| Table 3 Association of utilisation of ASRH services with knowledge characteristics |
|-------------------------------|-------------------------------|-------------------------------|-------------------------------|----------------------|
| Variable                     | Used services n (%)           | ASRH Did not use services n (%) | Total (n)                    | Odds ratio, 95% CI for OR & P-value |
| Knows ASRH package            |                               |                               |                              |                                    |
| Yes                          | 189 (56.1)                    | 148 (43.9)                     | 337                          | 23.11* (13.84-38.91)              |
| No                           | 21 (5.2)                      | 380 (94.8)                     | 401                          | 0.00001                           |
| Knows location                |                               |                               |                              |                                    |
| Yes                          | 196 (45.2)                    | 238 (54.8)                     | 434                          | 17.06* (9.40-31.49)              |
| No                           | 14 (4.6)                      | 290 (95.4)                     | 304                          | 0.00001                           |
| Source of information         |                               |                               |                              |                                    |
| H/W                          | 130 (90.3)                    | 14 (9.7)                       | 144                          | 13.12* (6.80-25.70)              |
| Other T                      | 80 (41.5)                     | 113 (58.5)                     | 193                          | 0.00001                           |

T = Teacher, Parent, Aunt, Friend, Siblings.
H/W = Health Worker
Accessibility characteristics

As shown in table 4 below, belief that there were payments for the services was preventing utilisation of ASRH services than those who believed that there were no payments to be made (O R 0.04 CI 0.01-0.12). Belief that the adolescents would be issued with receipts after paying was favouring utilisation of ASRH services more than the belief that receipts were not given/illegal payments (O R 26.77 CI 8.97-83.91). The adolescents who believed that there was short time of waiting before seeing a provider were more likely to use the ASRH services than those who thought there was long time of waiting before seeing a provider OR 2.74 95% CI=1.31-5.87. Geographical accessibility was not a significant factor for utilisation of ASRH services P-value was 0.4.

Table 4: Association of utilisation of ASRH services with what adolescents believed about the accessibility characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Used services (n(%))</th>
<th>ASRH</th>
<th>Did not use services (n(%))</th>
<th>ASRH</th>
<th>Total (n)</th>
<th>Odds (95% CI) &amp; P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of payments in units</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>65 (56.5)</td>
<td>50 (43.5)</td>
<td>115</td>
<td>0.04* (0.01-0.12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>145 (96.7)</td>
<td>5 (3.3)</td>
<td>150</td>
<td>0.000000000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Given receipt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>58 (81.7)</td>
<td>13 (18.3)</td>
<td>71</td>
<td>26.77* (8.97-83.91)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>7 (14.3)</td>
<td>42 (85.7)</td>
<td>49</td>
<td>0.000000000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30 minutes</td>
<td>126 (92.0)</td>
<td>11 (8.0)</td>
<td>137</td>
<td>2.74* (1.31-5.87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;30 minutes</td>
<td>84 (65.6)</td>
<td>44 (34.4)</td>
<td>128</td>
<td>0.000000000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographical Accessibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 5 KM</td>
<td>96 (39.0)</td>
<td>150 (61.0)</td>
<td>246</td>
<td>0.86 (0.59-1.26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 5 KM</td>
<td>104 (42.6)</td>
<td>140 (57.4)</td>
<td>244</td>
<td>0.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attitude characteristics

The majority of users 169/204 (82.8%) believed that the providers were friendly but some users 41/61 (67.2%) believed that the providers were rude as shown in table 5 below.

Adolescents who believed that providers were friendly or very friendly were more likely
to use ASRH services than the adolescents who believed that providers were rude O.R. 2.36 CI 1.17-4.72. This agrees with FGD results thus “I went to a health unit; the provider was very friendly and receptive to me. I directed my friend who had a similar problem as mine to go to this provider and get the problem sorted out” (FGD participant-Kirowa-Ward LC I Village in Busembatia Town Council). The adolescents who believed that the ASRH services were useful were more likely to use the services than those who thought the ASRH services were useless O.R 48.33 95% CI 21.51-114.38. This finding agrees with FGD results thus “I use those services because they are very useful for my well being. Otherwise I would not waste my time on useless issues”. (FGD participant-Minani LC I Village in Namalemba Sub-County).

Table 5 Association of utilisation of ASRH services with perceived attitude characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Used ASRH services n (%)</th>
<th>Did not use ASRH services n (%)</th>
<th>Total n</th>
<th>Odds ratio, (95%CI) for OR &amp; P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude towards ASRH services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services useful</td>
<td>203 (50.6)</td>
<td>198 (49.4)</td>
<td>401</td>
<td>48.33* (21.51-114.38)</td>
</tr>
<tr>
<td>Services useless</td>
<td>7 (2.1)</td>
<td>330 (97.9)</td>
<td>337</td>
<td>0.0000001</td>
</tr>
<tr>
<td>Attitude to providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendly</td>
<td>169 (82.8)</td>
<td>35 (17.2)</td>
<td>204</td>
<td>2.36* (1.17-4.72)</td>
</tr>
<tr>
<td>Rude</td>
<td>41 (67.2)</td>
<td>20 (32.8)</td>
<td>61</td>
<td>0.008</td>
</tr>
</tbody>
</table>

Stratified analysis

In all the relationships during stratified analysis as displayed in table 6 below, Mantel Hansel Odds ratios have been used. The crude odds ratios are those as displayed in table 5. Interaction is exhibited in the relationship between knowledge of ASRH services and utilisation of the ASRH services when stratified by age, sex, tribe, education level, marital status and whether the adolescent had ever engaged in sexual activities or not.
Occupation of head of household confounded the relationship between utilisation of ASRH services and knowledge about the ASRH services.
<table>
<thead>
<tr>
<th>Potential confounders, Crude O.R. for Knowledge = 23.11 (13.84-38.91)</th>
<th>Main exposure (Knowledge of ASRH)</th>
<th>Utilised ASRH</th>
<th>OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
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<td>171</td>
<td>97</td>
</tr>
<tr>
<td></td>
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<td>10-14</td>
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<td><strong>Total</strong></td>
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<td><strong>OR</strong></td>
<td><strong>OR</strong></td>
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</tr>
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<td><strong>95% CI</strong></td>
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</tr>
<tr>
<td></td>
<td><strong>Female</strong></td>
<td><strong>Female</strong></td>
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</tr>
<tr>
<td>Sex</td>
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<td>Yes</td>
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<td>No</td>
<td>10</td>
<td>96</td>
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<td><strong>Total</strong></td>
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<td>168</td>
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<td><strong>Male</strong></td>
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<tr>
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<td>Yes</td>
<td>61</td>
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<td>No</td>
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<td>35</td>
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<tr>
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<td>113</td>
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<td><strong>Education</strong></td>
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<tr>
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<tr>
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<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
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<td><strong>Total</strong></td>
<td>71</td>
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<td><strong>Occupation of HH</strong></td>
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</tr>
<tr>
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<td>No</td>
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<td><strong>Total</strong></td>
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<td>477</td>
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<td><strong>Location of LC I Village</strong></td>
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<td>125</td>
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<td><strong>Total</strong></td>
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<td>8</td>
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<td><strong>Total</strong></td>
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<td>271</td>
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<td><strong>Ever had Sex</strong></td>
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<td>Yes</td>
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<td><strong>Total</strong></td>
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</tr>
<tr>
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<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
<td>11</td>
<td>222</td>
</tr>
</tbody>
</table>

ψ Combined Odds ratios
**Multivariate analysis**

Backward stepwise conditional log likelihood ratio was used to control for confounding.

All the risk factors identified during bivariate analysis, all plausible factors and potential confounders for utilisation of ASRH services were entered into a model.

\[
\text{Logit } P(Y) = \alpha + \beta_1 \text{ (Respondent’s age)} \\
+ \beta_2 \text{ (Respondent’s tribe)} \\
+ \beta_3 \text{ (Respondent’s Educational level)} \\
+ \beta_4 \text{ (Respondent’s marital status)} \\
+ \beta_5 \text{ (Occupation of head of household)} \\
+ \beta_6 \text{ (Parental guidance-“parents still living”)} \\
+ \beta_7 \text{ (Ever had sex)} \\
+ \beta_8 \text{ (Respondent’s Knowledge of ASRH services)} \\
+ \beta_9 \text{ (Respondent’s perception of usefulness of ASRH services)} \\
+ \beta_{10} \text{ (Payments for services)} \\
+ \beta_{11} \text{ (Issuance of receipts for payment made)} \\
+ \beta_{12} \text{ (Respondent’s attitudes towards providers)} \\
+ \beta_{13} \text{ (Waiting time at service point)}
\]

Where

Logit \( P(Y) \) is the probability of utilisation of ASRH services that is explained by the variables in the model.

\( \alpha \) is the Y intercept

\( \beta \) is the coefficient estimate of the exposure or potential confounder variables in the model.

Table 7 below displays results of the best fitting model. After a log likelihood ratio test, all the 738 respondents were included in the analysis. Overall, 91.1% of the dependent
variable was correctly predicted by the variables in the model with a specificity of 90.5% and sensitivity of 92.4%. The -2log-likelihood was 107.36, and the Nagelkerke R square was 76.5%. The Hosmer and Lemeshow test revealed a non significant chi-square (chi-square $\chi^2= 1.504$; df=6; p-value = 0.96).

After adjusting for confounding and testing for effect modification, the variables that remained significantly associated with utilisation of ASRH services included: Location of LC I Village -urban (OR= 7.00, 95%CI:2.04 – 24.04), Respondent ever engaged in sex activity (OR=28.82, 95%CI: 7.13 - 116.60), Knowledge of ASRH services (OR= 11.56, 95% CI: 3.54 – 37.76), Perception of providers as friendly (OR = 4.51, 95% CI 1.29 - 7.61), while belief in existence of payment for the ASRH services prevented utilisation (OR=0.21, 95%CI 0.10 – 0.62).

The other variables: older age of ≥15years, (OR=1.69, 95% CI: 0.58 - 4.94), Getting receipt for payments made (OR=1.18, 95% CI: 0.26 - 5.32), shorter waiting time before seeing a provider (OR=4.83, 95%CI: 0.93-12.08), Respondent’s perception of the ASRH services as useful OR= 1.67, 95%CI: 0.35 -6.22, respondent having completed at least primary level of education level (OR = 1.02, 95% CI 0.11 - 2.02), female respondents (OR=0.88 95%CI 0.29 - 2.66), and non-basoga, (OR=0.98, 95% CI: 0.30 - 3.22) were not statistically significant but confounders and therefore were dropped at different steps in the regression.
<table>
<thead>
<tr>
<th>Variable</th>
<th>coefficient</th>
<th>Adjusted OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent's Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19 years</td>
<td>0.52</td>
<td>1.69</td>
<td>0.58 - 4.94</td>
</tr>
<tr>
<td>10-14 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of LC I Village</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>1.95</td>
<td>7.00</td>
<td>2.04 - 24.04</td>
</tr>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever had sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3.36</td>
<td>28.82</td>
<td>7.13 - 116.60</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of ASRH</td>
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</tr>
<tr>
<td>Yes</td>
<td>2.45</td>
<td>11.56</td>
<td>3.54 - 37.76</td>
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</tr>
<tr>
<td>Perception of ASRHs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Useful</td>
<td>3.31</td>
<td>1.67</td>
<td>0.35 - 6.22</td>
</tr>
<tr>
<td>Useless</td>
<td></td>
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<tr>
<td>Payment for services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.58</td>
<td>0.21</td>
<td>0.10 - 0.62</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>Getting receipt</td>
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<tr>
<td>Yes</td>
<td>0.17</td>
<td>1.18</td>
<td>0.26 - 5.32</td>
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<tr>
<td>Perception of providers</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Friendly</td>
<td>2.71</td>
<td>4.51</td>
<td>1.29 - 7.61</td>
</tr>
<tr>
<td>Rude</td>
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<tr>
<td>Waiting time</td>
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<tr>
<td>&lt;30 minutes</td>
<td>0.57</td>
<td>4.83</td>
<td>0.93 - 12.08</td>
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<tr>
<td>&gt;30 minutes</td>
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<tr>
<td>Yes</td>
<td>-2.24</td>
<td>1.02</td>
<td>0.11 - 2.02</td>
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<td></td>
<td></td>
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<tr>
<td>Sex</td>
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<tr>
<td>Male</td>
<td>-1.26</td>
<td>0.88</td>
<td>0.29 - 2.66</td>
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<td></td>
</tr>
<tr>
<td>Tribe</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Others</td>
<td>-0.02</td>
<td>0.98</td>
<td>0.30 - 3.22</td>
</tr>
<tr>
<td>Soga</td>
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</tbody>
</table>

* Statistically significant
Table 8 below shows the unadjusted and the corresponding adjusted odds ratios that were retained in the final model. The odds ratios of: location of the village, knowledge of ASRH services, belief in existence of payments for ASRH services, respondents who had ever engaged in sexual activity and perception of providers were statistically significant before and after adjustments. Age of respondents, sex, tribe, waiting time before being served, education level, and perception of the ASRH services turned out to be statistically insignificant after adjustments. This therefore means that the model was able to adjust for confounding in these variables.

Table 8: Comparison of the unadjusted with the adjusted Odds Ratios of variables that were significant for utilising ASRH services:

<table>
<thead>
<tr>
<th>Variable</th>
<th>Unadjusted OR</th>
<th>95% CI</th>
<th>Adjusted OR</th>
<th>95% CI</th>
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<tr>
<td>LC 1 Village location</td>
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<tr>
<td>Urban</td>
<td>10.85*</td>
<td>6.85 – 17.29</td>
<td>7.00*</td>
<td>2.04 - 24.04</td>
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<tr>
<td>Rural</td>
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<td></td>
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<td>Ever had sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6.53*</td>
<td>3.31 – 13.20</td>
<td>28.82*</td>
<td>7.13 - 116.60</td>
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<tr>
<td>No</td>
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<td></td>
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<td></td>
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<tr>
<td>Knowledge of ASRH</td>
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<tr>
<td>Yes</td>
<td>23.11*</td>
<td>13.84 – 38.91</td>
<td>11.56*</td>
<td>3.54 – 37.76</td>
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<tr>
<td>Payment for services</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.04*</td>
<td>0.01 – 0.12</td>
<td>0.21*</td>
<td>0.10 – 0.62</td>
</tr>
<tr>
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<tr>
<td>Perception of providers</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Friendly</td>
<td>2.36*</td>
<td>1.17-4.72</td>
<td>4.51*</td>
<td>1.29 - 7.61</td>
</tr>
<tr>
<td>Rude</td>
<td></td>
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</tr>
</tbody>
</table>

* Statistically significant
CHAPTER SEVEN

Discussion
This study was designed to determine the factors influencing utilisation of Adolescent Sexual Reproductive Health Services in Iganga District. Utilisation of ASRH services was 210/738 which is 28.5% while non-utilisation was found to be 528/738 which is 71.5%. The records with DDHS had indicated that utilisation of ASRH services was 40% and non-utilisation was 60%. The difference is due to the fact that health facility based data is biased and does not represent the whole population while the statistics from this study are population based and therefore more reliable. There is also the element of poor records management of the HMIS system.

The factors considered were socio-demographic characteristics (age of respondent, sex, occupation, religion, tribe, location of LC I Village, whether respondent had ever had sex, headship of household, and parental guidance), Knowledge of the ASRH services, Attitude of the respondents towards the services, and Accessibility factors of the adolescents to the available ASRH services as further elaborated below.

Social economic and demographic factors
The socio-demographic factors that were found to be significantly associated with utilisation of ASRH services in this study included whether the respondent had ever involved him/herself in sexual activity and type of the LC I Village whether urban or rural.

Respondent’s sexual activity
This study significantly established that the older the adolescent became, the more likely that she/he would utilize ASRH services, and the younger the adolescent the less likely to utilize the ASRH services OR 4.94 95% CI 2.98-8.19, (p=0.0000000). This is also related to the finding in this study that utilisation of ASRH services was significantly more in adolescents who had started sex than in those who had not. The UDHS of 2001
established that girls get initiated into sex activities earlier than boys. It is likely that the sexual activities then impose a need for ASRH services like condoms and contraceptives and therefore the more utilisation of the ASRH services in girls than boys. The UDHS of 2001 established that by 17 years of age, 75% of adolescent girls had already had sex and were more likely to have utilised family planning services. All these findings are in line with previous studies: Atuyambe (1998), in the study of health care seeking behaviour for sexually transmitted infections among adolescents established that older adolescents were less likely to fear to disclose their sexual problems and more likely to utilize health care services (p< 0.01). Nalugwa (1991), in the factors influencing contraceptive knowledge attitude and practice among adolescents in western Uganda pointed out that early initiation of sex and early pregnancy were responsible for increase in use of family planning services especially the pill and depo-provera in Western Uganda. As they grow, adolescents become more assertive and open minded in sexuality.

**Location of LC I Village**

Adolescents in the urban area were significantly more likely to utilize ASRH services than those in rural area (p=0.00001) OR 10.85 95% CI 6.85-17.29. The UDHS (2001) pointed out that urban women were much more likely to use modern contraceptives than rural women (46% compared with 19%). This may be due to the urban adolescents having more exposure to information from mass media and theatres which their counterparts in rural settings don’t have. Rural settings adolescents are poorer than their urban counterparts as the majority depend on peasant farming whereby any earning of money is at end of harvest seasons (after 3-5 months) while urban counterparts earn daily from trade and casual labouring. This implies that the urban dwellers are likely not to fear payments and therefore utilize the ASRH services more than the rural adolescents. In this study it has been established that inability to pay for services significantly limited
adolescents to use the ASRH services in Iganga District. There is also the fact that the ASRH services are more available in urban settings than in rural areas.

Knowledge of the ASRH services

Having knowledge about the package, location and the source of the information were significant factors in utilisation of the ASRH services (p value=0.00001). There is generally lack of knowledge about ASRH services in Iganga District as more than half of the adolescents (54%) are not aware of the package of ASRH services or where the services are located and this was accounting for the low utilisation level of only 28% as discovered in this study. This study has demonstrated the effects of lacking knowledge adversely affecting utilisation of ASRH services, a finding which is in agreement with the UDHS report (2001) which asserts that use of contraceptives is lower in the unknowledgeable than in those who know the existence and type of family planning methods available for use.

Quamrun et al (2000) in their study of knowledge attitude and practice of adolescents relating to contraceptive use in Bangladesh; information was collected on knowledge factors in addition to attitude, practice, socio-cultural and economic factors. They found significant association of knowledge with utilisation of contraceptive (OR=2.65, 95% CI=1.3-5.6). This study agrees with them where having knowledge of availability, location, package and good source of knowledge were significant for utilisation of ASRH services (p-value=0.00001, OR=11.56, 95% CI=3.54 - 37.76). Nalugwa (1991) in her study of factors influencing contraceptive knowledge attitude and practice in Western Uganda had similar findings. It was significantly established in this study that utilisation of ASRH was associated with knowledge got from health workers than from other sources OR 10.00 95% CI=6.50-15.41). This finding is also in line with what Ntozi (2001) observed in his study of sexual behaviours and practices of adolescents in Sub-
Saharan Africa where it was concluded that knowledge affected the practice of adolescents. Truly one utilises or practices what one clearly understands and knows.

**Perception/Attitude of the adolescents towards the providers of ASRH services**

In this study, the attitude towards providers was significantly influencing utilisation of the ASRH services whereby those who believed that the providers were friendly were more likely to use than those who felt providers were rude O.R. 4.51 95% CI 1.29-7.61. Those who felt that providers were friendly were 4.51 more times likely to use than other views. This finding agrees with the (WHO 1999) in the newsletter entitled ‘challenges of meeting the special needs of adolescents and young people’ in which it was observed that utilisation of services depends on the degree of humility of health workers. Where health workers are friendly to customers and observe ethical code of conduct, utilisation is bound to be optimum. In the (WHO 2000 report – responsiveness to adolescents problems and its distribution), it is observed that where health workers give respect for persons and provide autonomy on choice of therapy, the relationship is friendly and utilisation of services is observed to improve.

**Accessibility to the ASRH services**

In this study geographical accessibility was not significantly associated with utilisation of ASRH services OR 0.86 95% CI 0.59-1.26 p.value=0.4. This finding differs from that of Gish (1990) in his study of some links between successful implementation of PHC interventions and utilisation of health services; and that of Katende (1994) in his study of the impact of access to health services on infant and child mortality in rural Uganda where they both concluded that utilisation of services is improved by improved proximity to the service. The issue of insignificant geographical accessibility can be explained on the majority of adolescents lacking knowledge of the close-by ASRH services. However, the finding of insignificance of geographical accessibility in this study agrees with that of
Sengooba and Mcpake (2004) (financing maternal health services) in which they concluded that geographical access and being near to health facilities does not necessarily translate into utilisation of health services.

A belief by adolescents that there were payments made for the ASRH services was established as a significant barrier to utilisation of ASRH services-adjusted OR 0.21 95% CI 0.10-0.62 with p-value of 0.005. The majority of adolescents belonged to peasants’ class and therefore are poor people who can not afford services which they do not have adequate knowledge about and which they deemed useless.

Limitations

Determination of the ages of the adolescents accurately was a problem especially for those without birth cards. This may have led to inclusion of participants who did not qualify. However the research team tried as much as possible to verify the ages of respondents from their birth, immunization and baptism records.

Being a descriptive cross sectional study employing cluster sampling, inherent in this study was the problem of variability introduced by the cluster sampling technique. Design effect adjustments were done to address it.
CHAPTER EIGHT

Conclusion

All socio-demographic factors in this study were comparable between those who were using and those who were not using ASRH services except location of LC I Village and whether the respondent had never had sex that were found to be significantly influencing the utilisation of the ASRH services.

In Iganga district, having knowledge of availability and packages in ASRH services, good quality knowledge obtained from health workers, and knowing where the ASRH services are situated were found to be associated with the utilisation of ASRH services.

Good attitude towards providers where adolescents feel and know the providers are friendly was found to be associated with utilisation of ASRH services in Iganga District. Poor attitude to the services providers was hindering utilisation of the ASRH services.

In Iganga district, beliefs that there were payments for the services was limiting accessibility to, and hindering utilisation of the ASRH services. Geographical accessibility was found not to be associated with utilisation or non-utilisation of ASRH services.
Recommendations

The Iganga DHT should sensitize the community about existence, location and goodness of ASRH services. The DHT should facilitate the health workers to be vigilant in talking to the adolescents about ASRH services and should teach the adolescents on the importance of ASRH services. For those who still believe that there are payments to be made, they should be informed that the ASRH services are free of charge and have their confidence built in that regard. Health workers should use the mass media and also orientate teachers in delivery of correct ASRH messages to address the knowledge gaps.

The DHT should formulate ways of demonstrating to the adolescents that the ASRH services are useful. The district should address rudeness of staff possibly through reducing overworking by recruiting more man-power and motivating them to do the work well.

Though geographical access in this study was not associated with utilisation or non-utilisation of ASRH services, the DHT should not relax in improving geographical coverage by constructing health units in each parish and equipping them well to provide ASRH services.

The DDHS Iganga should prioritize further research to identify factors leading to poor utilisation of ASRH services in the rural areas in the district when compared to the urban areas. Research should also be done on quality of the available ASRH services and how friendly to adolescents the services are, and ascertain the current geographical coverage levels in the district.
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APPENDICES

APPENDIX I

Study tools

Questionnaire

Demographic and House hold related characteristics

COUNTY: .................................................................
SUB-COUNTY: .........................................................
PARISH: ............................................................... 
LCJ/ Village: ...........................................................

1. Questionnaire Code No: __________
2. Date of interview: ______/____/2007
3. Age __________
4. Sex __________
   Male (1)
   Female (2)

5. Religion __________
   Muslim (1)
   Catholic (2)
   Protestant (3)
   Born again (4)
   Other (5) (.....................)

6. Tribe __________
   Soga (1)
   Ganda (2)
   Samya (3)
   Teso (4)
   Other (5) (.....................)

7. Education level of respondent __________
   Nil (1)
   Primary (2)
   Secondary (3)
   Tertiary (4)

8. Marital status of respondent __________
   Single (1)
   Married (2)
   Widowed (3)
   Divorced (4)

9. What is your occupation? __________
   Peasant farmer (1)
   Market vendor/trader (2)
   Casual labourer (3)
   Civil Servant (4)
   Student (5)
   Other (specify) (6) __________

10. What is the occupation of the head of household? __________
   Peasant farmer (1)
   Market vendor/trader (2)
   Casual labourer (3)
Civil Servant (4)
Other (specify) (5)

11. Who of your parents is alive? ______
Both parents (1)
Father (2)
Mother (3)
None (4)

12. What is the gender of your head of household? ______
Male (1)
Female (2)

13. What is your relation to the household head? ______
Father (1)
Mother (2)
Aunt (3)
Sister (4)
Brother (5)
Other (Specify) (6)

14. Have you ever had sex? ______
Yes (1)
No (2) (if No go to 18)
Declined to answer (3)

15. What was your age at first sexual contact (in years) ______
16. Have you ever been pregnant (F) made somebody pregnant (M)? ______
Yes (1)
No (2) (If no, go to question (18)

17. What was your age at first pregnancy (in years) ______

Knowledge on ASRH services:
18. What are the services provided under ASRH? (Tick all responses given)
1. Family Planning
2. STD treatment
3. VCT for HIV/AIDS
4. Child care
5. ANC
6. Abortion services
7. Post Abortal care services
8. Condom use
9. I don’t know (If don’t know go to question.20)
10. Others (specify)

19. Who gave you information about ASRH? (Tick all responses given)
1. Parent
2. Teacher
3. Health worker
4. Friend
5. Aunt
6. Others (specify)
7. Nobody

20. Where is one likely to receive ASRH services? (Tick all responses given)
1. Drug Shop
2. Health Unit
3. Traditional Healer
4. Home
5. Church/Mosque
6. No where
7. Others (specify)

**Attitude of adolescents towards ASRH services**

21. Have you ever used any ASRH service? ____________
   Yes (1)
   No (2) (If no, go to question (23))

22. What service did you use? (Tick all responses given)
   1. Family Planning
   2. VCT for HIV/AIDS
   3. Condom use
   4. ANC
   5. Child care
   6. STD treatment
   7. Abortion services
   8. Others (specify)
   9. Nothing

23. If no why? (Tick all responses given)
   1. Stopped schooling
   2. Is pregnant
   3. Was stopped by parent
   4. Was stopped by religious leaders
   5. Does not have money
   6. Don’t know the use
   7. Don’t know where to find services
   8. Culture against
   9. Others (specify)

24. Do you intend to use ASRH services in future? ____________
   YES (1)
   NO (2)

25. What do you think about the ASRH services? ____________
   1. Useful
   2. Useless
   3. Don’t know
   4. Others (Specify)

26. What are your beliefs about using pills? (Tick all responses given)
   1. May cause infertility
   2. May cause cancer
   3. Reduces sexual pleasure
   4. become fat
   5. become thin
   6. Reduce appetite
   7. Others (Specify)

27. What are your beliefs about using condom? (Tick all responses given)
   1. Reduces sexual pleasure
   2. Causes pain
   3. Causes cancer
   4. No effect
   5. Can break and enter the uterus
6. I don’t know
7. Others (Specify) ————-

Accessibility of adolescents to ASRH services
28. How long do adolescents take to reach the nearest ASRH service point?
   (———)

29. Do you think adolescents pay for the services? ————-
   Yes (1)
   No (2) (If no, go to question 31)
   I don’t know (3)

30. Do you think adolescents get receipts for the payment made? ————
   Yes (1)
   No (2)
   I don’t know (3)

31. What do you think is the behaviour providers towards adolescent seeking help from them? ————
   Very friendly (1)
   Friendly (2)
   Rude (3)
   Very rude (4)
   Not friendly and not rude (5)
   Don’t know (6)

32. At the service unit, how long do you think adolescents have to wait before seeing the provider?
   ————
   Very long (>30 minutes) (1)
   Long (10 to 30 minutes) (2)
   Short time (<10 minutes) (3)
   Don’t know (4)

33. At the service point, who do you think serves the clients? ————
   Qualified provider/health worker (1)
   Nursing Assistant (2)
   Local council leader (3)
   Community provider (4)
   Other (specify) (5) ————
   Don’t know (6)

34. How do you think adolescent can be encouraged to use the ASRH services? (List all responses given)

THANK YOU SO MUCH FOR YOUR TIME
APENDIX II

Key informative guide:
As you may be aware Adolescents are not utilising ASRH services in Iganga District thereby leading to a number of Adolescent Sexual reproductive Health problems like unwanted pregnancies, abortions, early adolescent marriages, dropping out of schools, maternal morbidity and mortality;

1. Do you think the adolescents know what ASRH services are, and where do you think they learnt it from?
2. Where do you think adolescents go for ASRH advice?
3. How do communities influence the way ASRH services are run?
4. What do you think about the ASRH services provided in the district?
5. How do you think adolescents perceive the idea of going for ASRH services?
6. What mechanisms are in place to check performance of staff providing ASRH services?
7. What practices do you think affect adolescent’s pattern or trend of utilising ASRH services?

1. How do you think we can encourage adolescents to utilise ASRH services?
2. How do you finance ASRH services and what problems do you experience in providing ASRH services?
3. Do you think there are any payments made by the adolescents for the services?
4. How often do you experience stock outs for drugs and ASRH supplies?

Thank you for your time
APPENDIX III

Focus Group discussion guide

Date of FGD.............................................

LC I Village..............................................

1. Are there adolescents who utilise ASRH services?
2. What are the reasons for adolescents utilising ASRH services?
3. Are there some adolescents who do not utilise ASRH services?
4. What are the reasons for adolescents not utilising ASRH services?
5. Are there any costs involved in provision of ASRH services?
6. How much is paid?
7. How do adolescents meet cost for ASRH services if any?
8. What do adolescents like most at ASRH service points?
9. What do adolescents dislike most at ASRH service points
10. How far is the service point for ASRH services?
11. How do adolescents reach the services points?
12. What can be done to support adolescents to utilise ASRH services?

Thank you all for your time
APPENDIX IV
Check List for ASRH services

- STD treatments services
- STD diagnostic services
- VCT
- PMTCT
- ANC
- PNC
- YOUNG Children’s CLINIC

- FAMILY PLANNING INCLUDING EMERGENCY CONTRACEPTION
  
  Oral Pills
  Condoms
  IUCD
  Foaming Tablets
  Safe Period
  Nor-Plant
  Withdrawal

- ASRH services health education sessions
- Nutrition Education sessions
- Nutrition assessment e.g. weighing
- Immunisation
- Sex Education
- AIDS care and Support services
- ART
- Treatment of opportunistic infections
- ASRH-IEC materials like straight talk.
- Life Planning Skills services
- Abortion services
- Post Abortal Care
- Counseling Services and support for unwanted pregnancy
- Support for the prevention and protection of harmful traditional practices
Appendix V:

Consent Form for quantitative interviews.

Good morning/good afternoon sir/madam,

I have been permitted by the Makerere Institute of Public Health and the District Director Health Services (DDHS) Iganga District to carry out a study on the factors influencing utilisation of ASRH services in Iganga district. This will be by asking your child/you some questions and requesting for the answers from the child/you. The information generated by this study will help Iganga District design an appropriate approach for utilisation of adolescent reproductive health services to its population. I am requesting you therefore to voluntarily provide all the information required during the study. All information collected will be kept confidential. You are free to withdraw from the interview any time at your own discretion.

Now if you have no questions we can proceed.

I the undersigned Parent/Guardian/Respondent have understood the above information about the study and hereby consent to supply (child to supply) the required information.

______________________________  ________________________________
Witness’s signature (RA)        Parent/Guardian/Participant’s signature/Thumb print (Optional)

Researcher ---------------------  Date -----------/-/2004
Appendix VI

Consent Form for Focus Group Discussions

Good morning/afternoon to you all. I welcome you to this group discussion and thank you for coming.

I am (name of interviewer)…………………from the office of the District Director of Health Services Iganga. I together with my colleague(s) are conducting a study on Factors Influencing Adolescent Sexual Reproductive Health Services in Iganga District. The purpose of this study is to look for possible reasons why some adolescents use ASRH services while others do not use the services. We are here to learn from you and gather information about you. My job is to direct the discussion so that you will have a chance to speak your mind.

Let me take this opportunity to introduce Mr./Miss…………………………… She/he will be taking notes and I beg for your permission to let him/her tape record your comments so that we can be sure that everyone’s opinion is correctly noted. All information collected will be treated confidentially. No one except the research team will hear these comments. The information that you give us will be used by the District health officials together with Ministry of Health to implement interventions that will enhance utilization of ASRH services to reduce adolescent morbidity and mortality.

We are requesting you to participate in this study. Your participation is entirely voluntary and you are free to withdraw from this study at any time without penalty. You are free to ask questions about this study or what I have just talked to you about.

Please do sign this form if you have accepted to participate in this study.

Thank you for your valuable time.

Signature (or thumbprint) of Respondents:

1)........................................ 11)........................................ 21)........................................
2)........................................ 12)........................................ 22)........................................
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8)........................................ 18)........................................ 28)........................................
9)........................................ 19)........................................ 29)........................................
10)........................................ 20)........................................ 30)........................................

Signature of interviewer:................................. Date:.................................